Published in final edited form as:
Am J Community Psychol. 2013 March ; 51(1-2): 206–216. doi:10.1007/s10464-012-9515-9.

Rural Embedded Assistants for Community Health (REACH) Network: First-Person Accounts in a Community-University Partnership

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Abstract

Community research and action projects undertaken by community-university partnerships can lead to contextually appropriate and sustainable community improvements in rural and urban localities. However, effective implementation is challenging and prone to failure when poorly executed. The current paper seeks to inform rural community-university partnership practice through consideration of first-person accounts from five stakeholders in the Rural Embedded Assistants for Community Health (REACH) Network. The REACH Network is a unique

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community-university partnership aimed at improving rural health services by identifying, implementing, and evaluating innovative health interventions delivered by local caregivers. The first-person accounts provide an insider's perspective on the nature of collaboration. The unique perspectives identify three critical challenges facing the REACH Network: trust, coordination, and sustainability. Through consideration of the challenges, we identified several strategies for success. We hope readers can learn their own lessons when considering the details of our partnership's efforts to improve the delivery infrastructure for rural healthcare.

Keywords

Community-Based Participatory Research; Community-University Partnerships; Collaboration; Rural Health Care; Rural Elderly; Health Education; Prevention

Introduction

Compared with urban Americans, rural residents have higher poverty rates, a larger percentage of elderly, poorer health, and insufficient access to health care services (Jones, Parker, Ahearn, Mishra, & Variyam, 2009). These disparities have increased markedly in recent years, as reflected in a mortality rate disparity that increased 10 fold between 1989 and 2004 (Cosby et al., 2008). There is an urgent need to develop more effective models for providing access to health promotion services for the rural elderly, as current rural health services are typically lower quality and fewer in number (Butler & Kaye, 2004). Community-university partnerships are a promising approach to improving fragmented health service delivery systems, as they can improve coordination, reduce expensive redundancies, and enhance system capacity to advocate for policy reform and deliver innovative services (Nowell, 2009).

This paper aims to inform the practice of rural community-university partnerships and the implementation of an innovative rural preventive healthcare delivery system, tailored to meet the needs of our aging population in a period marked by both unprecedented longevity and growing shortages of primary care physicians, particularly within the rural regions of the country (Rosenblatt & Hart, 2000). To achieve these aims, we present a case study of the Rural Embedded Assistants for Community Health (REACH) Network, a community-university partnership aimed at improving rural health services in Pennsylvania through the identification, implementation, and evaluation of innovative health interventions delivered by locally-embedded caregivers. Key participants involved in the REACH Network generated first-person accounts to provide a diverse while cohesive midterm, formative perspective on the performance of REACH. The first-person accounts were developed to offer insight into the successes and challenges of REACH, including implementation issues critical for success. As the narratives illustrate, our collaborative experience has afforded us a common perspective on the nature of the challenges inherent in the process of developing rural community-university partnerships such as REACH. Our concluding discussion reviews these challenges, proposing tangible strategies to overcome each, as part of a concerted effort to assure the success of the REACH network in the years ahead.

A Partnership Approach to Rural Health

As a community-university partnership, REACH addresses a number of criticisms leveled against modern day institutions of higher learning, including their progressive commercialization, lost sense of civic purpose, and growing tendency to conduct research disconnected from real world problems and issues of societal importance (Bridger & Alter, 2006a). The partnership approach provides a more interactive relationship between

university and community that is characterized by reciprocity, rather than the traditional approach to outreach involving a one way transfer of information from the university to stakeholders. The development of ongoing, trusting reciprocal relationships between partners is essential for community development efforts to be effective, as the new relationships help compensate for the contemporary shift away from stable and predictable social relations that compromises social capital (Bridger & Alter, 2006b; Putnam, 2000). The reciprocal relations are also important because they aid the design of interventions that are culturally appropriate to the unique rural context (Stacciarini et al., 2011).

The REACH Network's use of participatory decision making has several advantages over more traditional unidirectional top-down decision making processes (Minkler & Wallerstein, 2003). Involving community members affected by the topic under study helps to ensure that research and action is consistent with the priorities of the local community and is contextually relevant (Cargo & Mercer, 2008). Further, the participatory process enhances local capacity and ownership, making subsequent action informed by the research more locally sustainable (Israel et al., 2006). Despite the clear advantages of community-university partnerships, successful implementation remains difficult and numerous pitfalls exist, such as insufficient trust between partners, lack of appreciation for partner's strengths, and an inequitable power distribution (Wallerstein, Duran, Minkler, & Foley, 2005).

The relative economic, political, and social isolation of rural communities means that their access to information, resources, new and progressive ideas, and possible sources of assistance are attenuated (Beaulieu & Israel, 1997). Community-university partnerships may be especially powerful in rural communities because they can help to reduce this isolation, building connections to innovative ideas and external resources. Although the potential benefits are compelling, partnerships must be handled carefully, as the isolation of rural areas leaves them vulnerable to exploitation by powerful external forces (Duncan, 2001).

Cooperative Extension is well positioned to facilitate community-university partnerships in rural communities, as they have a long standing presence in the community and can serve as a trusted link between university researchers and local residents (Molgaard, 1997). The dense social networks found in rural communities make it easier to include all relevant parties in a collaborative effort, but also complicate collaboration because of overlapping roles in different contexts, such as professional and private life (Corbie-Smith et al., 2011). As such, it is important to be conscientious of these interpersonal dynamics during collaboration. Overall however, a dense social network should facilitate collaboration, as strong relationships among partners are especially important when pursuing broad systems change efforts, such as those of the REACH Network (Nowell, 2009).

The REACH Network

The REACH Network is a multidisciplinary community-university partnership dedicated to enhancing evidence-based rural healthcare programs, as delivered by local caregivers, and to improving local health outcomes while reducing disparities. REACH is a collaborative effort among local community leaders and citizens, faculty and educators, researchers, and regional health care providers in central Pennsylvania. REACH targets two counties characterized by low population densities, containing either one or no hospitals, having few healthcare professionals, and populations of nearly 20% elderly (Center for Rural Pennsylvania, 2010). The conception of the REACH Network idea was generated through discussion between a small group of physicians, scientists, and research staff members from the spring of 2008 to the winter of 2009. During this time, the initial group also reached out to individuals involved with cooperative extension, who could help bring the ideas to fruition through collaboration in the community.

A local rural extension office was identified that could help provide a setting for the REACH Network to be launched. The location was a good one because the extension office had become a university learning center addressing the three missions of the university (research, teaching, service), whereas most extension offices in the state provide non-formal issue-based education programs. The REACH project could help the extension office establish itself as a center for community based participatory research and outreach. The Extension Director was critical in facilitating engagement in the REACH Network Community Advisory Board, as he worked directly in the community on several projects with various community organizations. His office, the learning center, was also the hub of several health related activities such as a site for college health courses in partnership with the local hospital and a health teaching laboratory. The extension office was also advantageous for the REACH Network in that it was next door to the aging services center.

In 2009, the initiators of REACH tasked themselves with identifying, inviting, and encouraging community members to become Community Health Assistants (CHAs) and representatives on the Community Advisory Board (CAB). The community was able to identify motivated individuals to participate and represent local interests. Together, these individuals along with university partners defined the scientific design, expectations, and endorsements of the REACH initiative. The REACH Community Advisory Board (CAB) serves as a consensus decision-making hub that helps to foster ownership among stakeholders. Each person in the CAB has equal representation. Members often represent a larger organization (e.g. a nursing association, an aging association, the county hospital), which helps to enhance the capacity of the REACH Network through the development of collaborative relationships with influential community organizations.

Community representatives on the CAB included members from the local hospital, a local well-respected physician, emergency medical support, home health care, a science teacher, and a cooperative extension director. University personnel came from numerous professional backgrounds including community outreach education, family and consumer science, emergency medicine, nursing, clinical neuropsychology, evaluation research, agricultural, environmental and regional economics, and landscape arts and architecture. Initially, most of the committee members did not know each other. Over time, we have developed more clarity of each other's expertise, along with more trust and concern for one another. The advisory committee meeting agendas are planned so that all voices have an opportunity to add agenda items, make presentations, ask questions, share information, contribute to decision-making, and help with follow-up.

The efficacy of the REACH Network model is grounded in the idea that health communication efforts are more successful when transmitted by trusted individuals (Balamurugan, Rivera, Sutphin, & Campbell, 2007; Street, Makoul, Arora, & Epstein, 2009). Locally-embedded community health assistants (CHAs) are ideally positioned to establish trusting, long-term relationships with community elders through regular home visits, during which time they can conduct in-home health assessments and share health information on a variety of topics. Although the REACH Network did not set out to focus exclusively on health services for the elderly, the need for elderly services was perceived to be high, as Pennsylvania has the second highest proportion of elderly residents across all 50 states (Florida is highest), many of whom are independently living rural elderly (U.S. Census Bureau, 1996). We therefore focused our initial efforts on the underserved independently living rural elder population.

To date, the REACH Network has specifically focused on the implementation and evaluation of two health education interventions that target the elderly. In the first intervention, CHAs conduct a home safety assessment aimed at identifying fall hazards.

CHAs then share the data with elders and work with them to improve home safety. The focus on fall-related injuries was justified by the fact that falls are the leading cause of accidental death among the elderly (George, 2008). The second intervention targets flu immunization. Influenza and pneumonia are the sixth leading cause of death in the United States, and flu immunization has a net cost savings of $117 for each elderly person vaccinated (Centers for Disease Control and Prevention, 1995, 2000; Nichol, Margolis, Wuorenma, & Von Sternberg, 1994). CHAs educate elders about why and how to get immunized for the flu. We are evaluating both of these interventions in a randomized control trial. If evaluation findings are encouraging, we will use them to seek funding for overall sustainability and to disseminate services in a larger region. In the interim, we will continue our collaborative partnership aimed at identifying cost-efficient methods for the delivery of preventive health education and services in this rural community.

Collaboration and Power in the REACH Network

To understand the REACH Network, it is helpful to consider it in the context of a continuum of partnership approaches (May, 2011). At one end of the continuum is the “consent” model, where the university requests and the community consents to research being conducted in the community, but community members have nothing to gain from the research. A modestly more collaborative approach is the “cooperation” model, where the community consents to research and receives incentives for their cooperation. At the next level is the “collaboration” model, where the university invites the community to be involved in some but not all aspects of the research process. Finally, in the full “partnership” model, the community invites the university (or vice versa) to collaborate in all phases of the research process as equals (May, 2011). The REACH Network invited community members to participate in the research process as equals after receiving grant funding. Thus, community members had substantial influence over the course of the research project but not at its conception.

Whether the university or community initiates the research project fundamentally influences the power dynamics of the partnership. The project initiator sets the initial agenda and often facilitates the collaborative process, both of which carry tremendous power (Nation, Bess, Voight, Perkins, & Juarez, 2011). A systematic review of the partnership literature found that most partnerships are initiated by university personnel, who seek to form a community advisory board, as was done by the REACH Network (Viswanathan et al., 2004). Thus, the REACH Network faced the common challenge of creating an equitable partnership despite power differentials in the conception phase of the project. One strategy the REACH Network uses to balance power is to have a community member and a university employee serve as co-chairs of the CAB, thus sharing the powerful group facilitation responsibilities between university and community partners. Another strategy is to hold meetings in the rural community rather than at the university or via phone. This strategy requires substantial travel time on the part of university partners but aids the development of relationships and a shared understanding of the community.

First-Person Accounts

The REACH Network decided to pursue a first-person accounts paper because we felt it would be a good opportunity for multiple stakeholders to reflect on and share with others their perspectives on our collaborative processes, along with how some of our efforts have succeeded while others have not. Consideration of stakeholder perspectives is particularly important because we want to avoid marginalizing stakeholder voices. The least-privileged stakeholders; typically the target population of a community partnership, often have the smallest voice in intervention planning processes (Lasker & Guidry, 2009). If these voices

are marginalized, programs become disconnected from the needs of the target population and fail because of insufficient understanding of the problems at hand (Creighton, 2005; Fraser & Lepofsky, 2004).

The first-person accounts provided each individual stakeholder an opportunity to carefully reflect on how the collaboration has progressed thus far, including what has worked well and where we have struggled. Collective consideration of all first-person accounts as a group provided us with an opportunity to celebrate what we had achieved thus far, concomitantly clarifying for us where we were falling short and what we could do about the REACH Network collaboration moving forward.

We wanted the narratives to contain a diversity of perspectives, while still including those individuals most central to the REACH Network. Thus, we agreed to have two narratives from university employees who were central to the conceptualization and execution of REACH Network activities. We also sought out narratives that could represent the perspective of three key community partner constituencies: 1) local health service providers involved in shaping REACH Network activities; 2) community health assistants involved in delivering REACH Network services; and 3) elders who received REACH Network services. These five first-person accounts represented almost one third of the active REACH Network membership, as 17 individuals responded to a REACH Network collaboration survey administered at approximately the same time the first-person accounts were written.

First-person account authors were required to reflect deeply upon their experience with REACH. This reflection process consisted of two phases. The first phased consisted of the five chosen authors simply writing a reflection on their personal REACH experience. These reflections were edited for readability and style, but their substance was not altered. The second phase consisted of discussing the recurring issues and challenges addressed in the first-person accounts. Following discussion, we asked the first-person account authors to revise their initial reflection where necessary to discuss more fully the challenges encountered.

The first-person accounts enable consideration of the distinct motivations, goals, and behavior of each author. The use of situated knowledge derived from lived experience provides insight into the nature of collaboration within the REACH Network and has important implications for practice. The following accounts are reflections from only five people, and do not fully represent all REACH Network perspectives or the experiences of other community-based initiatives. However, these accounts provide a grounded sense of the important issues, challenges, and implications for practice that can be derived from our collaboration experiences within the REACH Network.

First-Person Account #1

An opportunity to study and improve upon rural public health problems through collaboration with rural community members represents a culmination of points in my upbringing and career as a health professional. Raised in the coal mining and steel production communities of the Allegheny Mountains by a committed Extension educator-family, I find it exciting to potentially bring benefits to people and families I grew up alongside. As a clinical scientist, the innovation and opportunity inherent in training under-utilized rural providers to provide the infrastructure for preventive rural healthcare services is satisfying both personally and professionally. It is also exciting to be involved in the training of rural health professionals to carry out well-designed, randomized trials evaluating the impact of their service delivery efforts in their communities. As a principal investigator, I helped lead the effort to establish the network, and likely strongly influenced the intervention design and the conduct of the study. Our preliminary results have been

encouraging, from a scientific design, feasibility, community acceptability, and skill development perspective. I do, however, have considerable concern about the sustainability and expansion of REACH. Garnering funds and other resources to support the initiative going forward is an ongoing challenge that has implications for maintaining and strengthening community trust.

The health challenges facing families in rural communities are numerous. For example, Aunt Lilly and Uncle Frederick live in a small rural community outside a struggling ex-steel town. Their children have departed for employment opportunities that no longer exist here. As they age, the challenges of chronic diseases and disabilities have taken an enormous toll on their independence causing further conflict within their frail support structure. Doctors, clinics, and health staff are somewhat distant and transportation assistance marginally available. As neuro-cognitive decline has reduced their resiliency and understanding, activities of daily living have become more complicated. When Uncle Frederick fell in the bathroom, he fractured his hip, requiring hospitalization and ultimately he was unable to return home. The support he provided to his spouse was no longer possible and she suffered a bad thermal burn while cooking. Both these preventable in-home injuries were devastating, and neither returned to independent living. I have witnessed many similar examples both personally and professionally. The REACH network has an opportunity to work directly with this critical and susceptible group, struggling to maintain their desired independence and health.

Like county-based Extension of olden days, the REACH network has an opportunity to engage effectively with our sometimes fragile elderly rural community members. REACH is not a replacement for any existing services, but attempts to work with existing services to identify and test the effectiveness of appropriate new health intervention strategies, delivered by the CHA's directly in the community member's home. The trust and engagement provided for many years by Extension workers to rural citizens can be further leveraged to provide an increased emphasis on health, safety, aging in place, and other features that are codified by the community board of REACH. My sense at this point is that we have tentatively gained the trust of some health entities in the community. While skepticism will remain, the proof of gaining at least some elements of trust with certain individuals seems self-evident at this point. Trust seemed to come from our co-creation and seeking community members input in the very beginning. I am certain that several community members were concerned that we would just do some research project "on them", and then we would leave. A focus on elders is appropriate, but other rural citizens and family members may benefit as well, from maternal and newborn health to interventions with overweight teens. The REACH network can 'reach-out' to communities by engaging effectively with citizens.

First-Person Account #2

As the primary contact person and coordinator for the REACH Network, I have had the opportunity to interact with everyone involved in this project. My office is located at the Affiliation Masked office, directly in the rural community that REACH aims to serve. This gives me the advantage of getting to know community members as well as getting a better sense of the difficulties facing this population.

During the process of recruiting local rural health providers (nurses and emergency medical technicians) to perform the health education interventions, I came across a variety of people who were excited about the opportunity to participate and potentially help older adults in their community. Many were enthusiastic for the chance to take part in a research study designed to benefit a population that is comprised mainly of their friends, relatives and, neighbors. Many had personally seen how falls can affect a person.

The health professionals (known as Community Health Assistants, CHAs) were mostly receptive to the online based research ethics training as well as the hands on training for the mobile data acquisition device. An Apple iPod Touch with a custom programmed data entry application served as the mobile data acquisition device for the observational survey of home safety. Although most CHAs were unfamiliar with this device, the majority of CHAs trained felt comfortable with it after repeated use. Recruiting participants was done mostly by CHAs through word of mouth, reaching out to neighbors, friends, relatives, and to churches. Participants were more willing to take part in this network if they knew the CHA. Attempts by the CHAs and I to recruit participants who were not personally familiar with us were not as successful. Presentations done at the local senior centers and to community organizations did not make much impact in the way of recruiting participants. Since we are making visits to participants' homes, establishing trust is a critical issue.

Working with the CHAs has presented a few challenges. Most of the CHAs work full or part time jobs with one being a full time college student. Their schedules vary greatly because of work, family and school commitments. Due to the differences in their schedules, they are usually unable to meet all together as a group. However, I try to communicate with them on a regular basis via email and phone as well as in person with brief one-on-one meetings. This has helped them, for the most part, to stay on task with important study and data collection milestones.

The community has been mostly supportive of the REACH Network. Board members from the community continue to offer their help in various ways from referring participants, recommending ways to connect with local organizations, as well as offering suggestions on how I can do more outreach activities. I am also hearing positive feedback from both the CHAs and their participants. If we continue to actively engage the community and promote the possible benefits of the network, REACH has a good chance of being successful. My hope is that we will be able to eventually expand the network to include interventions and programs for other populations living in this rural area.

First-Person Account #3

I function as a co-chair for the Community Advisory Board for the REACH Network. I am a regional director of a local health provider, with one of my agencies being a home health agency. Our service area encompasses the rural communities targeted by the REACH Network. When I was asked to be a part of this group, I was not sure what it would entail. The concept of research, outreach, and preventative healthcare melded together sounded nebulous and, at the same time, intriguing.

From the very first meeting, there were things that stood out to me. The effort and focus to obtain the community perspective and ensure community investment has been consistent. As our Network is so diverse, varying perspectives and input from all of our disciplines, roles, and perspectives has been valuable and unique. For those who know research, those who know healthcare, or those who know outreach, our discussions and interventions have a blended impact.

As a community healthcare provider, our organization's goal is to care for the people we serve, empower and educate them to take care of themselves, and identify opportunities to enhance healthcare services and delivery. Our involvement in the REACH Network is central to our mission because the partnership signifies a crucial commitment between higher education, research, community providers, and community members to improve healthcare delivery. Coordination and communication are central challenges facing our complex healthcare delivery system, as providers often make seemingly logical service provision decisions that turn out to be ineffective because the larger healthcare service

delivery context was not known to the provider. REACH helps to address these challenges by creating a formal structure that brings people together to communicate and coordinate action. Although REACH helps to make coordination possible, it does not come automatically. It has been challenging to integrate diverse processes, ideas, and political factors to operate synergistically as one group. Another challenge, perhaps one of the biggest barriers across healthcare, was the identification of actual practices of our participants in their homes. Service providers are typically unaware of these conditions and sometimes make ineffective or worse, counterproductive healthcare service decisions because they do not understand the clients home environment. Examining the actual homes of participants provided a rare and powerful opportunity for healthcare providers to identity avenues for intervention that they are not typically able to consider.

Essential to the success of REACH is the empowerment of each person in this partnership to facilitate awareness of important issues and identify best practices. For example, the community health assistants gleaned information from community elders, identifying barriers and safety needs that had to be addressed to make our interventions more effective. The REACH Network provided one of the first true opportunities for community organizations to correlate best practices, thus the trust and benefit of REACH unfolded with time and collaboration. As a representative from a community provider, our organization has the added benefit of strengthening our existing community relationships through this collaborative effort. It will be challenging for the REACH Network to maintain its focus and interest over time. As community needs and services change, so will the REACH Network.

First-Person Account #4

Joining the REACH Network as a Community Health Assistant/Emergency Medical Technician has been an eye opening experience for me. Initially, I anticipated that recruitment would be the easy part and the home visits would be more demanding and time consuming. As it turns out, however, recruitment has sometimes been challenging, while the home visits have gone rather smoothly.

One of the challenges I have faced in recruitment is overcoming the stigma our culture attaches to aging. A number of elders with whom I spoke about the study responded that they were still active, and they did not have any concerns about falling. Therefore, they did not feel they were good candidates for the study. Many seemed to think that participating in a study for people age 65+ made them old, or at least older than they feel. I try to explain, however, that the reality is about one-third of older adults fall each year, and the study is aimed at helping make their homes safer places to live so that they can remain active. Another challenge has been overcoming concerns participants have that: 1) REACH is trying to sell them something; 2) we are a scam; and 3) their information will be used against them to displace them from their homes and into long term care, contrary to our goal to help them age in place safely. Word of mouth from the participants themselves has been the most effective tool in overcoming these concerns and recruiting new elders to the study. I have one participant, in particular, who recruited several neighbors and continues to talk very positively about the REACH Network.

Interestingly, participants often reveal to me why they decided to participate during our first visit and interview. Some have told me they want to participate to be part of a research study. Others say they desire to improve their home safety and help the community. A few seem most drawn by the opportunity to have someone come visit them in their homes. The home visits, regardless of a participant’s motivation for joining the study, have been the most rewarding part for me. To date, I’ve met with elders ranging in age from 65 to 91 years, most of whom remain very active both physically and socially. Conducting the brief cognitive tests and observational home safety assessments has gone smoothly in all cases.

Many of my participants expressed pride in their homes and the modifications they already have in place to make their homes safer. Still, they were very pleased with the assessment, and most of all by the fact that it was relatively simple and short to complete. One 91-year-old participant told me: “This is an excellent survey.” Others have said: “That was easy.” Those participants have, more often than not, been the ones who go on to refer other participants to the REACH Network.

While the most rewarding aspect of participating in the REACH Network as a CHA has been connecting one-on-one with the elders in our community, the opportunity to work with the researchers and community partners and to be a contributing part of the research team has been rewarding as well. I feel as though the thoughts and opinions of the CHAs and the local partners are valued by the research team and have been incorporated into the study to create an effective, one-on-one approach to rural community health. That’s why I believe the REACH Network is truly making a difference in our community and improving the lives of our local elders.

First-Person Account #5

I was approached by my neighbor Sue who is a nurse and a Community Health Assistant for the REACH network. Last fall, she asked me if I would be willing to participate in the study. Sue explained to me what the program would entail and that she would be making several home visits to me over the course of 2 years. I am 82 years old and live alone, so I thought this program may be of some benefit to help with safety issues in my home.

Sue and I have been neighbors for a while, but I met her at church over 20 years ago. My husband is deceased, and Sue helps me out a lot. Even though I know Sue well, I still would have been willing to participate if approached by a CHA that I did not know.

I received my home safety assessment in February 2010. I appreciated how Sue was very patient and observant when doing the home safety assessment. She took her time looking and checking for possible fall hazards. I learned that my bathroom was a particular area of concern, especially the absence of non-slip strips in the shower area. I had purchased throw rugs for the bathroom, but they slid around a lot, so I removed them. I now have slip-resistant mats to put under the rugs and will have my son place them in the bathroom underneath the throw rugs. In other areas of my home, the throw rugs are secured to the floor. As a result of my home safety assessment, I also plan on putting slip resistant strips in the shower but I need someone else to do so. Thankfully, Sue volunteered to install the strips.

So far, the services I have received from Sue have been excellent. Her efforts helped to raise my awareness of some important safety features I had never previously considered. I can’t say that there was anything I did not like about participating. I feel this program may be helpful to those who think that a fall would not happen to them.

REACH Network Successes and Challenges

The first-person accounts provide insight into the successes and challenges of the REACH Network. One of its most important successes was the design and implementation of a low-cost health education intervention intended to reduce falls among the elderly in their own homes (first and fourth account). Working within the elders’ home environment, involving them directly in their needs assessments regarding fall risk resulted in elders ultimately embracing the interventions offered, allowing the REACH Network to fulfill its mission of reaching underserved and vulnerable residents of a rural community (first and fourth account). Community and university partners collaborated in the design and execution of a

rigorous evaluation that met the needs of stakeholders and built local research capacity (first and second account). The collaboration managed to mobilize existing but untapped energy in the community to improve the health and safety of community elders (first account). The home safety assessment has been well-received by community elders, has led to safety improvements, and has formed a relational foundation between community elders and community health assistants that we hope to build on as we work to deliver other health education interventions (first, fourth, and fifth accounts). The relationships and trust that have formed between community and university stakeholders throughout the process will serve as a foundation for future work aimed at further developing the infrastructure for preventive rural healthcare services (third account).

Along with the successes, the first-person accounts discuss several important challenges faced by the REACH Network. We summarize them here as trust, coordination, and sustainability. The challenge of trust impacted both our ability to engage people in the community advisory board (first account) and in the health education intervention (second and fourth account). Coordination was a challenge in the sense that there were many different ideas and perspectives brought to the table that had to be integrated to create synergy (third account) and the different schedules of the community health assistants made communication and keeping everyone on the same page difficult (second account). Sustainability is another challenge, as we need to secure funding to continue services (first account), while maintaining focus and interest (third account). We discuss each of these three challenges, along with strategies for success in each the following three sections. We hope readers interested in pursuing similar community-university partnerships in rural settings can learn from our understanding of these challenges and strategies for success in the context of our project.

Trust

In order to have an effective partnership, trust must first be established (Christopher, Watts, McCormick, & Young, 2008). Trust is both particularly important in rural settings, and especially hard to develop (Vissing, Salloway, & Siress, 1994). The magnitude of the trust challenge is striking, and likely to be a major problem in other rural contexts. Although the REACH Network hired locally-embedded community health assistants to deliver health education services, the service providers still faced several trust-related concerns among community elders they did not already know. For example, elders expressed concerns that REACH is trying to sell something, is a scam, or is trying to collect data that would displace them from their homes.

To address the issue of trust, we plan to enhance efforts to engage the target population in the partnership. Authentic partnerships require the engagement of community members in deliberation and consensus-driven decision making processes about the needs of the community and how to most effectively address those needs (Becker, Israel, & Allen, 2005). If a partnership focuses solely on the voice of community-based organizations and not community members, it risks taking an “organization-first approach,” which emphasizes the development of the organizational partners own programs, internal strategic planning, and fundraising (Harwood & Creighton, 2009). If collaborations to lose sight of the interests and needs of community members, it can create tension between outside organizations and the community, causing the initiatives at hand to fail, disempowering the community, and impeding future community development efforts (Labonte, 2005).

Although the REACH Network has engaged some community elders in the planning process, we would like to strengthen this aspect of the partnership moving forward. As described in account four, we currently struggle with community elders perceiving the intervention as unnecessary. Having more input from the target population will help us

refine our engagement strategies and our intervention, so that it can better address the needs of community elders. One strategy we can use to improve the engagement of community elders in the planning process is to provide compensation for their time and expertise, just as university personnel and local health providers participate in the REACH Network as part of their job. An honorarium for participation can help reduce power differentials and communicate to community elders that their input is valued just as much as that of professionals (Jordan & Gust, 2011).

We also want to engage community elders more directly in our outreach. Given that trust of outsiders is generally low in rural communities but trust of insiders is relatively high (Eriksson, Hochwälder, & Sellström, 2011; Solomon, Hiesbergr, & Winer, 1981), we hope to extend the REACH Network through existing social networks of community elders who are already involved in REACH. Our experiences suggest that when local residents outreach to community elders they already know, trust is not an issue and the outreach is successful. Thus, if we can provide community elders with an honorarium to help with outreach to their local social network, we may be able to overcome the trust challenge.

Coordination

The REACH Network faced unique coordination challenges in that very few of the collaborating individuals knew one another prior to REACH Network formation. Thus, collaborators had to figure out how to successfully interact and communicate effectively. Coordination was particularly challenging in the rural context because of the physical distance between university and community partners, which made face-to-face communication and team cohesion difficult. Substantial time and effort was invested in traveling to in-person meetings. Although challenging, the meetings were critical in establishing adequate lines of communication, which are essential for coordination (Nowell, 2009).

Coordination was also difficult among the community health assistants, who had other part-time jobs and were frequently taking classes as well. To manage this unique challenge, the REACH Network coordinator (second account) met with the community health assistants on a one-on-one basis. Consistent with previous research on the value of partnership coordinators (Butterfoss, 2008), the role of the REACH Network coordinator was critical to successful coordination, as this person kept the Network informed, organized the monthly board meetings, coordinated with community partners, planed and delivered media announcements, organized the community health assistants, and kept up with their schedule and performance.

Moving forward, we see the promotion of meaningful contribution and the cultivation of joint ownership as central to overcoming the challenge of coordination (Hartnett, 2010). One strategy to get more people meaningfully involved in REACH Network operations is to assign tasks to small subcommittees, where each member’s contribution is vital (Butterfoss, 2008). Rotation of subcommittee chairs and other formal leadership positions can also help to ensure numerous members are empowered to contribute to the REACH Network and prevent the establishment of entrenched hierarchies and power differentials (Erez, Lepine, & Elms, 2002).

One factor that may have impeded coordination and the cultivation of joint ownership is the fact that the initial project pursued by the REACH Network was conceived by a relatively small number of university personnel, with the engagement of community partners occurring after the attainment of grant funding. Although university partners sought an equal partnership, it is more difficult to create joint ownership when partnership initiation is not a mutual effort (Nation, et al., 2011). As the REACH Network seeks sustainability funding,

we want to involve community and university partners equally in the conception of project ideas, thus enhancing joint ownership, reciprocity, and coordination.

Sustainability

Several factors are important with regard to sustainability. Funding and other resources typically come to mind first, and First-Person Account 1 author explains that grants and other sources of funding are critical for the ongoing work of the REACH Network. Within a rural community, it is often difficult to find sustainability funding internally because there are fewer resources available (Audirac, 1997). University partners with grant writing skills can contribute substantially by preparing applications for external funding. In the case of the REACH Network, we are currently pursuing funding from the Health Resources and Services Administration (HRSA) to enhance our understanding of the needs and strengths of elders in the community. In pursuing this and other grants, we plan to continually assess mission fit to avoid the common problem of mission drift when seeking sustainability funding (Brown, Feinberg, & Greenberg, 2010).

Irrespective of funding, stakeholders must identity substantial engagement benefits that can justify the time costs of involvement for a partnership to be sustainable (Chinman & Wandersman, 1999; Jameson, Clayton, & Jaeger, 2011). The first-person accounts regularly discuss the benefits of REACH from the perspective of the writer, helping to explain why each participant is involved. For example, researchers benefitted by learning more about local contextual factors that impact the study and service delivery. Similarly, community members learned about the research process and the advantages of various research methods. If we can promote capacity building and transformative learning among all partners, it will lead to high levels of trust and motivation to sustain the partnership (Jameson, et al., 2011).

As noted in the first-person account 1, one of the most powerful benefits of engaging in community-university partnerships is the opportunity to fulfill a desire to help others and contribute to the community (Chinman, Wandersman, & Goodman, 2005). Additionally, first-person account 2 notes that many community health assistants are excited by the possibility of helping older adults in their community. To enhance sustainability, we intend to cultivate this affective component in our collaboration by better articulating the value of REACH Network efforts for the elderly, as this focus on helping others provides the necessary fuel for continued commitment toward program success (Austin, 2000; Wolff, 2010).

Moving forward, we also hope to enhance the benefits of engagement by better aligning our mission, strategy, and values so that all partners have the ability to grow together (Austin, 2000). By continually providing a safe space where people can learn from one another, we can develop creative solutions to the challenges we face based on a shared understanding of the problem (Kaner, 2007). Over time, these collaboration successes can help alleviate sustainability concerns expressed by potential stakeholders who feared university researchers would conduct a study “on them” and then leave (first account).

Conclusion

The five first-person accounts are richly storied narratives that cover a wide range of issues from several different perspectives. We were better able to understand the successes and challenges of the REACH Network through the examination of first-person accounts. Consideration of the challenges led to the identification of several strategies for success. Readers with a different perspective may conceptualize our successes and challenges differently and identity alternative strategies for success. However, readers can judge for

themselves the plausibility of our assertions. Although generalizations from this study are limited because of the unique context, readers can use the descriptive data to make judgments about the degree of fit or similarity between the context studied and the context where findings might be applied (Lincoln & Guba, 1986). We hope that readers can learn from our challenges and our efforts to identify strategies for success. Perhaps most importantly, we hope readers can learn their own lessons from our first-person accounts, as these narratives are open to many different interpretations.

Acknowledgments

The authors would like to acknowledge the citizens of Juniata and Mifflin counties engaged as participants in the REACH initiative; The REACH Citizens Advisory Group; Mr. Tom Walker, Director of the Penn State Learning Center, all of the staff of Penn State Cooperative Extension in the Juniata and Mifflin counties; and all members of the Reach Network. This project is funded, in part, under a grant with the Pennsylvania Department of Health using Tobacco CURE Funds. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions. The project described was also supported by the National Center for Research Resources and the National Center for Advancing Translational Sciences, National Institutes of Health, through Grant UL1RR033184. Suport for this project also comes from the National Cancer Institute of NIH Community Networks Program Centers Training Core in Community Based Participatory Research, through Grant U52CA153505. The content is solely the responsibility of the authors and does not necessarily represent the official views of the NIH.

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