VOICE

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"Are you an innovator or an implementer?" A colleague at a philanthropy conference posed the question to me, just one year into my work as a program officer at The Leona M. and Harry B. Helmsley Charitable Trust. At the time I had not thought about it. As a new trust we were moving rapidly, working to manage existing grants, researching potential projects and partners, and making new grants—all while building internal infrastructure. As one of the primary focus areas within the Trust, the Rural Healthcare Program was just beginning to form an identity: operating from a strategic plan created by consultants. Now, the Rural Healthcare Program is four years old. We have been out in the field, updated and made the strategic plan "ours," and are starting to create an identity—an identity that I feel focuses primarily on innovation and on sharing our voice.

As a new funder bringing new resources to a seven-state geographic focus area, including Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, and Wyoming, the Trust brings a new perspective to health care philanthropy. Our focus, simply stated, is improving access to quality care. "Access," according to the Rural Healthcare Program is just that: Do residents have access to a physician or hospital within a reasonable number of miles or minutes? Can an ambulance staffed with volunteer emergency medical services (EMS) personnel rapidly respond and transport residents to receive care in a timely manner?

Access also ties to quality. When access to care exists, what will it be like? Will EMS personnel be well-trained and up-to-date on training? Will the hospital have access to the type of specialist needed? Is the local facility able to provide the care required or appropriately stabilize and prepare for transfer to a larger facility? If advanced treatment is necessary, how far must a resident travel, how new and safe is the equipment?

Improving access and quality in rural health necessitates creating innovative new systems of care. The Rural Healthcare Program has used its voice to convene stakeholders, state government, and health care systems and providers to address the access and quality challenges collaboratively. It is not always a popular position and some entities prefer to go it alone, but we know that with scarce resources and sparse, spread-out populations we all must work together. As the Rural Healthcare Program has "grown up" over the past four years, we found a niche in the area of health care delivery via technology (telehealth) that improves both access and quality. Telehealth offers a solution to health care professional workforce shortages and the difficulty of recruiting and retaining in rural areas. Implementing innovative and comprehensive telehealth models, especially in extreme rural and frontier areas, is challenging. Creating the infrastructure for a hub-and-spoke system is time and resource consuming– and every health system typically wants its own hub. Health care systems do not want to use another system's services. Yet to make a feasible, affordable, and sustainable model, a system needs more than its own network to participate. Over the past four years, the Rural Healthcare Program has been reaching out to systems and independent rural hospitals to educate and rally people to work together. We have become a leader in providing telehealth funding because of the needs in this region.

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Our focus on this niche reaches beyond our geographic service area. Recently the Rural Healthcare Program nominated Avera eCare (the telehealth hub-and-spoke model, which the Trust has funded in the upper Midwest) to the Social Impact Exchange for other philanthropic organizations and individuals to fund the scaling of this model nationwide via regional hubs. We want to share this and other innovative ideas and models, models that work in the upper Midwest, with the rest of the country. The Trust believes if a model can work in a frontier or rural area, it

can work in other areas of the country as well. We invite policymakers, health care system leaders, philanthropic colleagues, and entities interested in health care delivery via technology to learn about and observe projects that we have funded and to share what we have learned.

In addition to sharing our innovative models and what we have learned, how should we be using our voice? The program is listening to other foundations, learning from their experiences, and working in more collaborative ways—and we need to do more of that. We should be using our voice to do more sharing and education in conjunction with and following funded projects. In addition to expanding telehealth, we have listened to the voices of our native tribal leaders and people to understand their unique health care system and immense disparities. We are using our voice to suggest that the best option may be to negotiate for self-determination of health care services by each respective tribe. A toolkit has been created to lay out the options, obstacles, benefits, and steps to help tribes with self-determination. We want to use our voice to share with other potential funders, government entities, and health care systems and work together on how to most effectively decrease the health care disparities and improve access for American Indians. We are giving a continued and future voice to this effort by helping to create an American Indian Public Health Resource Center. We will continue to listen to the voices of the people we aim to help so that projects are culturally appropriate and relevant.

We also know we can and should do more. As we learn about and become more involved with telehealth and tribal health disparities, we need an awareness of the advocacy efforts going on in those areas. We need to assist in educating our peers, our partners, and our leaders. It is essential that we are a part of rural America's voice. Recently a South Dakota and Montana rancher, businesswoman, and philanthropist posed the question to me, "How do we keep 'rural' relevant?" She had recently returned from a national meeting where the decreasing rural population was a point of discussion. How do we gain attention to rural issues and needs when the population is significantly less than urban areas of the country? The simple, obvious answers are the importance of the core agricultural economy and food production that happens here, but there is a sociological aspect as well. There is a distinct way of life in the upper Midwest. There are incredible work ethics and morals, multigenerational homesteads and farms— a way of life that is at risk. We need to be the voice that says, "Just because someone chooses to live where fewer people reside, they still deserve access to quality health care."

We also need to be a reasonable and sensible voice. Because there are huge expanses of sparsely populated areas, we need to be open to cost-effective ways to provide health care in rural and frontier regions. We should get involved in the public debate about Critical Access Hospitals. It is not a pretty debate, and we will not make friends by using our voice. The point of debate: Should all of the existing Critical Access Hospitals maintain their status and continue to receive the current reimbursement? Advocacy groups say yes. Is that reasonable or feasible? I do not see how it could be. Do we have a better idea or model? Not yet, but we continue to learn; we watch how the Affordable Care Act is impacting rural health care; we follow access, workforce, delivery, and telehealth models; we work with groups like the Rural Policy Research Institute (out of the University of Iowa) to dig into issues affecting rural health care.

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So, rounding back to the original question mentioned earlier: "Are you an innovator or an implementer?" After my three fleeting years at the Trust, I think I can now confidently say that the primary focus of the Rural Healthcare Program is innovation; however, we are also implementers and adapters—implementing and adapting proven models and making them work in extreme rural and frontier areas. We are also a voice. As we work to collaborate and share what we have learned, we have been finding our voice and sharing our experiences. We have served as eager students and fledgling educators. I see the discovery and purposeful utilization of our voice as another milestone in our growth and maturation as a funder.