2026 Needs Assessment

# From Collapse to Connection: Designing Infrastructure for a Health System in Crisis

Missouri Rural Health Association

Landes, D., Trammell, L., Onanian, K.

**From Collapse to Connection: Designing Infrastructure for a Health System in Crisis**

Rural Missouri (RuMO) stands at a breaking point. Hospitals are closing at alarming rates, life expectancy is falling, and preventable deaths are rising in ways unseen in prior generations. Families are traveling hours for emergency care, children are growing up in counties with some of the nation's highest poverty rates, and entire communities face the collapse of the very systems meant to sustain them. These are not isolated problems but converging pressures: economic decline, provider shortages, overdose deaths, and entrenched inequities reveal a health system unable to meet the needs of its dependents.

However, even in the face of collapse, resilience persists. Across Missouri, frontline providers, community health workers, and local leaders continue to innovate under challenging conditions, deploying mobile clinics, expanding telehealth services, and forging necessary partnerships that keep people alive. These efforts show that rural communities are not defined by deficit, but by determination and creativity. Unfortunately, courage and innovation alone are not enough. The challenges ahead demand something larger than local solutions; they require infrastructure capable of connecting every corner of the state, rural and urban alike, into a collective force for Missouri's health.

This is the moment for The Causeway to emerge. Built as a digital hub linking more than 850 health stakeholders, The Causeway can move beyond a network to function as statewide infrastructure for collaboration, advocacy, and shared learning—matching the scope and complexity of Missouri's rural health crisis. Developing The Causeway into a disciplined, statewide virtual community of practice provides a practical pathway to align stakeholders,

translate knowledge into action, and support coordinated policy efforts across rural and urban Missouri.

## Looking Back to Look Forward: Lessons from 2023

The 2023 Missouri Rural Health Association (MRHA) Needs Assessment documented an increasingly fragile rural health landscape. At the time of the assessment, Missouri was experiencing a deepening health crisis driven by limited access to care, economic instability, educational disparities, hospital closures, a shrinking healthcare workforce, and the ongoing effects of the COVID-19 pandemic. More than 400 stakeholders across nine regions identified core challenges, including limited transportation, provider shortages, inadequate broadband, and insufficient insurance coverage, alongside rising mortality, declining birth rates, and escalating substance use and mental health crises (Landes & Bondurant, 2023). Despite these persistent challenges, rural communities have responded with resilience through cross-sector collaboration, expanded telehealth services, mobile health delivery, and strategic partnerships to improve access to care. In response to this local innovation and leadership, MRHA was inspired to build lasting infrastructure for connection, coordination, and shared rural health leadership throughout the state.

Responding to the strengths observed in Rural Missouri (RuMO), MRHA began developing The Causeway (formerly *MRHA Connect*) as a statewide tool to strengthen collaboration, share resources, and support locally driven rural health strategies. Designed as a virtual community of practice for rural health stakeholders, The Causeway has grown to include several hundred active members and is supported by a full-time community manager. The platform connects rural health leaders across geographic and professional silos, promotes

advocacy and professional development, reduces isolation and burnout, and supports collective action in the face of escalating rural health challenges. While participation has expanded steadily, constrained resources and the scale of unmet need have limited the network's ability to keep pace with the accelerating demands facing rural communities.

## Nowhere to Turn: Disparities, Closures, and Decline in Rural Missouri

Rural hospital closures are accelerating across Missouri. Nearly half of rural hospitals now operate at a loss, with many more at risk—threatening to deepen health disparities and severely limit access to life-saving care (Dockins & Lingerfelt, 2024). Between 2020 and 2022, Missouri experienced a sharp rise in deaths alongside a corresponding decline in statewide life expectancy, with rural areas among the hardest hit (Missouri Department of Health and Senior Services [MDHSS], 2023c). This spike underscored existing health inequities in rural Missouri and coincided with ongoing rural population decline, as barriers to care intensified and mortality rose among vulnerable populations. At the peak of the pandemic in 2021, rural residents faced mortality rates 40% higher than those of their urban counterparts (MDHSS, 2023c), reflecting preexisting weaknesses in rural healthcare infrastructure, including hospital closures, workforce instability, and extended emergency transport times (Dockins & Lingerfelt, 2024). RuMO continues to face a sustained health crisis, as rising mortality, health professional shortages, Medicaid instability, and entrenched inequities have left many communities without the care and infrastructure needed to recover.

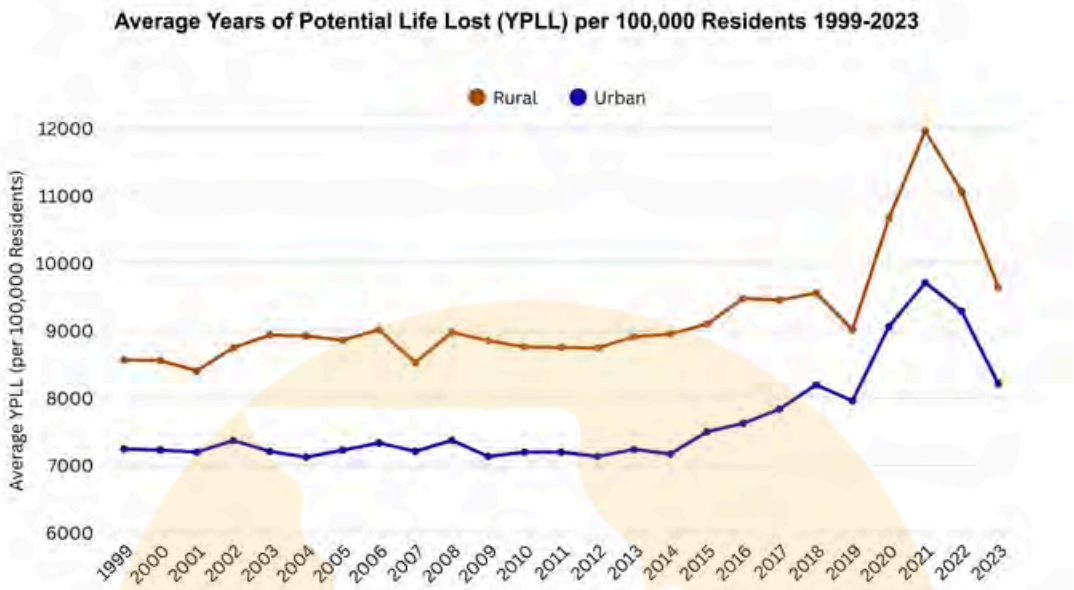
Rural Missourians are dying from preventable diseases at dramatically higher rates than their urban peers, a stark indicator of systemic failure in early detection and primary care. Compared to the urban population, RuMO experiences 19% more heart disease deaths, 13%

more cancer deaths, and 61% more deaths from chronic lower respiratory disease (CLRD) (MDHSS, 2023a). The 28 Missouri counties with the highest heart disease rates are all rural, with angina or coronary heart disease as major contributors (MDHSS, 2023a). Despite cancer screening recommendations, one in three rural citizens over 50 has never received a sigmoidoscopy or colonoscopy (MDHSS, 2023a). CLRD deaths are primarily caused by COPD, asthma, emphysema, and bronchitis, all worsened by tobacco use; all ten Missouri counties with the highest smoking rates are rural (MDHSS, 2023a). These disparities reflect persistent gaps in prevention and connected care that continue to shape early mortality trends.

Post-pandemic data show RuMO far behind its urban counterparts' recovery. After 2020, rural Missouri shifted from near-zero natural population change to a sustained natural decrease, with deaths exceeding births by roughly 20–25% each year from 2020–2022 (see Figure 2). Years of Potential Life Lost (YPLL), a metric used to quantify early mortality, increased by 26% in rural areas during the pandemic, reaching the highest level in recorded Missouri history (see Figure 1); the rural YPLL has yet to return to its pre-COVID norms (see Figure 1). Missouri is now falling behind nationally, with the cumulative impact of rural health disparities contributing to its drop from 36th to 39th in state health rankings (America's Health Rankings, 2024).

**Figure 1**

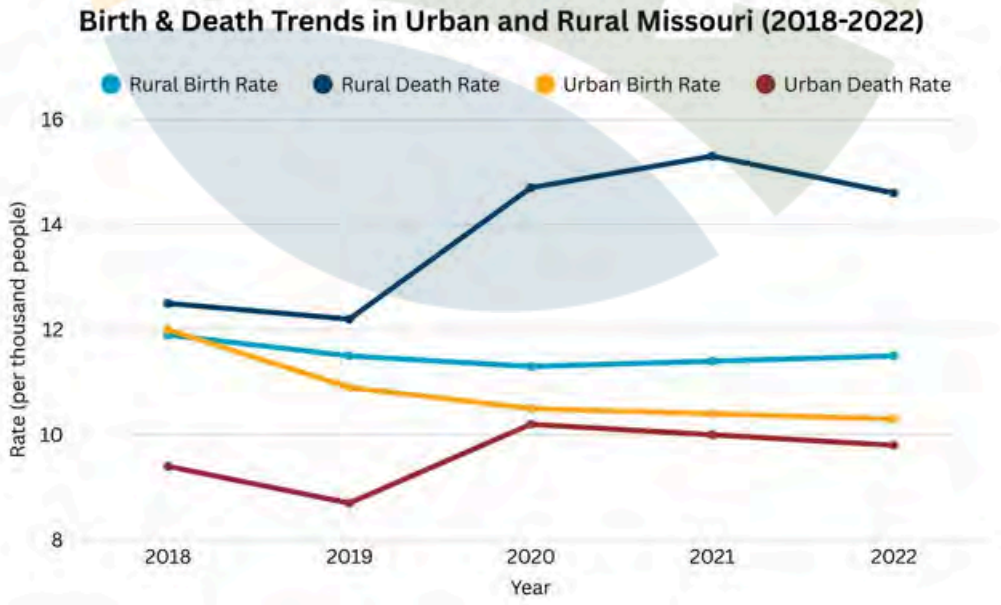
*Average Rate of Years of Potential Life Lost in Missouri (Rural vs. Urban) 1999-2023*




*Note. Years of Potential Life Lost (YPLL) values were obtained from the Missouri Department of Health and Senior Services. Counties were classified as rural or urban using a 16-county urban definition. Rural andurban YPLL rates per 100,000 residents and all trend calculations were performed by the authors (MDHSS, 2023e).*

**Figure 2**

*Birth & Death Trends in Urban and Rural Missouri 2018-2022*




*Note: Rural and urban birth and death rates were calculated using Missouri Vital Statistics data (Missouri Department of Health and Senior Services, Bureau of Health Care Analysis and Data Dissemination, 2018–2022).*

Rural disparities are especially evident in Missouri's overdose (OD) crisis, which has eclipsed nearly every other public health need in urgency and scale. ODs have become the leading cause of death for 18- to 44-year-olds in Missouri, with 80% of the highest-burden counties being rural (MDHSS, 2023b). Substance use disorders and ODs contributed to 12% of pregnancy-related deaths in Missouri (author's calculation based on MDHSS, 2025a), and fatal overdoses have risen 36% from 2017 to 2022 (MDHSS, 2023b). However, overdose-related hospital visits declined, with 10 rural counties experiencing a sharp drop in patients seeking OD assistance. This pattern indicates that overdoses remain prevalent in Missouri, while a growing number of individuals are unable to access care (MDHSS, 2023b). The sharp rise in fatal overdoses, coupled with declining hospital visits, signals a dangerous shift in which more people are dying from preventable causes without ever accessing care.

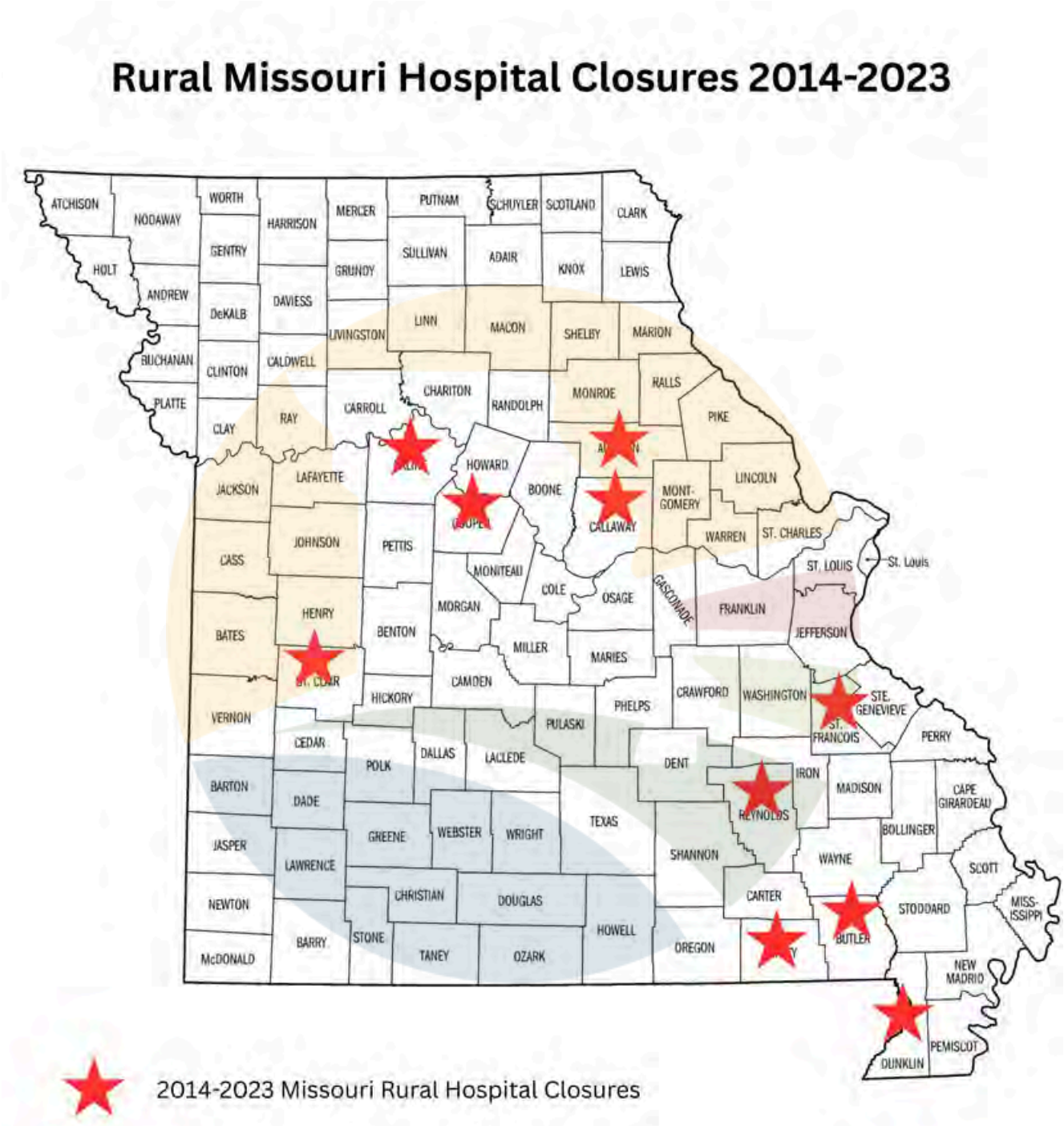
## Eroding Infrastructure and Policy Threats

Rural health inequities in Missouri persist because the healthcaresystem remains structurally misaligned with the realities of rural life, shaped by limitedaccess, cultural disconnects, and persistent socioeconomic barriers that have deepenedsince the pandemic. Residents report being "in a healthcare trap," unable to find providerswho accept Medicaid or understand their cultural background, while earning too much to qualifyfor assistance but not enough to afford care (Missouri Department of Health and Senior Services, 2024a). Rural residents face layered access and health-management barriers, including widespread provider shortages (Gordon, 2025), limited access to chronic disease self-management resources (Yun et al., 2013), and a rapidly aging population (Yun et al., 2013). These vulnerabilities are further intensified by structural conditions, including persistent poverty (Yun et al., 2013) and the loss of local hospitals, which has widened travel distances and weakened access to emergency and

specialty care in many rural communities (Dockins & Lingerfelt, 2024). Together, these overlapping barriers have left many rural Missourians detached from the very systems meant to support their health, creating conditions where access is not only limited but structurally out of reach.

Rural hospitals are closing across Missouri, and without timely intervention, many more are likely to follow, threatening the already-fragile infrastructure that rural communities depend on for care. Over the past decade, Missouri accounted for 10 of the 120 rural hospital closures nationwide (Dockins & Lingerfelt, 2024), representing 8% of all closures despite comprising only 2.8% of the U.S. population (author's calculation). More than 45% of rural hospitals in Missouri operate at a financial loss (Mills & Bennett, 2025), with non–Critical Access Hospitals averaging a negative 7.4% Medicare margin and facing an average of $7.6 million in annual compliance costs (Dockins & Lingerfelt, 2024). Hospital closures have already forced residents to travel as far as 40 additional miles to the nearest emergency room (Dockins & Lingerfelt, 2024). This growing wave of rural hospital closures is increasing travel distances, constraining access to care, and acceleratinghealth disparities and poor patient outcomes.

**Figure 3**
*Rural Missouri Hospital Closures from 2014-2023*



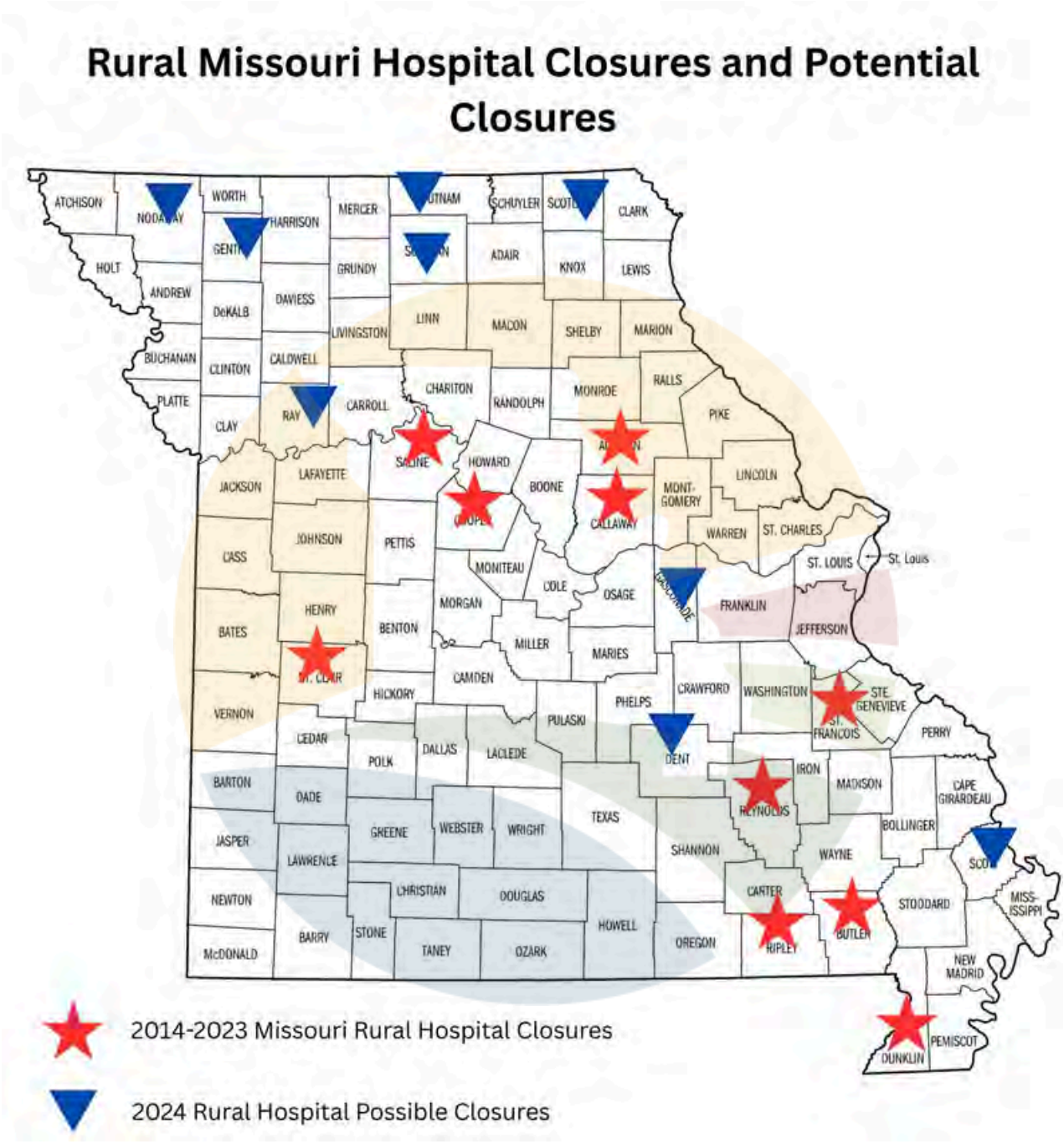

*(Dockins & Lingerfelt, 2024)*

Transportation challenges in rural Missouri limit access to both routine and emergency care, placing residents at heightened risk. The ten counties with the highest rates of extreme

commutes (150 to 300 miles round trip) are all rural, with up to one in five households making these long drives to get to work (Center for Applied Research and Engagement Systems [CARES], 2022). Many rural counties are located far from healthcare facilities, with residents of Carter County living more than 50 miles from care (Missouri Department of Health and Senior Services, 2023a). Thirty rural Missouri counties exceed the state average for households without a vehicle, and in five rural counties, one out of every ten households lacks access to a car (United States Census Bureau [USCB], 2023). With hospital closures accelerating and Medicaid funding at risk, these transportation gaps are intersecting with a collapsing care network.

Proposed federal Medicaid cuts pose a persistent threat to rural Missouri, where healthcare access and hospital stability rely heavily on public coverage. Medicaid expansion data shows the highest rates of Medicaid enrollment occur overwhelmingly in rural Missouri counties, particularly in the southern region of the state (Saint Louis University Center for Health Law Studies & Washington University Center for Health Economics and Policy [SLU & WU], 2021). Missouri's rural hospitals are deeply tied to public coverage, as nearly one-third of all Medicaid enrollees in the state live in rural areas (Kaiser Family Foundation [KFF], 2025). Additionally, 61% of opioid-related ER visits are covered by Medicaid, Medicare, and other government programs (Missouri Department of Health and Senior Services, 2023b). Cuts to Medicaid could result in coverage losses for 40% of rural children and 20% of non-elderly adults, putting essential care out of reach for thousands (Mills & Bennett, 2025). Thirteen percent of Missouri rural hospitals have closed over the past decade (author's calculation based on Dockins & Lingerfelt, 2024; MDHSS, 2023d), and nine more are now at high risk (Dockins & Lingerfelt, 2024) due to funding cuts, low reimbursement rates, and staffing shortages that are accelerating a cycle of decline and threatening further closures.

**Figure 4**
*Rural Missouri Hospital Closures and Potential Closures*

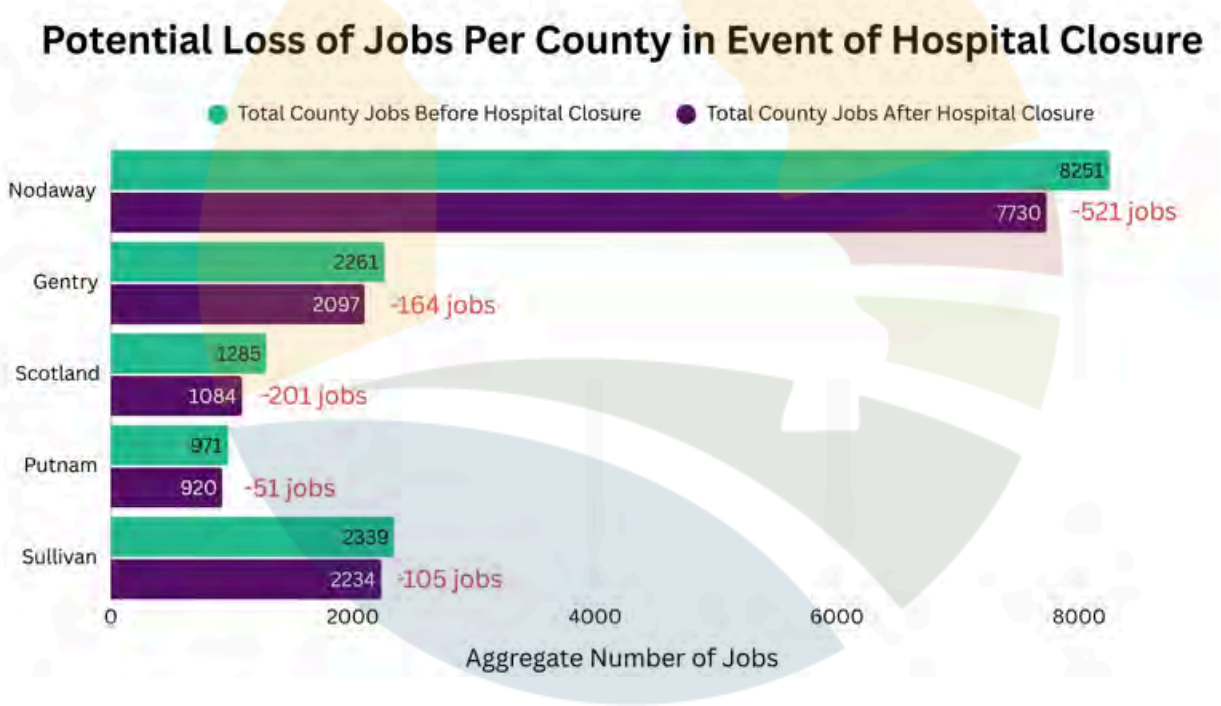



*Dockins & Lingerfelt, 2024*

Northern Missouri is on the brink of losing its last lines of defense. Scotland, Putnam, Sullivan, Nodaway, and Gentry counties each have a single hospital (MDHSS, 2025b), and every

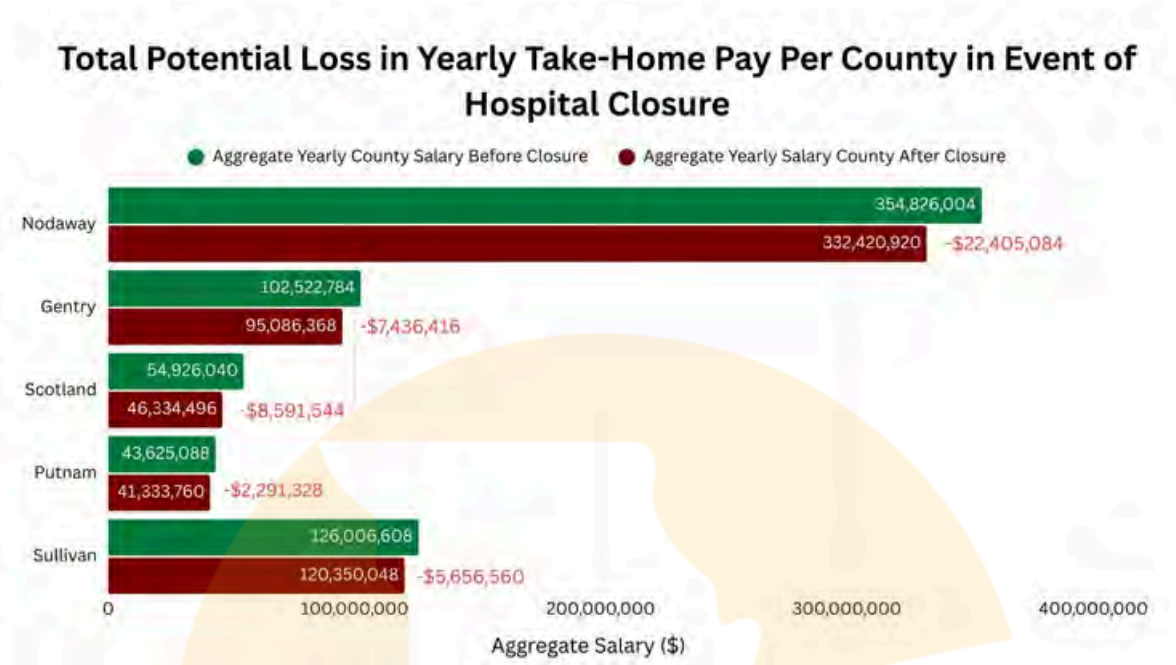
one of them is now at risk of closing (Dockins & Lingerfelt, 2024). If they shut their doors, more than 1,000 jobs (see Figure 5) and $46 million in wages (see Figure 6) will vanish within a year, stripping already fragile economies of their largest employers and pushing many families deeper into poverty (U.S. Bureau of Labor Statistics [BLS], 2025). In places where healthcare and social assistance make up as much as 16% of the job market (MERIC, 2025), the loss of even one facility would destabilize the entire community.

**Figure 5**
*Potential Loss of Jobs in At-Risk Northern Missouri Counties in Event of Hospital Closure*




*Note: Estimates reflect author calculations using publicly available employment data (Cause IQ, 2024; LinkedIn, 2025a & 2025b; Indeed, 2025). If exact number of employees was unavailable, low-end estimates were used.*

**Figure 6**
*Projected Loss of Annual Wages Following Hospital Closure in Northern Missouri*




*Note: Total potential loss in yearly take-home pay per county in the event of hospital closure. Estimates reflect author calculations using county-level average weekly wages and employment counts from the U.S. Bureau of Labor Statistics [USBLS] (USBLS, 2025).*

The health toll would be even more severe. A California-based study found that inpatient mortality increased by nearly 9% after a rural hospital closure, while survival rates for time-sensitive conditions such as heart attacks and strokes declined by approximately 10% (Gujral & Basu, 2019). Vulnerable patients—particularly those on Medicaid and racial minorities—face the steepest increases in mortality, at 11.3% and 12.6%, respectively (Gujral & Basu, 2019). For residents of Northern Missouri, these closures would mean longer drive times, overwhelmed neighboring hospitals, and the loss of trusted local providers—conditions that translate into preventable deaths and worsening chronic disease. Job-loss–driven poverty would further compound these health impacts (Alexander & Richards, 2021), leaving families with fewer resources as access to care disappears.

Each community stands to suffer devastating consequences if its hospital closes, but the combined effect would be far worse. The loss of five hospitals in close geographic proximity would not only dismantle access to care but also accelerate outmigration, unravel surrounding industries, and erode the tax base that sustains schools and public services (Wishner et al., 2016). What begins as a health crisis in one county would ripple outward, triggering a cascading cycle of poverty, worsening health outcomes, and community decline across the entire region.

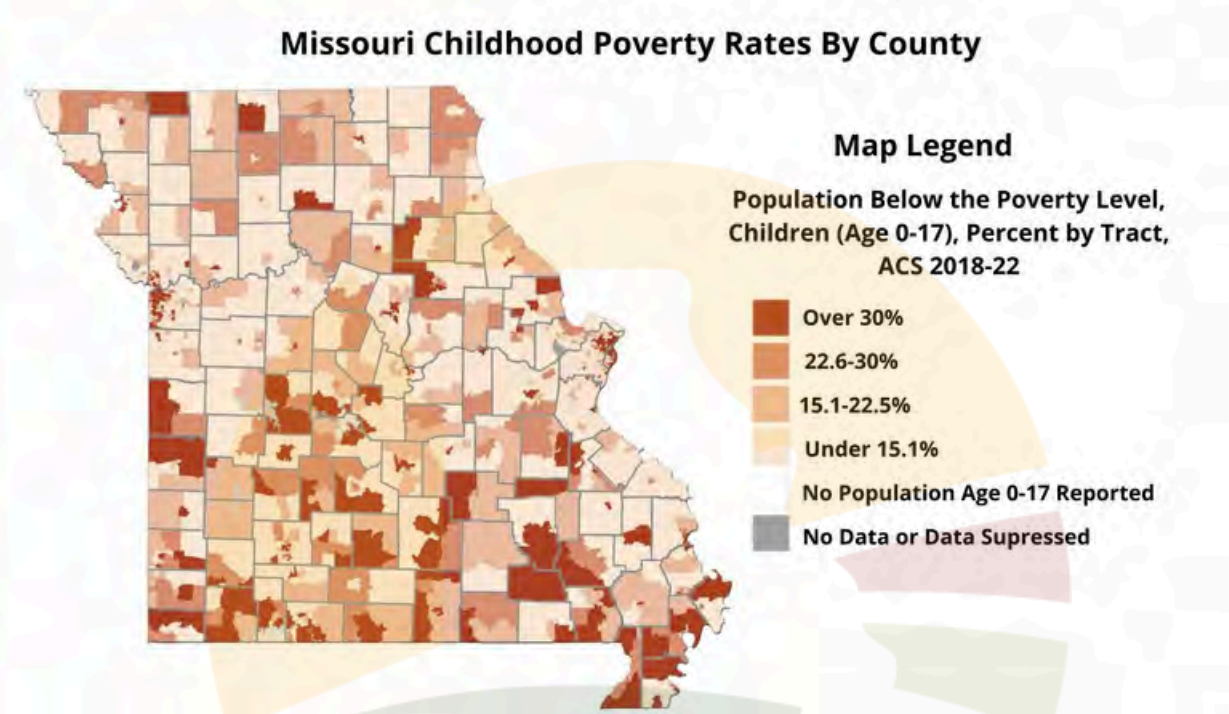
**Intersecting Barriers to Rural Health Equity**

Missouri's rural communities are facing a multifaceted health crisis shaped by overlapping social and structural inequities. Deep-seated poverty remains one of the most significant drivers, with 16.5% of rural Missourians living below the poverty line compared to 12.3% in urban areas (MDHSS, 2021). These conditions are compounded by persistent racial disparities, geographic isolation, and strained infrastructure, producing some of the worst health outcomes in the state. Nowhere is this more evident than in Missouri's Bootheel region, where extreme poverty, hospital closures, and limited access to transportation converge. Taken together, these compounding challenges demonstrate that rural health disparities cannot be understood in isolation; they are layered, mutually reinforcing, and demand systemic solutions rather than piecemeal interventions.

Poverty remains one of the most potent drivers of health disparities in Missouri, shaping lifelong outcomes. Apart from the city of St. Louis, every Missouri county with a poverty rate over 20% is rural; Pemiscot county leads at 35.3% (Missouri Community Action Network, 2022). Childhood poverty remains significantly higher in RuMO than in urban areas, with well-documented links to asthma, obesity, developmental delays, and early mortality in adulthood (MDHSS, 2023a). High-poverty rural counties consistently rank among the lowest in educational

attainment and the highest in unemployment (MDHSS, 2023a). These persistent divides fuel generational inequities and reinforce structural barriers to care for rural Missourians.

**Figure 7**
*Missouri Childhood Poverty Rates by County*

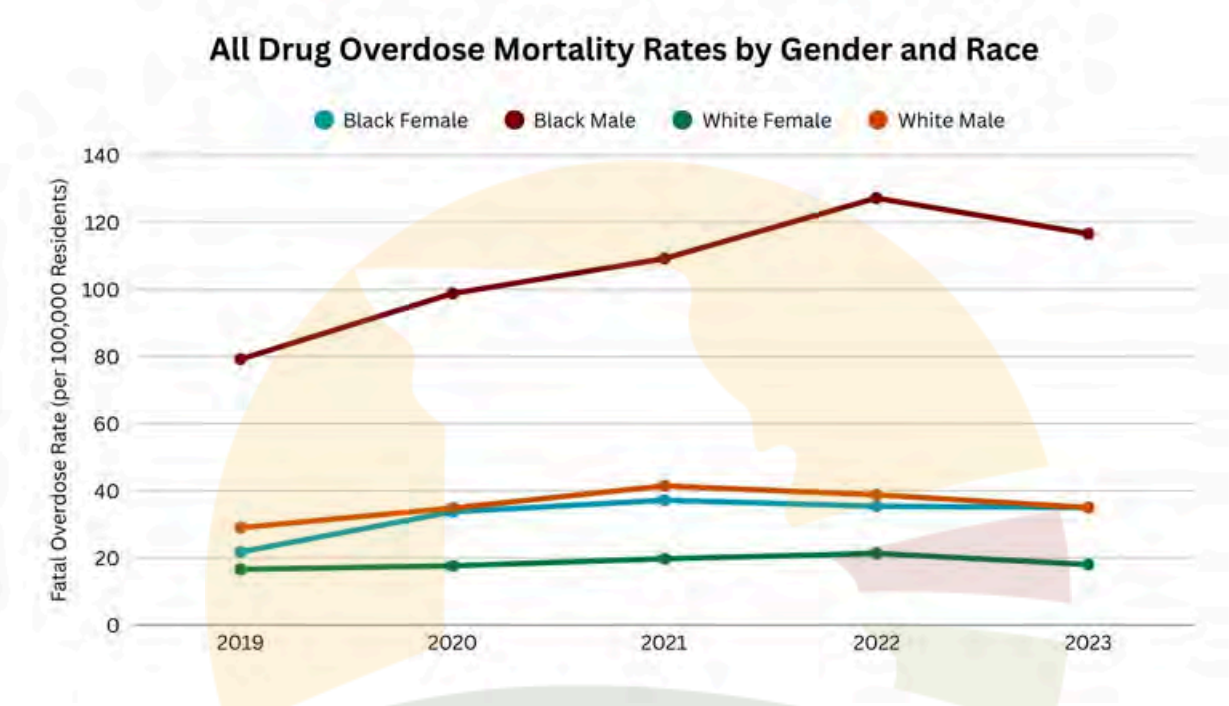



(CARES, 2023)

Blackresidents face a unique and compounding set of health disadvantages shaped by both racial andgeographic inequities. Although Black residents make up a small portion of Missouri's overall ruralpopulation, they often bear the brunt of negative health disparities. Regardless of region, BlackMissourians experience double the poverty rate that white individuals residing in the same areado (MDHSS, 2023a). Black infants in Missouri experience a mortality rate of 13.2 per 1,000 livebirths (MDHSS, 2024b), more than three times higher than that of white infants, and Black mothers are 2.5 times more likely to die from pregnancy-related causes (MDHSS, 2025a). These disparities extend to chronic illness (MDHSS, 2023a), hospitalization (Cairns et

al., 2024), and premature death (MDHSS, 2023a). Additionally, Black men and women experience significantly higher OD rates than their white counterparts (see Figure 8).

**Figure 8**
*All Drug Overdose Mortality Rates in Missouri by Gender and Race*




*(Missouri Department of Health and Senior Services, 2023b)*

Rural Missourians with disabilities face some of the state's most severe and compounding health disparities. In Missouri, all 27 counties with disability rates above 21% are rural, far exceeding the national average of 13.7% (Center for Research on Disability, 2023). Children with disabilities in rural Missouri experience more frequent emergency room visits and higher hospitalization rates than their urban peers (Arakelyan et al., 2024), costing an average of $2,100 per visit for those without insurance (Farmer, 2025). Stigma remains a major barrier to mental health care in rural areas, where attitudes toward seeking help are often more negative (Schroeder et al., 2021); 6 of the 10 counties with the highest suicide rates in Missouri are rural

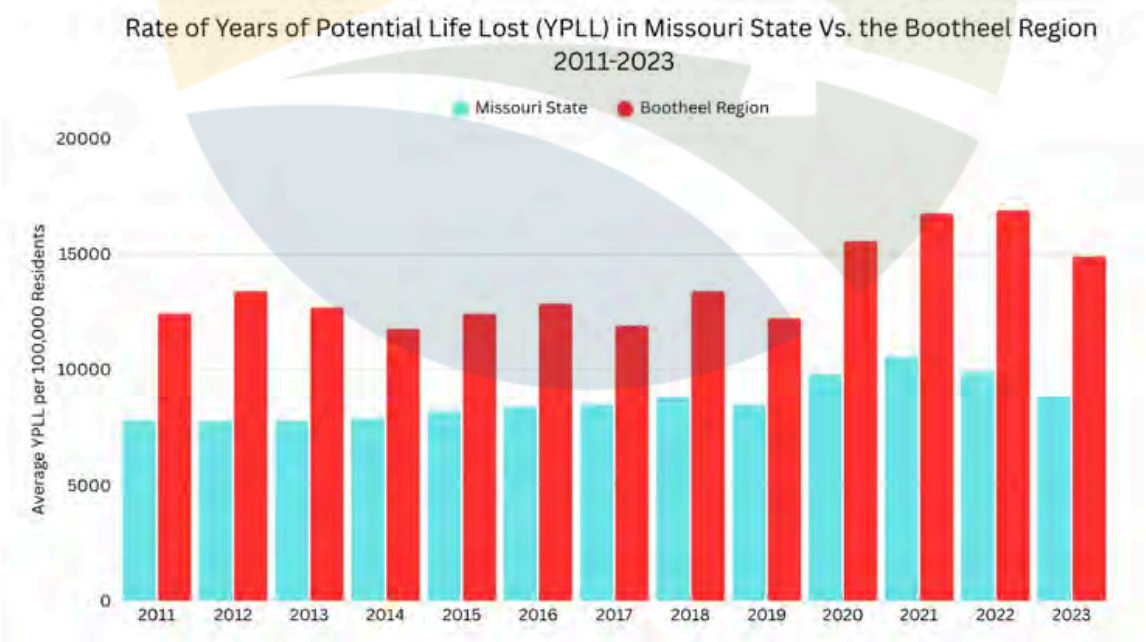
(CARES, 2024). These layered challenges isolate rural Missourians with disabilities from both essential care and community life, driving worse outcomes.

Similarly, Missouri's veteran population bears heightened strain from the rural health system, with geographic distance, chronic illness, and access barriers combining to produce some of the bleakest outcomes in the state. Suicide rates among Missouri veterans are 74% higher than those of non-veterans statewide and 23% higher than the national veteran average (U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, 2024). Missouri's veterans are disproportionately older (U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, 2021) and frequently live with multiple chronic and service-related conditions requiring sustained, coordinated care (Rural Health Information Hub, 2025). However, access to comprehensive care remains severely constrained, as only 26% of veterans nationwide live within 40 miles of a VHA facility offering full specialty services (Rasmussen & Farmer, 2023). Workforce shortages and access failures within the VHA continue to push veterans into already overburdened private systems (Armstrong et al., 2025), a matter especially pressing in Missouri, where all rural counties now experience partial or severe shortages in both primary care and mental health providers (Gordon, 2025). At the same time, ten rural hospitals have closed in the past decade, and nearly half of those remaining operate at a financial loss, further destabilizing the system that veterans and civilians alike depend upon (Dockins & Lingerfelt, 2024). These conditions leave many rural veterans navigating a system that is increasingly unable to meet even their most basic health needs.

Southeast Missouri sits at the center of the state's rural health crisis, where entrenched economic, demographic, and geographic disadvantages have created some of Missouri's highest rates of poverty, mortality, and hospital instability. Counties in the Bootheel region face

especially severe risk: aging populations, high uninsured rates, and declining economic opportunity weaken the payer mix and drive high uncompensated care burdens (MDHSS, 2023a). These pressures are evident in Southeast Missouri's infrastructure—four of Missouri's ten rural hospital closures have occurred here (Dockins & Lingerfelt, 2024), and Pemiscot County reports a childhood poverty rate of 42.1%, among the highest in the state (MDHSS, 2023a). Basic access barriers compound these challenges: 10% of households in Pemiscot County and 16% in Mississippi County lack a vehicle (USCB, 2023), severely limiting reach to care and job opportunities. In May 2023, Dunklin, Iron, and Wayne Counties recorded the state's highest unemployment rates, a pattern that mirrors the region's persistently poor health outcomes (MDHSS, 2023a). The result is a region consistently positioned at a disadvantage compared to the restof the state.

**Figure 9** *Rate of Years of Potential Life Lost in Missouri State Compared to the Bootheel Region*




*Note: Data calculated using available YPLL data. Counties Dunklin, New Madrid, Pemiscot, Scott, Mississippi, and Stoddard were used to determine rate of YPLL in the Bootheel region (Bureau of Health Care Analysis & Data Dissemination, 2023).*

Missouri's rural health crisis is not static but transforming, with Southeast Missouri continuing to endure the state's worst outcomes and northern counties facing an escalating risk of "being next." These disparities are the product of deeply intertwined forces—poverty, geography, race, disability, and workforce decline—leaving no community untouched and no single sector able to respond alone. The lesson is clear: rural Missouri does not just need more services; it needs new systems and resources. What is required is infrastructure capable of connecting across regions, bridging rural and urban divides, and transforming fragmented local efforts into a coordinated movement. Only by building networks of trust, collaboration, and shared leadership can Missouri begin to confront the scale of the crisis now bearing down on its health infrastructure.

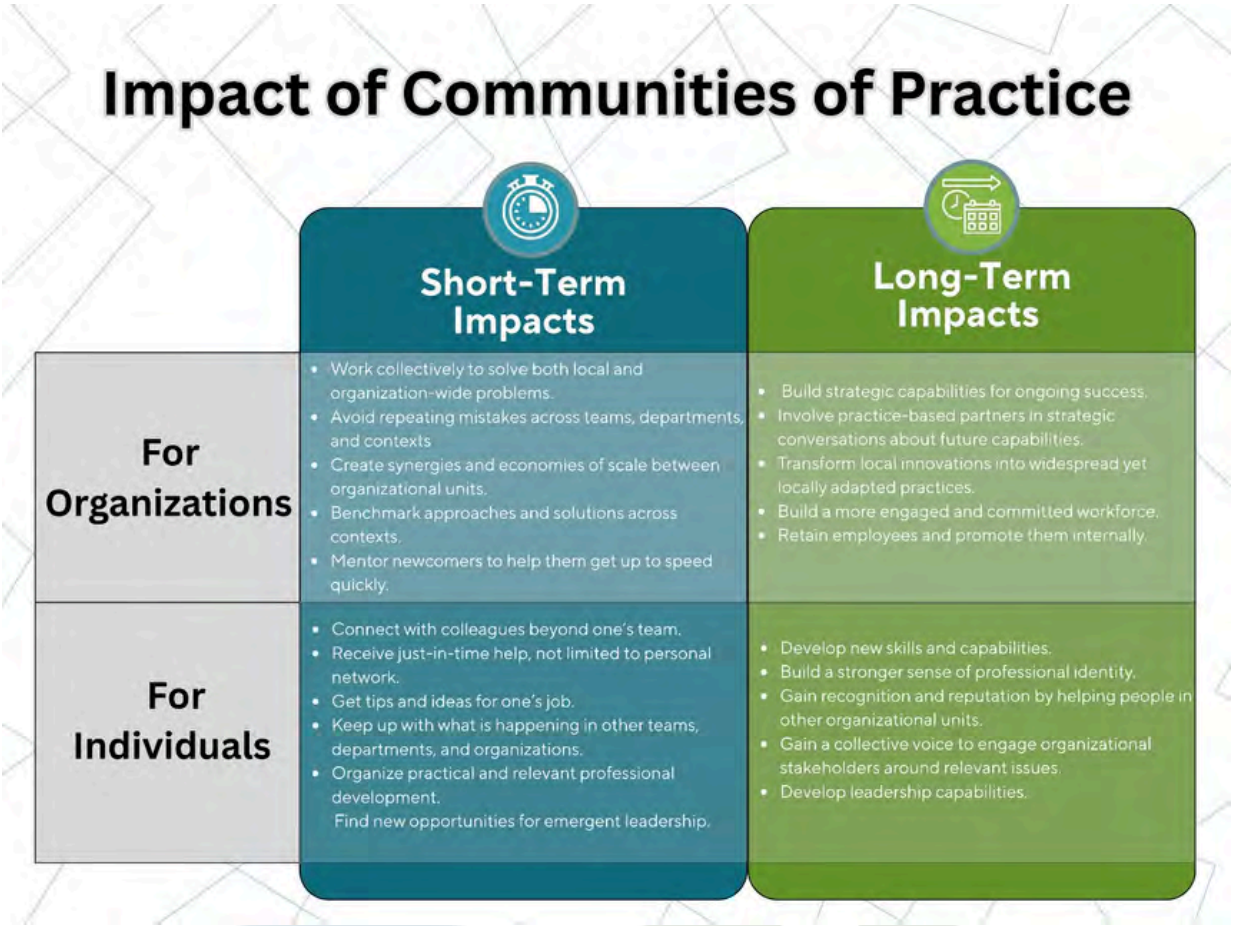
## Building a Statewide Engine for Health-Related System Learning

If Missouri's rural health system is collapsing under the weight of closures, workforce shortages, and preventable deaths, the question is no longer what is wrong, but what can be done. Local innovation and grit have kept communities afloat, but piecemeal solutions cannot meet the scale of the crisis now unfolding. What is needed is infrastructure that does more than connect people; it must align efforts, amplify expertise, and convert shared struggle into collective capacity. Wenger-Trayner's concept of a Virtual Community of Practice (VCoP) offers such a model, describing a structured environment in which members sustain engagement around shared challenges, develop a common professional identity, and co-create context-specific solutions (Wenger-Trayner & Wenger-Trayner, 2015; Wenger-Trayner et al., 2023). Unlike traditional networks that stop at connection, VCoPs provide the foundation for shared learning, applied problem-solving, and coordinated action. Evidence shows that VCoPs improve clinical decision-making, reduce professional isolation, and strengthen interdisciplinary collaboration

across healthcare, education, nonprofit, and international development settings (Woods et al., 2023; Lardier et al., 2024; Shaw et al., 2022; Browne et al., 2022). Their influence extends beyond individual participants, diffusing knowledge across organizations and systems (Elbrink et al., 2024) and supporting community-informed solutions that link local realities to broader strategies (Christson & Adedoyin, 2016).

In Missouri's fragmented health system, a VCoP offers both the framework for collaboration and the means to evaluate whether it produces real impact. Wenger-Trayner's research demonstrates that Communities of Practice yield benefits at multiple levels: they enhance organizational performance in the short term, build strategic capacity over time, and provide individual members with practical tools, professional identity, and pathways into leadership (Wenger-Trayner et al., 2023). These impacts emerge because VCoPs are structured around three interdependent elements—domain, community, and practice—and evolve through patterns of participation, learning, and value creation that can be measured over time. Together, these characteristics establish a clear basis for evaluating The Causeway as Missouri's emerging statewide engine for health system learning and collaboration.

**Figure 10**
***Impact of Communities of Practice***




*(Wenger-Trayner et al, 2023; Wenger-Trayner & Wenger-Trayner, 2015)*

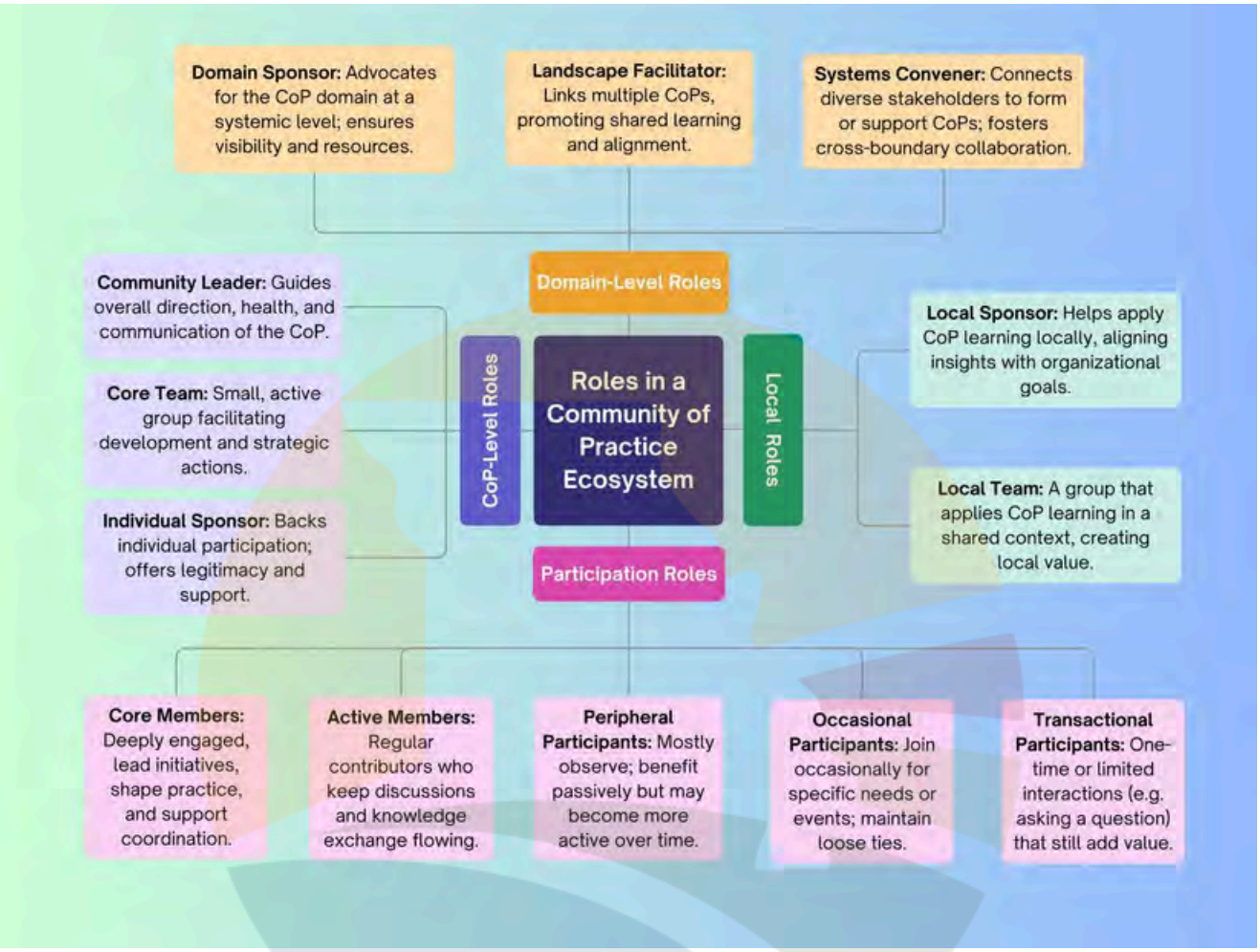
## The Architecture of Shared Learning

A VCoP is defined by the presence of three interdependent elements: a domain, a community, and a practice. The domain establishes a shared area of inquiry that gives the group a sense of identity, purpose, and legitimacy. The community fosters relationships, trust, and mutual engagement that sustain learning and collective growth (Sibbald et al., 2022). The practice encompasses the shared tools, frameworks, language, and lived experiences that members develop and refine together. These three components are mutually reinforcing. Without a salient domain, there is no focus; without community, there is no sustained interaction; without practice, there is no meaningful application. This structure distinguishes VCoPs from other group

forms, such as networks (which prioritize connection), teams (which focus on discrete tasks), or interest groups (which may lack shared methods or long-term collaboration).

Participation in a VCoP is both a mode of learning and a means to shape professional identity through shared activities and social interactions (Teoh, 2022). As members engage with a community's domain, they develop a sense of purpose and belonging (Wenger-Trayner & Wenger-Trayner, 2015). Core members often guide the group's direction, active members contribute and apply shared practices, and peripheral participants observe and learn before engaging more fully. Occasional and transactional users join as needed, asking questions, attending events, or accessing resources; they still contribute to community vitality, though less so than their counterparts. These roles evolve, but all support the sharing of advice, collaboration, and collective growth (Nixon et al., 2024). In rural health, where professionals often face isolation and limited resources, this flexible model enables The Causeway to meet members where they are, fostering meaningful engagement and identity development.

**Figure 11**
*Roles in a Community of Practice Ecosystem*

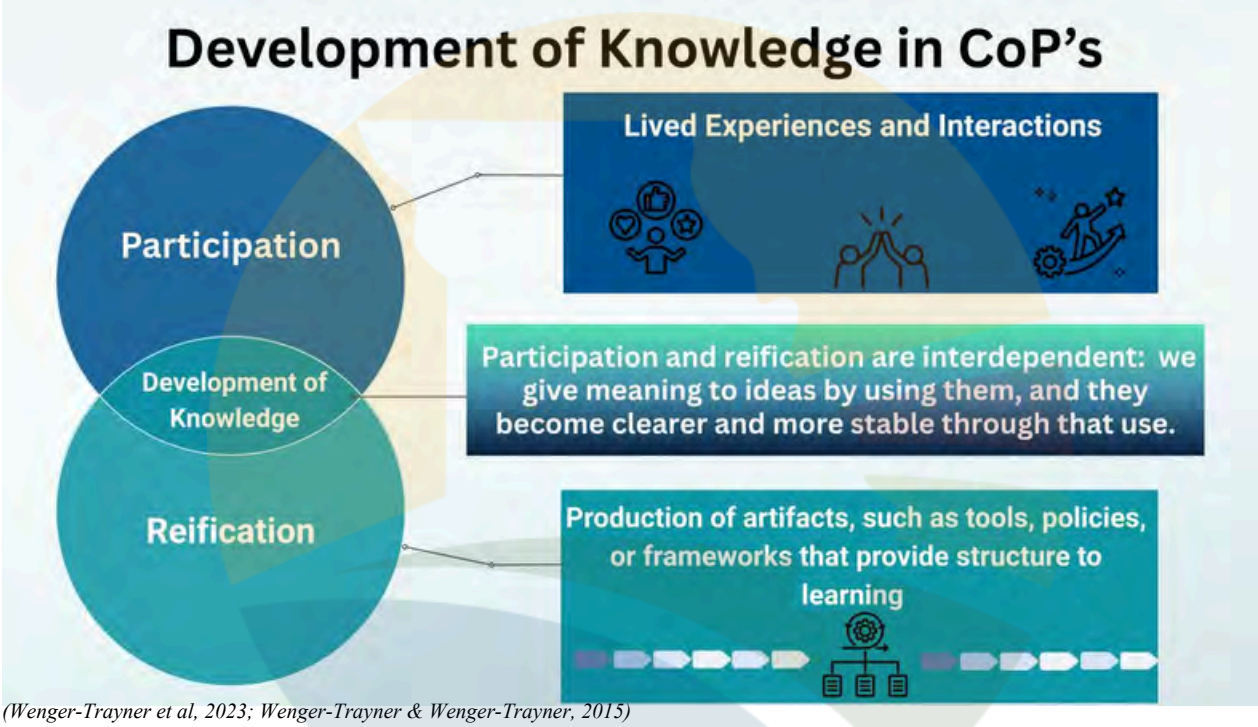



*(Wenger-Trayner et al, 2023; Wenger-Trayner & Wenger-Trayner, 2015)*

VCoPs function as dynamic learning infrastructures where knowledge is socially constructed through shared activity, reflection, and interaction with trusted peers (Elbrink et al., 2024). Unlike traditional models that treat knowledge as static content delivered to isolated learners, VCoPs support collaborative sensemaking, especially in complex environments like rural health, where context-specific solutions are essential (Barnett et al., 2013). Learning occurs through the interdependent processes of participation and reification—ongoing engagement with peers and the creation of tools, policies, or frameworks that structure collective understanding.

Participation brings reified knowledge to life (Albert et al., 2023), while reification ensures learning is durable and transferable. When balanced, these processes produce shared repertoires of practice and support professional identity development, enabling members to refine not only what they know but how they see themselves within evolving systems (Barnett et al., 2016).

**Figure 12**
*Development of Knowledge in Communities of Practice*




*(Wenger-Trayner et al, 2023; Wenger-Trayner & Wenger-Trayner, 2015)*

## Value in Communities of Practice

Understanding the impact of The Causeway as a VCoP requires a framework that captures how participants derive meaning, utility, and strategic insight over time. Wenger-Trayner et al. (2023) outline five interrelated cycles of value—immediate, potential, applied, realized, and reframed—that make this possible (Appendix A). Immediate value arises from direct interactions, such as receiving answers or feeling a sense of connection. Potential value encompasses accumulated ideas, relationships, or resources that can be leveraged in the future.

Applied value occurs when those assets are translated into practice, while realized value reflects measurable outcomes, such as improved care coordination or reduced provider burnout. Reframed value involves shifts in how participants define success or approach their work, often signaling more profound systemic change.

To remain viable and aligned with broader goals, VCoPs must demonstrate value not only for participants but also for organizations, funders, and policy systems. Traditional evaluation methods often fail to properly gauge the effectiveness of VCoPs, as they overlook the cumulative and nonlinear effects of social learning, particularly in relation to identity formation, decision-making, and changes in professional and organizational practice (Lardier et al., 2024). The value creation framework addresses these limitations by providing tools to surface both tangible and intangible forms of value. A central component is the value creation story, a narrative that traces how community experiences generate outcomes across the value cycles. These stories support internal learning while also offering credible, context-specific evidence for external stakeholders. Effective evaluation requires mixed-method strategies that combine quantitative indicators—such as platform analytics—with qualitative insights from interviews, reflective sessions, and participatory inquiry. This approach reveals less visible outcomes, including shifts in problem framing or professional confidence (Koatz et al., 2024). Ultimately, the value creation framework functions not only as an accountability tool but as a learning process that supports adaptation and strategic refinement.

**Figure 13**
*Types of Value that Arise in Virtual Communities of Practice*

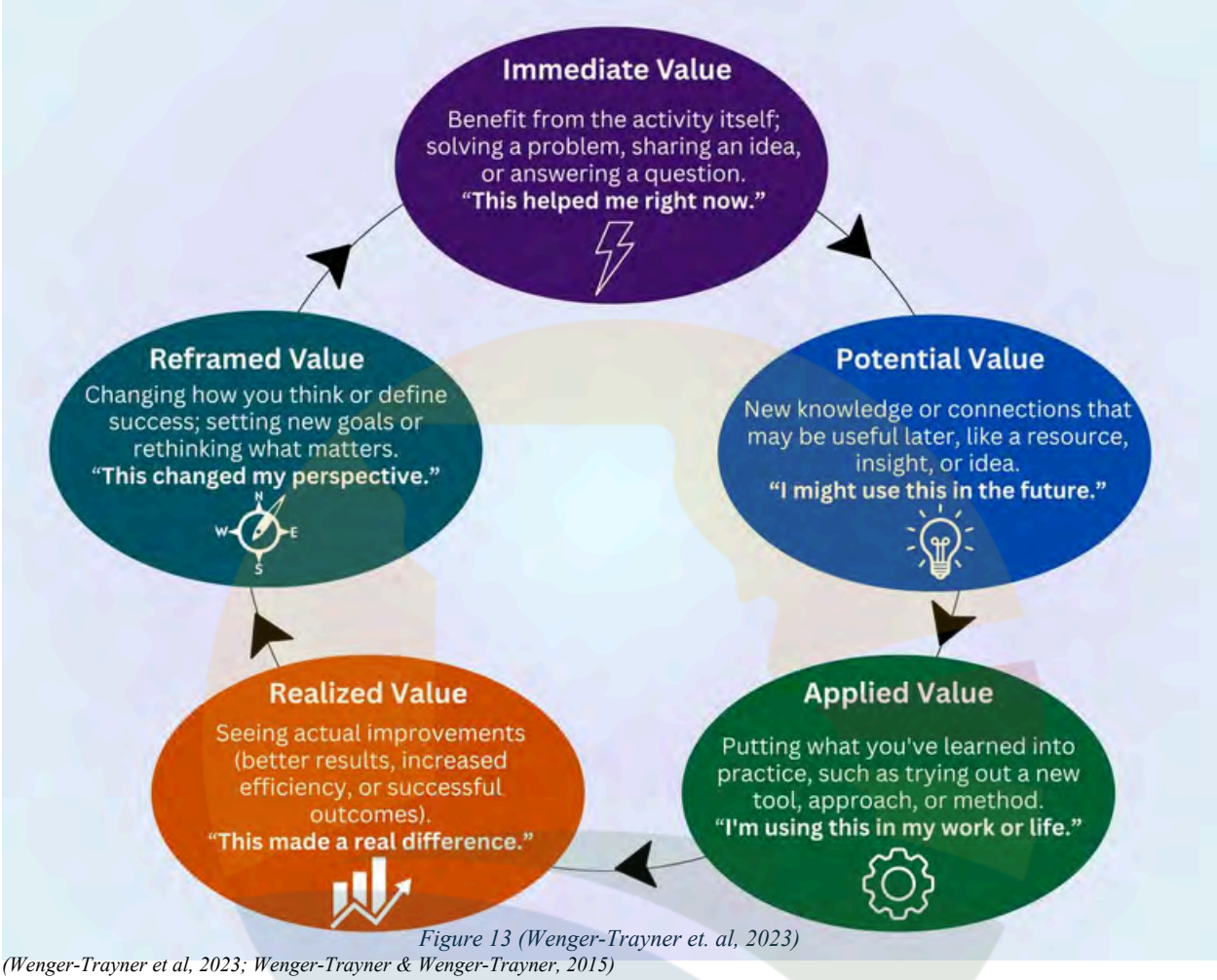



*Figure 13 (Wenger-Trayner et. al, 2023)*
*(Wenger-Trayner et al, 2023; Wenger-Trayner & Wenger-Trayner, 2015)*

## Evaluating The Causeway as a Community of Practice

To assess whether The Causeway is maturing into a valid Community of Practice, this assessment applies Wenger-Trayner's social learning and value creation frameworks. The goal is not simply to measure activity, but to understand whether the platform is fostering the cycles of learning and collaboration that generate real system change. This requires examining both quantitative benchmarks and qualitative reflections, capturing who participates, how they experience value, and what shared priorities emerge. To capture these dynamics, a survey was designed to assess both metrics. It focused on four key areas (see Appendix B):

- **Domain, Community, and Practice** – Members assessed their alignment with The Causeway's shared domain, evolving practices, and interpersonal connections.
- **Role Typologies** – Members self-placed along Wenger-Trayner's participation spectrum, generating data on patterns of involvement across roles.
- **Value Creation Cycles** – Scaled items measured experiences across the five types of value (immediate, potential, applied, realized, and reframed), establishing a baseline for growth over time.
- **Open Reflections** – Members provided qualitative insights into barriers, motivations, and priorities to contextualize their engagement experiences.

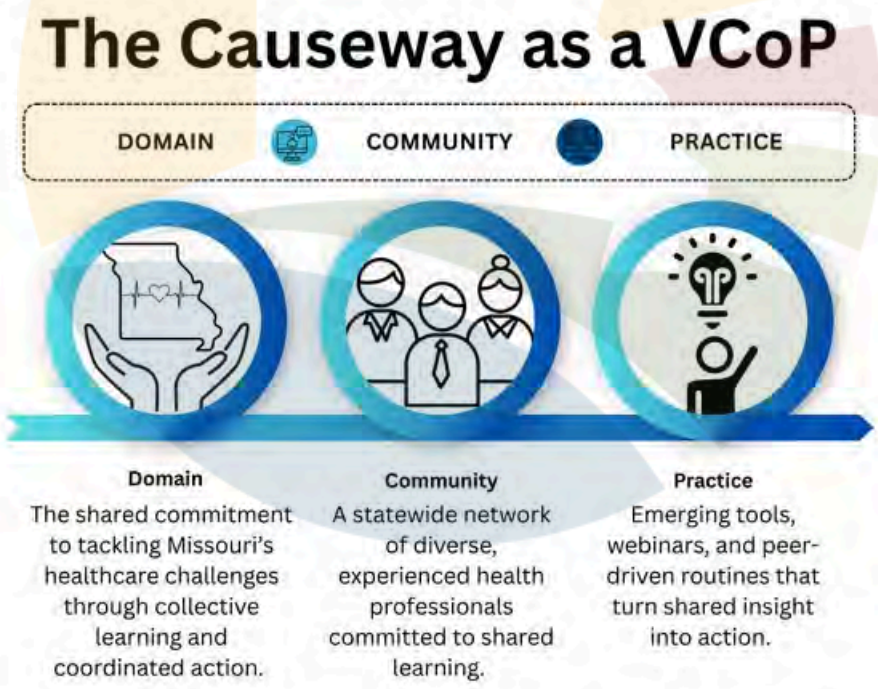
The survey was distributed electronically to The Causeway members, with incentives offered for early participation. Responses were cross-referenced with membership records to ensure accuracy, resulting in 48 verified responses. Identity fields were used only to confirm unique participation, stored separately, and scrubbed at the end of the evaluation period. By combining structured metrics with narrative insights, this methodology links the established theory of Communities of Practice with the lived realities of rural health stakeholders in Missouri.

## Establishing the Domain, Community, and Practice of The Causeway

The Causeway is beginning to demonstrate how a statewide VCoP can address Missouri's most pressing health challenges. In its early stages, the platform has already established a shared domain, diverse membership, and emerging practices that reflect the realities of working in under-resourced, high-pressure environments. Members consistently frame their concerns in structural terms, citing limited resources, workforce shortages, policy barriers, and inequities—highlighting that the value of The Causeway lies not in isolated

expertise but in its ability to convene stakeholders around complex problems that no single sector can solve alone. Baseline measures across Wenger-Trayner's five cycles of value creation confirm this trajectory: immediate and potential value are evident in the flow of ideas, resources, and relationships, while applied, realized, and reframed value remain underdeveloped. This mix of early promise and clear gaps underscores both the urgency and the opportunity; The Causeway has the foundation to grow into a vital infrastructure for collective learning and coordinated action, but realizing its potential will require intentional investment in participation, alignment, and impact.

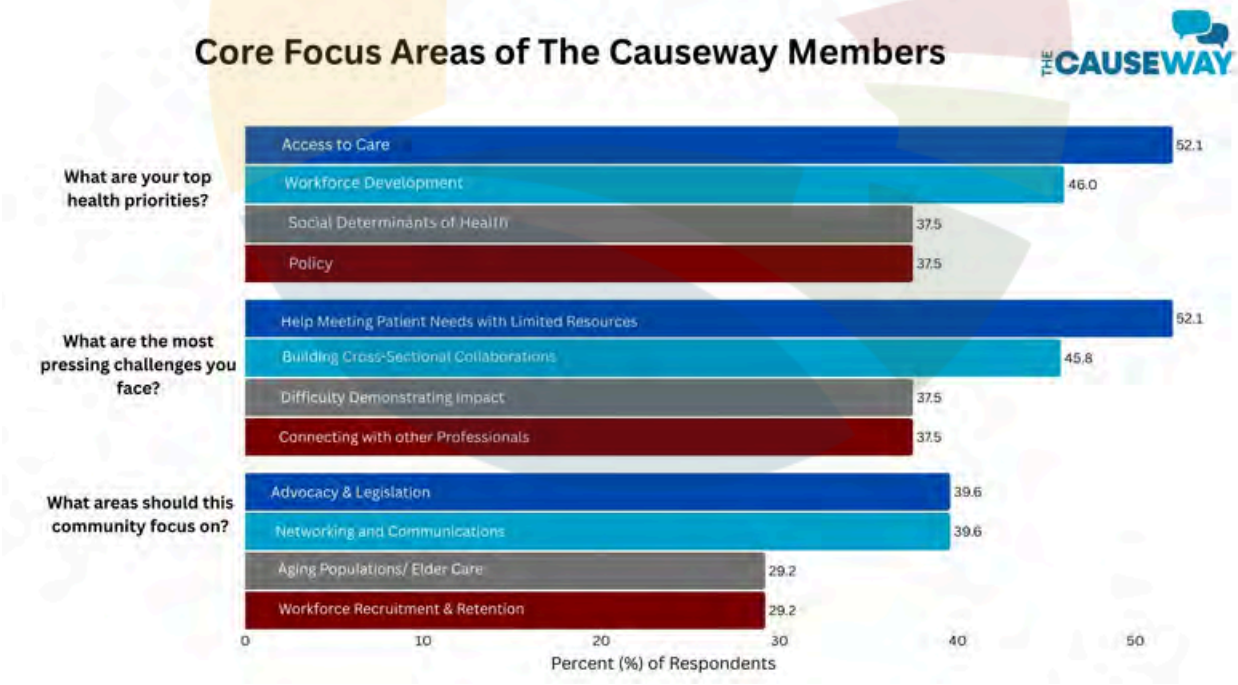
**Figure 14**
*The Causeway as a Virtual Community of Practice*




The domain of The Causeway (Appendix C) is defined by a shared commitmentto addressing structural barriers in healthcare access and workforce capacity, grounded inrural realities but oriented toward systems-level collaboration across Missouri. Survey results

highlight access to care (52.1%), workforce development (45.8%), social determinants of health (37.5%), and policy (37.5%) as top priorities, with concerns of limited resources, provider shortages, uneven infrastructure, and regulatory complexity. More than half of the members reported needing help meeting patient needs with limited resources (52.1%), nearly half emphasized the importance of cross-sector collaboration (45.8%), and many pointed to the difficulty of demonstrating impact (37.5%). Looking ahead, members want The Causeway to expand its advocacy and legislation (39.6%) and strengthen its networking (39.6%), underscoring that the domain is not defined by narrow clinical issues but by the broader, systemic conditions that shape who receives care, where, and how it is defined.

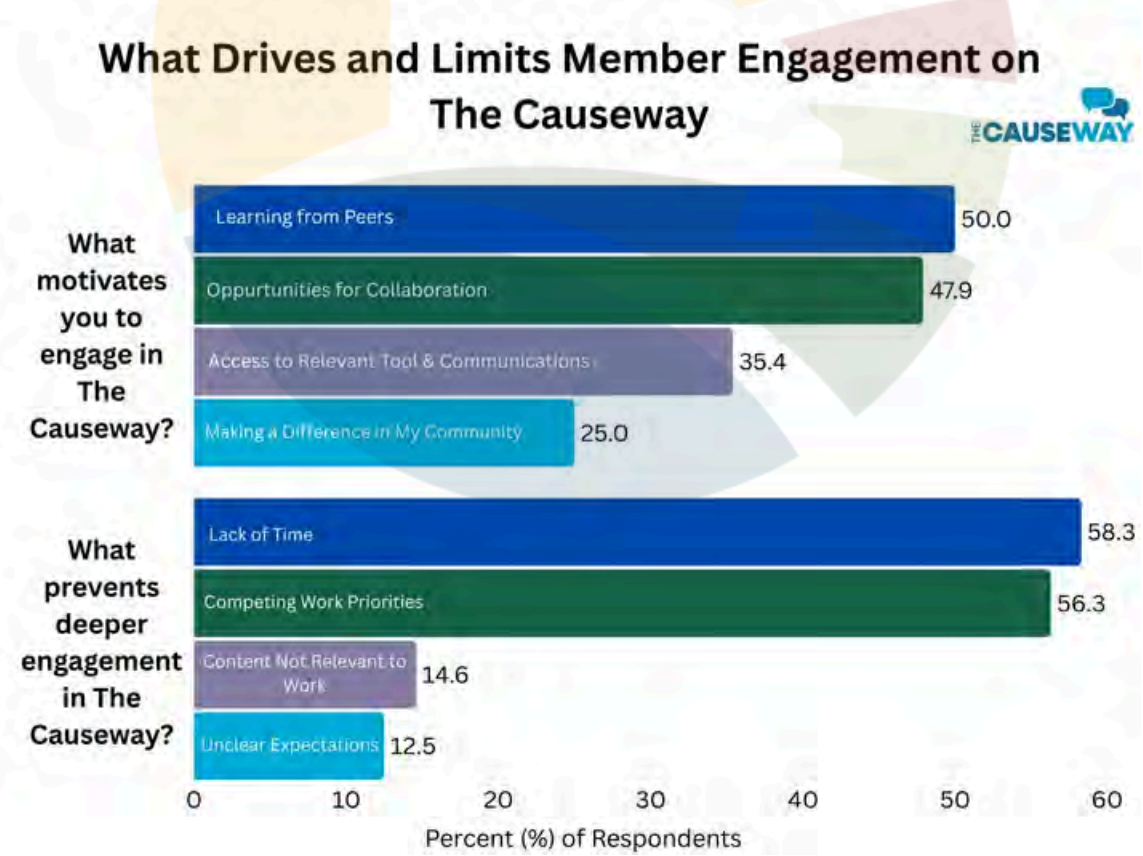
**Figure 15**
*Core Focus Areas of Members of The Causeway*




The community (Appendix D) of The Causeway is a peer-driven, cross-sector network spanning more than 25 professional roles across every region of Missouri, with over 70% of members bringing at least eight years of healthcare experience and 41.7% having more than 15

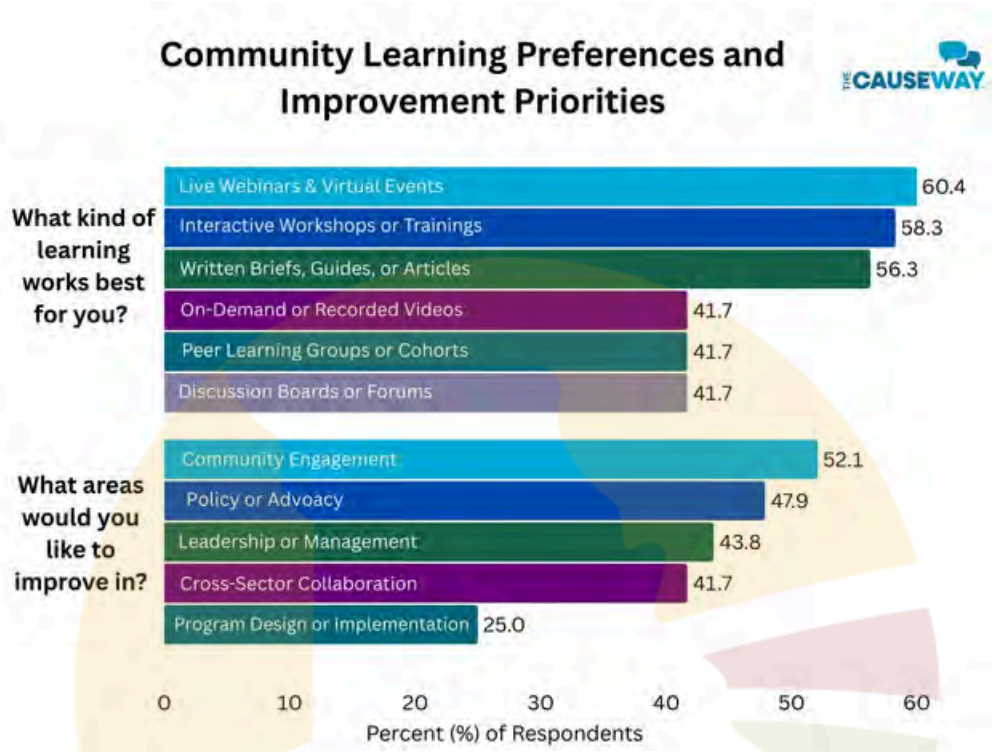
years of experience. Engagement patterns reflect a balanced but evolving community: 27.1% primarily observe, 25% contribute occasionally, another 25% contribute regularly, and 10.4% help lead or coordinate efforts. Members are motivated most by collaboration (50%) and peer learning (47.9%), which positions The Causeway less as a training platform and more as a practical support network. However, participation is constrained by structural barriers, most notably a lack of time (58.3%) and competing work priorities (56.3%), as well as challenges related to relevance (14.6%) and unclear expectations (12.5%). To grow into a true learning partnership, The Causeway must lower these barriers and ensure engagement is intuitive, accessible, and directly connected to members' daily work.

**Figure 16**
*What Drives and Limits Member Engagement on The Causeway*



Practice (Appendix E) within The Causeway is beginning to emerge through webinars, policy updates, peer conversations, and collaborative problem-solving, though integration into daily work remains limited. Only 6.3% of members report frequently applying what they learn, while 31.3% apply insights occasionally. An additional 36.9% of members have not yet applied what they have learned but report an intention to do so, reflecting limited current use alongside strong latent engagement. Regarding information delivery preferences, nearly 60% of members prefer live webinars, 58.3% interactive workshops, and 56.3% written briefs, with additional interest in peer-driven formats (41.7%). This pattern indicates a clear demand for practical, accessible professional development. However, barriers such as time constraints, platform navigation challenges, and unclear role relevance continue to limit impact: 29.2% report no change in their work, and another 29.2% remain unsure. Members' top areas for growth— community engagement (52.1%), policy and advocacy (47.9%), and leadership (43.8%)— underscore that The Causeway has the potential to become a central hub for applied learning and leadership development in Missouri if it prioritizes clear pathways from awareness to action.

**Figure 17**
*Member Learning Preferences and Priority Areas on The Causeway*




## Bridging Potential and Realized Value

The Causeway has transitioned beyond its launch phase and established itself as an active community; however, participation remains uneven and underutilized. While most members currently engage at lower levels, observing or contributing only occasionally, survey results reveal clear ambitions for deeper involvement. One-third want to contribute actively, another third to support others regularly, 25% to help guide The Causeway's direction, and nearly half to expand collaboration across organizations. This divergence between how members participate today and how they hope to engage illustrates the gap between potential and realized value in a community of practice, as Wenger-Trayner identifies. Addressing this gap requires intentional

participation pathways, the reduction of structural barriers, and expanded opportunities for members to assume leadership roles.

To better understand this gap, Wenger-Trayner's narrative dimension of evaluation emphasizes the importance of member stories that reveal how participants experience and interpret a community (Appendix F). Survey responses and qualitative reflections converge around five recurring archetypes that capture these lived realities. Executives (15%) focus on organizational survival while meeting community needs and turn to The Causeway for policy updates and advocacy resources to navigate closures and workforce shortages. Policy Advocates (15%) connect frontline realities to systemic reform, drawing on legislative updates and webinars to amplify healthcare voices in a polarized political environment. Community Connectors (15%), such as nurses and community health workers, carry the burdens of daily patient care and seek solidarity, resources, and encouragement through peer exchange. Educators (12.5%) include faculty, trainers, and public health professionals who use the platform to expand outreach across dispersed rural populations. System Builders (12.5%) represent administrators and nonprofit leaders who sustain essential programs behind the scenes, often with limited recognition and resources.

**Figure 18**
*The Causeway Member Archetypes*

**The Causeway Member Archetypes**

| Archetype | Proportion of Members | Motivation | Biggest Barriers | Value in MRHA Connect | Future Needs |
|---|---|---|---|---|---|
| EXECUTIVE | 15% | Financial stability and survival of organizations while meeting community needs | Workforce shortages, hospital closures, escalating costs | Legislative webinars, policy updates, peer framing of issues | Advocacy hub with streamlined policy intelligence and pooled influence |
| POLICY ADVOCATE | 15% | Equity, systemic change, amplifying rural voices | Political climate, fragmented advocacy, lack of cross-sector coordination | Legislative updates, webinars, solidarity with peers | Shared policy agendas, partnerships, collective rural voice |
| COMMUNITY CONNECTOR | 15% | Direct patient/community support, solidarity in frontline roles | Staffing shortages, lack of recognition/compensation, overwhelming workload | Forums, weekly updates, resource-sharing, peer validation | Stronger peer exchange, visibility for CHW/provider innovations, networks beyond clinics |
| EDUCATOR | 12.5% | Expanding public health education, prevention, and workforce training | Limited rural reach, information overload, lack of structured cohorts | Webinars, legislative updates, shared resources, exposure to peers | Curated resources, cohort-based peer learning, translation of policy into teaching |
| SYSTEM BUILDER | 12.5% | Expanding reach and visibility of essential but overlooked services | Limited recognition, fragmented networks, unsustainable funding | Practical content, resource-sharing, visibility of key actors | Referral pipelines, amplification of models, linking grassroots work to policy/funding |

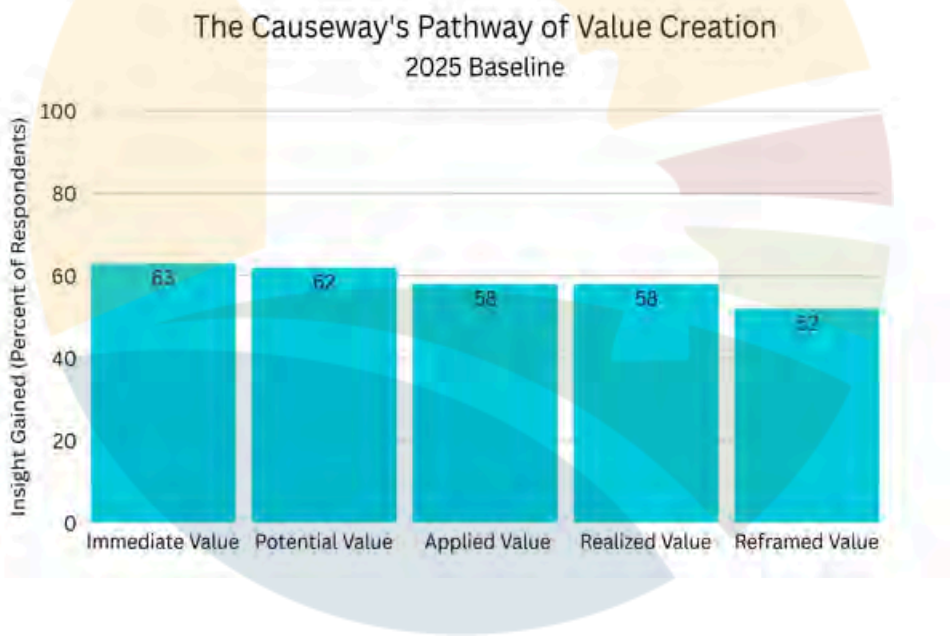
Taken together, these archetypes shift the evaluation from statistics to stories, grounding the abstract measures of domain, community, and practice in the realities of members' work. Each highlights a distinct way The Causeway generates value. Executives emphasize collective influence, Advocates call for structured advocacy channels, Connectors rely on resources and peer validation, Educators want cohort-based learning, and System Builders seek stronger referral pipelines and greater visibility. More importantly, these narratives reveal where value is constrained and identify the kinds of supports and design choices needed for the community to evolve.

## Evaluation and Growth

In Wenger-Trayner's framework, value creation describes how VCoPs generate benefits for members and the broader systems they influence, moving from immediate insights to long-term transformation. Baseline results show that The Causeway has established this foundation,

with members reporting consistent access to ideas, resources, and relationships that they expect will grow into measurable improvements over time. The most substantial evidence lies in immediate value (63%) and potential value (62%), where legislative updates, grant opportunities, and peer exchanges are frequently cited as applicable. Applied value (58%) and realized value (58%) remain modest, with fewer participants translating what they learn into organizational change. Reframed value (52%), the most profound shift in defining success or strategy, is the least developed but present among a meaningful minority.

**Figure 19**
*The Causeway's Pathway of Value Creation*

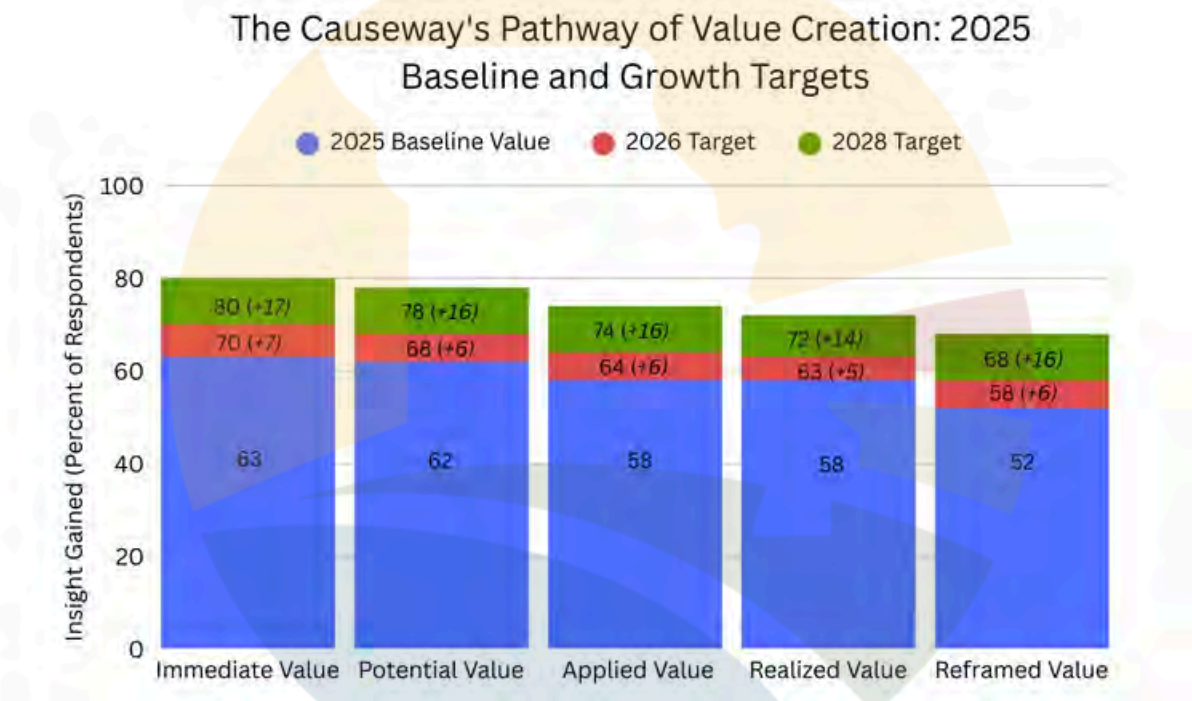



Survey responses offer a more detailed insight into these dynamics. Nearly halfofthe members (47.9%) reported gaining helpful ideas or encouragement through The Causeway, and 45.9% noted forming new professional relationships. About one-third have applied something learned, most often policy updates or grant opportunities, but only 12.5% reported measurable organizational outcomes. Reframed value remains an emerging concept, with 20.8% noting shifts in priorities or perspectives. Qualitative reflections highlight areas where growth is needed,

including curated resource libraries, simplified navigation, and peer spotlights that convert occasional insights into lasting knowledge. These patterns suggest that The Causeway is strongest at providing immediate benefits and fostering early relationship-building, but it still faces challenges in helping members consistently translate insights into sustained practice or systemic impact.

**Figure 20**

*The Causeway's Pathway of Value Creation: Current and Growth Targets*



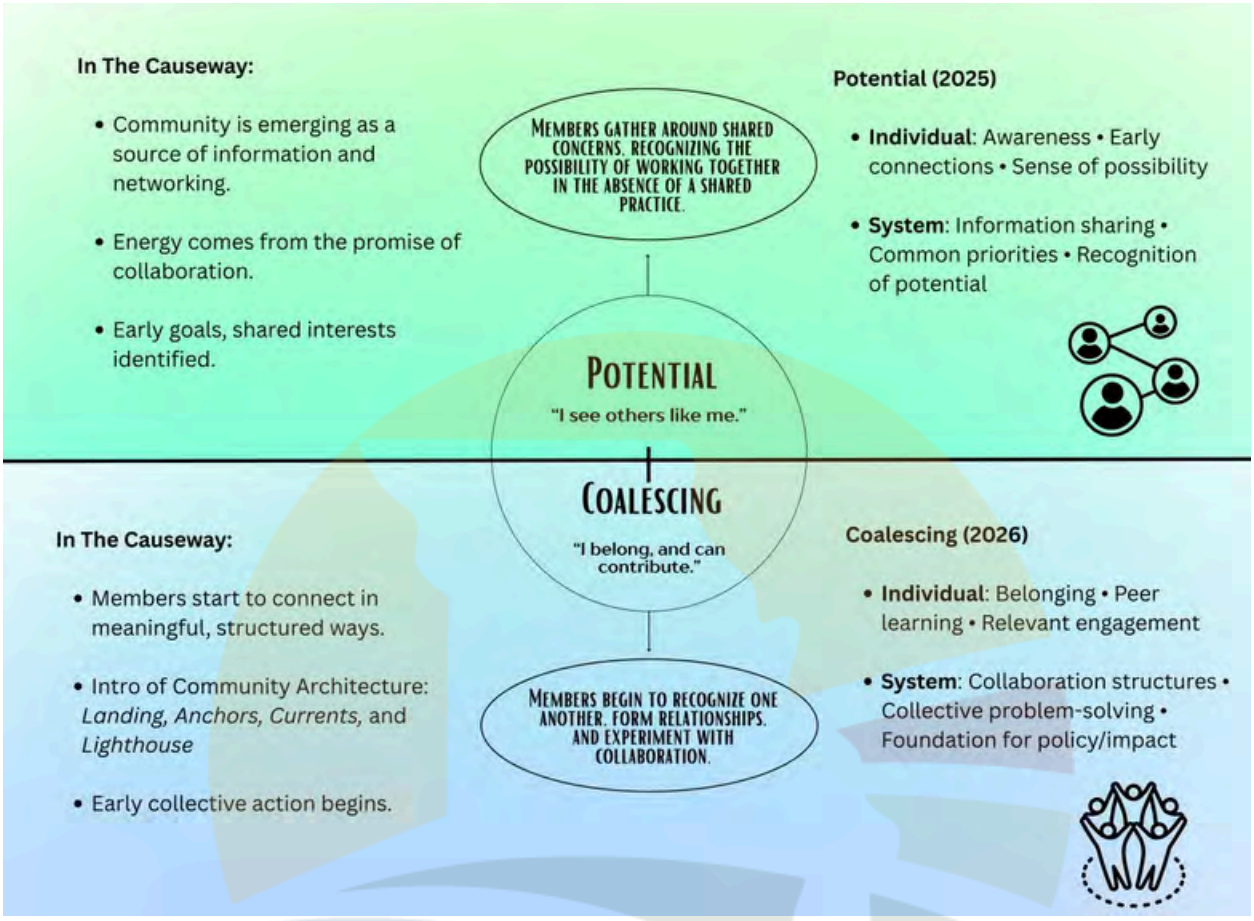

Taken together, the baseline data reveal a motivated community that is still finding its footing. Members report consistent immediate benefits and emerging potential value, but applied, realized, and reframed value remain underdeveloped. At the same time, many express readiness to deepen collaboration, share tools, and assume leadership if clearer pathways and stronger peer structures are in place. These patterns highlight both the promise and the gaps: The Causeway is beginning to function as a support system for immediate needs, but its evolution

into a catalyst for lasting system change will depend on reducing barriers and cultivating sustained engagement.

## The Causeway as a Catalyst for a Unified Rural Health Workforce

The Causeway is entering a pivotal stage of development in which its value as a source of information and connection must give way to a more profound systemic impact. As of 2025, the community is in the potential stage, uniting healthcare providers around shared concerns and early goals. The next step is coalescing, when members begin to recognize one another, form relationships, and collaborate around shared priorities. In 2026, this transition will be driven by building community architecture through the Landing for newcomers, role-based Anchors that provide identity and peer learning, and issue-focused Currents that channel discussion toward Missouri's most urgent health challenges. By investing in these structures, The Causeway can move decisively beyond surface-level exchange and begin laying the foundation for collective action, policy influence, and system transformation.

**Figure 21**
*The Transition from the Potential to Coalescing Stage in The Causeway*

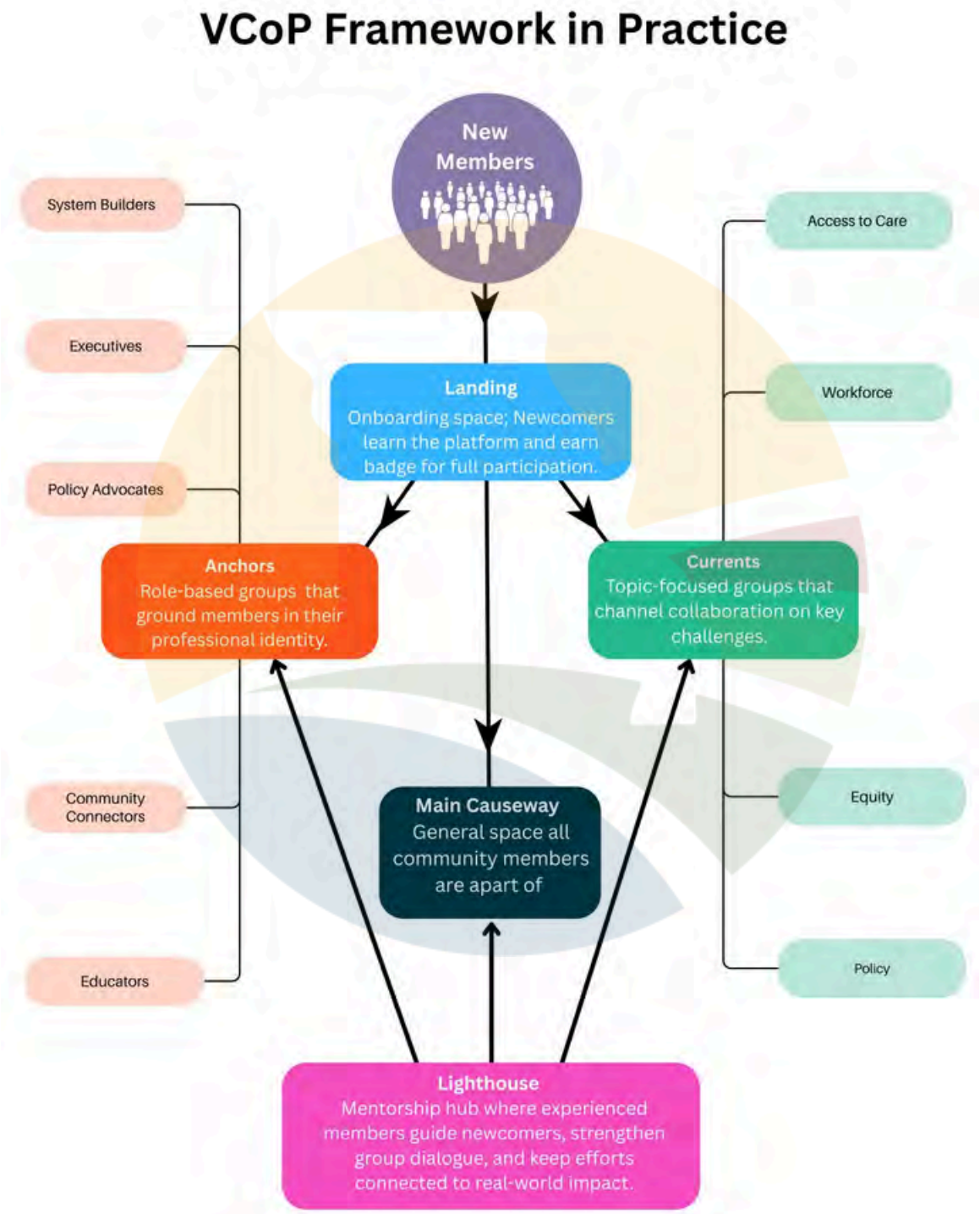



In Wenger-Trayner's framework, the coalescing stage is when members begin to recognize each other, form relationships, and experiment with collaboration around shared priorities. For The Causeway, 2026 represents the year to move decisively from potential into coalescence by creating the systems that make meaningful engagement possible. The goal is to ensure every member can enter confidently, find a place that reflects their professional identity, and connect to topical discussions that matter to their daily work. By the end of 2026, The Causeway should function as a structured yet flexible environment where members begin to experience applied and realized value, laying the foundation for future growth.

**Key 2026 Priorities:**

- **Newcomer Cohorts (The Landing):** Structured onboarding with clear expectations, orientation activities, and digital badges marking transition into the full network.
- **Archetype Communities (Anchors):** Role-based groups (executives, policy advocates, community connectors, educators, system builders) that provide stable identity and peer learning.
- **Causeway Currents (Topic Communities):** Thematic groups focused on access to care, workforce, policy/advocacy, and social determinants of health, each supported by practical resources and dialogue.
- **Mentorship Community (The Lighthouse):** Experienced members who guide newcomers, strengthen Anchors and Currents, and provide facilitation and support to sustain vibrant participation across the network.
- **Early Evaluation Loops:** Integrate pulse polls, engagement analytics, and member reflections to monitor coalescing and to adjust design choices in real time.

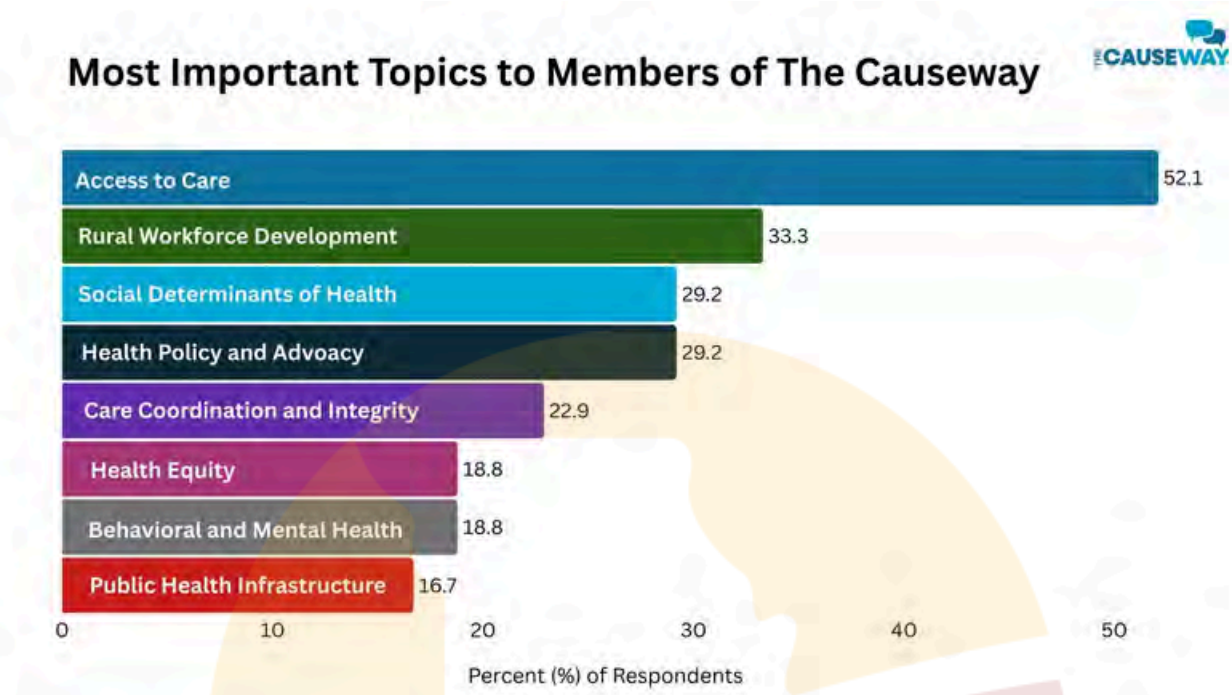
**Figure 22**
*Virtual Communities of Practice Framework*



To put the VCoP framework into practice, The Causeway will establish a structured community architecture that guides members from entry to sustained participation. This design balances inclusivity with intentional pathways, ensuring every member can join with confidence and quickly find spaces aligned with their role. All new participants will begin in the Landing, a short-term newcomer cohort where orientation activities introduce platform tools, expectations, and opportunities for engagement. Completion of this onboarding is recognized with a digital badge displayed on users' profiles, signaling readiness to participate fully in the broader network.

Once oriented, members will connect through two primary structures: Anchors and Currents. Anchors are role-based communities built around the five archetypes identified in the survey: executives, policy advocates, community connectors, educators, and system builders. These groups provide members with a clear professional identity, opportunities for peer learning, and practical strategies tailored to the realities of their roles, ensuring that each participant sees where their expertise contributes to the collective effort. Currents, by contrast, are topic-focused communities designed to channel discussion toward the most pressing challenges reported by members. Survey results highlight access to care (52.1%), rural workforce development (33.3%), health policy and advocacy (29.2%), and social determinants of health (29.2%) as the highest priorities, with additional interest in care coordination and integration (22.9%), behavioral and mental health (18.8%), health equity (18.8%), public health infrastructure (16.7%), maternal and child health (14.6%), and technology and telehealth (12.5%). By grounding Anchors in shared roles and Currents in member-defined priorities, The Causeway creates a dual structure that supports both professional identity and issue-specific collaboration across the statewide community.

**Figure 23**
*Most Important Topics to Members on The Causeway*




To sustain this architecture, The Causeway will also develop the Lighthouse, a mentorship community designed to guide and support activity across the Landing, Anchors, and Currents. Members of the Lighthouse will serve as peer leaders who help newcomers integrate, strengthen dialogue within archetype and topic groups, and ensure conversations remain connected to real-world impact. These leaders provide continuity, encouragement, and facilitation, creating a layer of distributed leadership that keeps participation vibrant. By positioning the Lighthouse as both a home for experienced members and a support system for emerging leaders, The Causeway establishes an internal engine of mentorship that reinforces community sustainability and builds long-term capacity across Missouri's rural health ecosystem.

For examples of members and how they may fit into these systems, please review Appendix G.

**Evaluation as a Driver of Learning and Adaptation**

Sustaining The Causeway requires a practical, responsive, and aligned evaluation rhythm with Wenger-Trayner's value creation framework. While large-scale surveys will continue to serve as foundational assessments, they are too cumbersome to repeat annually and risk producing delayed insights. Beginning in 2026, the platform will adopt agile/SCRUM project management with two-week agile sprints. Each sprint will culminate in a release for the community, ensuring that members see tangible improvements regularly. These sprints will integrate continuous user feedback, keeping the platform design closely tied to the evolving needs of the community.

This evaluation approach will draw on multiple data streams: pulse polls integrated directly into the platform to gauge member priorities and emerging needs; engagement analytics tracking activity across the Landing, Anchors, and Currents to identify where participation is thriving or lagging; quarterly value creation stories that illustrate how The Causeway insights have been applied in practice; and mentor feedback loops to capture lessons from community leaders. Together, these tools create a participatory evaluation ecosystem where members contribute directly to a living evidence base.

To complement this continuous feedback cycle, a streamlined version of the full evaluation survey will be administered annually to measure progress in value creation. Findings from agile sprints, ongoing feedback, and survey data will be synthesized into two levels of reporting: quarterly updates that track the pulse of participation and system learning, and an annual report on the overall health of The Causeway. These reports will provide stakeholders with a clear, consistent view of progress, reinforcing transparency and accountability while guiding collective decision-making. By embedding agile development, participatory evaluation,

and structured reporting, The Causeway will remain adaptive, document progress at each developmental stage, and steadily mature into a trusted engine of health professional transformation.

**Areas for Further Work**

The long-term vision for The Causeway is to evolve from a promising network into a statewide engine of health transformation. Achieving this requires not only cultivating participation but also building the internal capacity to support and sustain growth. The following areas represent key priorities for further development:

- **Strengthen Facilitation**: Continue supporting the Community Manager with systems and tools that make facilitation of newcomer cohorts, archetype communities, and niche groups more efficient.
- **Evaluation and Learning Integration**: Build an evidence base through lightweight, ongoing evaluation, and align it with the learning cycle of The Causeway.
- **Integrated Learning Management System (LMS)**: Develop and launch an LMS linked with The Causeway to provide structured training, onboarding modules, and continuing education opportunities for members.
- **Policy Integration:** Ensure that insights from community discussions and evaluation are systematically translated into policy advocacy.
- **Cross-Sector Collaboration:** Expand the network to intentionally include education, transportation, agriculture, and economic partners who intersect with rural health.

Taken together, these strategies show how The Causeway can move from a promising idea to a durable system of shared learning and action. The community enters this next stage with clear strengths: a broad and experienced membership, early structures for identity and collaboration, and a growing culture of peer support. At the same time, it faces significant challenges, including uneven participation, limited staff capacity, and the need to demonstrate applied and realized value. By investing in community architecture, mentorship, and agile evaluation, while also expanding partnerships and staff roles, The Causeway can address identified gaps and build on its momentum. The result will not be a static network but a living infrastructure for Missouri's health workforce—capable of mobilizing in response to urgent threats, sustaining long-term collaboration, and influencing interdependent policy and practice at a scale no single organization could achieve alone.

## Conclusion

Missouri's healthcare system stands at a critical moment. Hospital closures, workforce shortages, and rising preventable deaths have exposed its fragility, while also revealing the determination of communities that continue to adapt under extraordinary pressure. Meeting this crisis requires more than short-term fixes; it calls for durable infrastructure that can sustain collaboration, move knowledge quickly across sectors, and organize collective action at the scale the challenge demands. Without this, Missouri risks a future in which disparities widen, hospitals disappear, and access to care erodes further.

The Causeway provides a foundation for a different path. As a statewide virtual community of practice, it is designed to bridge divides, align stakeholders, and transform fragmented responses into coordinated strategies. Investment in community architecture, agile

evaluation, and mentorship will deepen participation and create clear pathways from shared learning to practice change. These investments will ensure that the insight of Missouri's health workforce is not lost in isolation but translated into action that informs policy and strengthens systems.

The path forward is urgent and possible. With sustained support, The Causeway can expand professional capacity, amplify frontline innovation, and shape policy that reflects the realities ofboth rural and urban communities. Its success, however, will depend on the leaders, providers,and partners who choose to use it. The Causeway will only realize its potential if membersbring their voices, ideas, and leadership into the community and if decision-makers committheresources required to sustain it. By doing so, Missouri can move from potential collapsetoconnection and build a health system resilient enough to serve every community in the state.

## References

Albert, Kwong, & Ibrahim. (2023). Factors influencing professional virtual communities towards public service efficiency. In *24th European Conference on Knowledge Management* (Vol. 1, pp. 24–32). ACI UK.

Alexander, D., & Richards, M. R. (2021). Economic consequences of hospital closures. *Journal of Public Economics*, 221, 104821. https://doi.org/10.1016/j.jpubeco.2023.104821

America's Health Rankings. (2024). *Overall in United States*. United Health Foundation. https://www.americashealthrankings.org/explore/measures/Overall

Arakelyan, M., Freyleue, S. D., Schaefer, A. P., Austin, A. M., Moen, E. L., O'Malley, A. J., Goodman, D. C., & Leyenaar, J. A. K. (2024). Rural–urban disparities in health care delivery for children with medical complexity and moderating effects of payer, disability, and community poverty. *Journal of Rural Health*, *40*(2), 326–337. https://doi.org/10.1111/jrh.12827

Armstrong, D., Umansky, E., & Coleman, V. (2025, August 8). Doctors and Nurses Reject VA Jobs Under Trump. *ProPublica*. https://www.propublica.org/article/veterans-affairs-hospital-shortages-trump

Barnett, Jones, Bennett, & Bonney. (2013). Usefulness of a virtual community of practice and web 2.0 tools for general practice training: experiences and expectations of general practitioner registrars and supervisors. *Australian Journal of Primary Health*, *19*(4). https://www.publish.csiro.au/py/PY13024

Barnett, S., Jones, S. C., Bennett, S., Iverson, D., & Robinson, L. (2016). A virtual community of practice for general practice training: A preimplementation survey. *JMIR Medical Education*, *2*(2). https://doi.org/10.2196/mededu.5318

Browne, T., McKinney, S. H., Duck, L., Baliko, B., Blake, E. W., Bethel, S. R., & Christopher, R. (2022). An academic-community interprofessional telehealth online training partnership: Impact on students and providers. *Journal of Interprofessional Care*, *36*(5), 643–650. https://doi.org/10.1080/13561820.2021.1967896

CauseIQ. (2024a). *Mosaic medical center - Albany.* https://www.causeiq.com/organizations/northwest-medical-center,440580870/

CauseIQ. (2024b). *Mosaic medical center center-maryville*. https://www.causeiq.com/organizations/mosaic-medical-center-maryville,832249459/

Cairns, C., Ashman, J. J., & Kang, K. (2024). *Emergency department visit rates by selected characteristics: United States, 2022* (NCHS Data Brief No. 503). National Center for Health Statistics. https://www.cdc.gov/nchs/products/databriefs/db503.htm

Center for Applied Research and Engagement Systems. (2022). *Residents with very long commute by county* [Interactive map]. All Things Missouri, University of Missouri Extension. https://short-link.me/17HeQ

Center for Applied Research and Engagement Systems. (2023). *Childhood poverty map* [Interactive map]. All Things Missouri, University of Missouri Extension. https://short-link.me/11r7i

Center for Applied Research and Engagement Systems. (2024). *Suicide death rate by county* [Interactive map]. All Things Missouri, University of Missouri Extension. https://short-link.me/13vsG

Center for Research on Disability. (2023). *County level statistics*. https://www.researchondisability.org/build-your-own-statistics-county-level-statistics

Christson, A., & Adedoyin, A. (2016). Deploying virtual communities of practice as a digital tool in social work: a rapid review and critique of the literature. *Social Work Education*, *35*(3), 357–370. https://doi.org/10.1080/02615479.2016.1154660

Dockins, J., & Lingerfelt, D. (2024). How far is too far? Rural hospital closures and emergency room travel distances. *Management in Healthcare: A Peer Reviewed Journal*, *8*(4), 354–366. https://doi.org/10.69554/NHHU5825

Elbrink, S. H., Elmer, S. L., & Osborne, R. H. (2024). How communities of practice generate knowledge translation outcomes to support public health issues: A realist synthesis. *Health and Social Care in the Community*, *2024*. https://doi.org/10.1155/2024/1960806

Farmer. (2025, April 9). *Average ER visit cost*. Better Care. https://bettercare.com/costs/er-visit-cost?

Gordon, S. (2025). *Veterans Healthcare Choice—Myth or Reality? A State-By-State Reality CheckoftheFalsePromiseofVA Privatization* (pp. 61–62). Veterans Healthcare Policy Institute . https://st ati c1.squarespac e.com /stati c/68a3 a7a086f56 252a95e0de0/ t/68bc5 a27dc6309018509081f/1757174311055/MO_Fixed.pdf

Gujral, K., & Basu, A. (2019). *Impact of rural and urban hospital closures on inpatient mortality.* National Bureau of Economic Research. https://doi.org/10.3386/w26182

Indeed. (2025). *Putnam county memorial hospital*. https://www.indeed.com/cmp/Putnam-County-Memorial-Hospital

Kaiser Family Foundation. (2025, May). *Medicaid in Missouri*. https://files.kff.org/attachment/fact-sheet-medicaid-state-MO

Koatz, D., Torres-Castaño, A., Salrach-Arnau, C., Perestelo-Pérez, L., Ramos-García, V., González-González, A. I., Pacheco-Huergo, V., Toledo-Chávarri, A., González-Pacheco, H., & Orrego, C. (2024). Exploring value creation in a virtual community of practice: A framework analysis for knowledge and skills development among primary care professionals. *BMC Medical Education*, *24*(1). https://doi.org/10.1186/s12909-024-05061-6

Landes, D., & Bondurant, A. (2023). Listening to rural missouri: a needs assessment. Missouri Rural Health Association. https://mrhassociation.org/wp-content/uploads/2024/01/RUMO_NeedsAssess.pdf

Lardier, D. T., Dickson, E. L., Hackett, J. M., & Verdezoto, C. S. (2024). A scoping review of existing research between 1990 and 2023: Measuring virtual communities of practice across disciplines. *Journal of Community Psychology*, *52*(1), 198–225. https://doi.org/10.1002/jcop.23092

LinkedIn. (2025a). *Scotland County Hospital*. https://www.linkedin.com/company/scotland-county-hospital/people/

LinkedIn. (2025b). *Sullivan County Memorial Hospital*. https://www.linkedin.com/company/sullivan-county-memorial-hospital/people/?facetGeoRegion=103644278

MERIC. (2025, March). North WDA Commuting Profile. Missouri Economic Research and Information Center. https://meric.mo.gov/media/pdf/north-wda-commuting-profile

Mills, & Bennett. (2025, April 8). *Critical condition: how medicaid cuts would reshape rural health care landscapes*. National Rural Health Association.

https://www.ruralhealth.us/blogs/2025/04/critical-condition-how-medicaid-cuts-would-reshape-rural-health-care-landscapes

Missouri Community Action Network. (2022). *2022 Missouri poverty report*. https://www.communityaction.org/wp-content/uploads/2022/09/2022-POVERTY-REPORT-web.pdf

Missouri Department of Health & Senior Services. (2021). *Health in rural Missouri: Biennial report*, 2020–2021. https://health.mo.gov/living/families/ruralhealth/pdf/biennial2020.pdf

Missouri Department of Health and Senior Services. (2023a). *Health in rural Missouri biennial report*, 2022–2023. https://health.mo.gov/living/families/ruralhealth/pdf/biennial2022.pdf

Missouri Department of Health and Senior Services. (2023b). *Missouri drug overdose dashboard* [Data dashboard]. https://health.mo.gov/data/opioids/

Missouri Department of Health and Senior Services. (2023c). Missouri COVID-19 mortality, 2020–2022. https://health.mo.gov/data/pdf/20202022-covid-deaths.pdf

Missouri Department of Health & Senior Services. (2023d, March 30). *Missouri rural hospitals and critical access hospitals.* https://health.mo.gov/living/families/ruralhealth/pdf/rural-hospitals.pdf

Missouri Department of Health and Senior Services. (2023e). *Years of potential life lost (YPLL)*, 1999–2023 [Data set]. https://health.mo.gov/data/ypll/xls/yearlyrangedata1999-2023.xlsx

Missouri Department of Health and Senior Services. (2024a). *Missouri state health assessment 2024*. https://health.mo.gov/accreditation/pdf/state-health-assessment.pdf

Missouri Department of Health & Senior Services. (2024b). *Vital Statistics FOCUS: 2023*. https://health.mo.gov/data/focus/pdf/2023-focus.pdf

Missouri Department of Health and Senior Services. (2025a). *A multi-year look at maternal mortality: 2018–2022 pregnancy-associated mortality review*. https://health.mo.gov/data/pamr/pdf/2025annual-report.pdf

Missouri Department of Health & Senior Services. (2025b, October 3). Missouri hospital profiles by county. https://health.mo.gov/safety/healthservregs/pdf/MOhospbyCounty.pdf

Missouri Department of Health and Senior Services & Bureau of Health Care Analysis and Data Dissemination. (2019). *Missouri vital statistics 2018*.

Missouri Department of Health and Senior Services & Bureau of Health Care Analysis and Data Dissemination. (2020). *Missouri vital statistics 2019*.

Missouri Department of Health and Senior Services & Bureau of Health Care Analysis and Data Dissemination. (2021). *Missouri vital statistics 2020*.

Missouri Department of Health and Senior Services & Bureau of Health Care Analysis and Data Dissemination. (2022). *Missouri vital statistics 2021*.

Nixon, P., Broccatelli, C., Moss, P., Baggio, S., Young, A., & Newcomb, D. (2024). Healthcare social network research and the ECHO modelTM: Exploring a community of practice to support cultural brokers and transfer cultural knowledge. *BMC Health Services Research*, *24*(1). https://doi.org/10.1186/s12913-024-11024-w

Rasmussen, P., & Farmer, C. M. (2023). The Promise and Challenges of VA Community Care: Veterans' Issues in Focus. *Rand Health Quarterly*, *10*(3), 9.

Rural Health Information Hub. (2025, March 17). *Rural Veterans and Access to Healthcare Overview*. https://www.ruralhealthinfo.org/topics/returning-soldier-and-veteran-health

Saint Louis University Center for Health Law Studies, & Washington University Center for Health Economics and Policy. (2021, March). *Medicaid expansion enrollment and*

*eligibility update: Geographic distribution of Medicaid enrollees—Maps*. Missouri Foundation for Health. https://www.slu.edu/law/health/-pdf/factsheet_county_enrollees_march2021.pdf

Schroeder, S., Tan, C. M., Urlacher, B., & Heitkamp, T. (2021). The role of rural and urban geography and gender in community stigma around mental illness. *Health Education & Behavior*, *48*(1), 63–73. https://doi.org/10.1177/1090198120974963

Shaw, L., Jazayeri, D., Kiegaldie, D., & Morris, M. E. (2022). Implementation of virtual communities of practice in healthcare to improve capability and capacity: A 10-year scoping Review. *International Journal of Environmental Research and Public Health*, *19*(13). https://doi.org/10.3390/ijerph19137994

Sibbald, S. L., Burnet, M. L., Callery, B., & Mitchell, J. I. (2022). Building a virtual community of practice: experience from the Canadian foundation for healthcare improvement's policy circle. *Health Research Policy and Systems*, *20*(1). https://doi.org/10.1186/s12961-022-00897-0

Teoh, J. Y. (2022). How occupational therapy practitioners use virtual communities on the Facebook social media platform for professional learning: A critical incident study. *Scandinavian Journal of Occupational Therapy*, *29*(1), 58–68. https://doi.org/10.1080/11038128.2021.1895307

U.S. Bureau of Labor Statistics. (2025, September 16). *County employment and wages in missouri — first quarter 2025* (Mountain–Plains information office news release). Bls.Gov. https://www.bls.gov/regions/mountain-plains/news release/countyemploymentandwages_missouri.htm

U.S. Department of Veterans Affairs, National Center for Veterans Analysis and Statistics. (2021). *State Summaries-Missouri*. [Data Set]. https://www.data.va.gov/stories/s/State-Summaries_Missouri/ggvb-7ke9/

U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention. (2024). *Missouri Veteran Suicide Data Sheet 2022*. https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022_State_Data_Sheets_Missouri_508.pdf

U.S. Census Bureau. (2023). *Selected housing characteristics: ACS 5-year estimates* (DP04). https://data.census.gov/table/ACSDP5Y2023.DP04

Wenger-Trayner, E., & Wenger-Trayner, B. (2015). *Introduction to communities of practice*. https://www.wenger -trayn er.com/wp-con tent /upload s/2022/06/15 -06-Brief- introduc tion-to-communities-of-practice.pdf

Wenger-Trayner, E., Wenger-Trayner, B., Reid, P., & Bruderlein, C. (2023). *Communities of practice within and across organizations*. https://www.wenger-trayner.com/cop-guidebook/

Wishner, J., Solleveld, P., Rudowitz, R., Paradise, J., & Antonisse, L. (2016). *A look at rural hospital closures and implications for access to care*. The Urban Institute & Kaiser Foundation. https://www.urban.org/sites/default/files/publication/82511/2000857-brief-a-look-at-rural-hospital-closures-and-implications-for-access-to-care.pdf

Woods, L., Martin, P., Khor, J., Guthrie, L., & Sullivan, C. (2024). The right care in the right place: a scoping review of digital health education and training for rural healthcare workers. *BMC Health Services Research*, *24*(1). https://doi.org/10.1186/s12913-024-11313-4

Yun, S., Noaman, K., Homan, S., Jiaqing, L., McBride, D., & Wilson, J. (2013). The burden of chronic diseases in Missouri: progress and challenges. *Mo Med*, *110*(6), 505–511. https://pmc.ncbi.nlm.nih.gov/articles/PMC6179805/

## Appendix A: Value Creation Table

| Cycle | Definition | Examples |
|---|---|---|
| **Immediate Value** | Value derived from direct participation in community activities and interactions. | Receiving an answer to a question, feeling less isolated, and enjoying a lively exchange. |
| **Potential Value** | Value from knowledge capital accumulated for future use. | Gaining a new idea or resource, building relationships, and increasing confidence or visibility. |
| **Applied Value** | Value realized when knowledge is applied to real-world situations or practice. | Implementing a new protocol, adapting a shared tool, launching a joint initiative. |
| **Realized Value** | Value is expressed as improved performance or measurable outcomes in practice or policy. | Better patient outcomes; cost savings; increased coordination; reduced provider turnover. |
| **Reframed Value** | Value realized when goals, success metrics, or strategic perspectives are redefined. | Shifting focus from program delivery to community empowerment, adopting new evaluation lenses. |

## Appendix B: Evaluation Survey

### Part 1: Defining Our Community of Practice

*In this section, we gather information to better understand the structure and identity of our community through the lens of Wenger-Trayner's framework. By exploring our shared domain, the nature of our community, and our evolving practice, we aim to clarify who we are, what connects us, and how we learn together. This foundation will guide future programming, resource development, and evaluation.*

#### Domain

*These questions help define the shared purpose, focus areas, and evolving concerns that unite this community.*

**1. What topics orissues in health care are most important to you right now?**
*Select up to three.*

- Access tocare
- Behavioraland mental health
- Care coordination and integration
- Health equity
- Health policy and advocacy
- Hospital closures
- LGBTQ+ health
- Maternal and child health
- Public health infrastructure
- Rural workforce development
- Social determinants of health
- Substance abuse and addiction

- Technology and telehealth
- Other (please specify): _____

**2. What challenges in your work do you most want help solving?**
*Select up to three.*

- Recruitingor retaining staff
- Meeting patient or community needs with limited resources
- Navigating health policy or regulatory changes
- Implementing new technologies or systems
- Building cross-sector partnerships
- Measuring and demonstrating impact
- Reducing burnout or stress
- Connecting with other professionals across the region
- Other (please specify): _____

**3. What common goals do you believe connect members of this community?**
*Select all that apply.*

- Improving access to care
- Sharing tools and practices
- Supporting the health care workforce
- Reducing disparities
- Advancing innovation in service delivery
- Strengthening community-based solutions
- Influencing health policy
- Building relationships across roles or regions
- Understanding the impact of policy changes
- Other (please specify): _____

**4. How well do you feel the current domain of this community reflects your priorities?**
*Select one.*

- Very well

- Somewhat well
- Neutral
- Not very well
- Not at all well

*Optional: Please explain your answer (open text)*

**5. Are there emerging areas or themes you believe this community should focus on more intentionally?**

*Select up to three or write your own.*

- Youth and adolescent health
- LGBTQ+ health
- Emergency preparedness and crisis response
- Aging and elder care
- Data use and interoperability
- Community-based participatory models
- Substance abuse and addiction
- Hospital closures
- Advocacy and legislation
- Maternal health
- Networking and connections
- Workforce recruitment and retention
- Other (please specify): _____

**6.Whatmotivates you to stay involved in a community like this?**

*Select up to two.*

- Learningfrom peers
- Access torelevant tools and resources
- Opportunities for collaboration
- Feeling connected to a larger movement
- Gaining professional visibility or growth

- Making a difference in my community
- Other (please specify): _____

**7. In your view, what problem or opportunity is this community really here to address?**
*Open-endedresponse*

**Community**

*These questions help understand who is in the community, how they relate to one another, and what kind of connection or identity is forming among members.*

**8. What is your role or professional identity within the broader health care system?**
*Select the option that best fits your primary role.*

- Physician or Provider Nurse or Nurse
- Practitioner Community Health
- Worker CEO/Executive Peer Support
- Public Health Official Health System
- Administrator Behavioral Health
- Professional Policy or Advocacy
- Professional Researcher or Academic
- Social Worker Student or Trainee
- Other (please specify): _____
-
-
-
-

**9. How long have you been involved in health care work?**

- Less than 1 year
- 1–3 years

- 4–7 years
- 8–15 years
- More than 15 years

**10. What part of Missouri best describes where you live and/or work?**

- Northwest
- Northeast
- Central
- Kansas City Metro
- St. Louis Metro
- Southeast
- Southwest
- I live or work outside Missouri
- Other (please specify): _____

**11. How would you describe your level of participation in the community?**

- I mostly observe or read
- I engage when I need something specific
- I participate occasionally (e.g., in events or discussions)
- I contribute regularly and share with others
- I help lead or coordinate activities

**12. What kind of relationships have you developed (or hope to develop) through this community?**
*Select all that apply.*

- Peer support
- Professionalcollaboration
- Cross-sectorpartnerships
- Mentorship(giving or receiving)
- Personal connection or friendship
- I haven’t developed any relationships yet

- Other (please specify): _____

**13. Do you feel like you belong here?**

- Yes, strongly
- Somewhat
- Not sure
- Not really
- No

*Optional: Please explain your answer (open text)*

**14. What barriers make it hard for you to participate in this community?**
*Select up to three.*

- Lack of time
- Unclear expectations for participation
- Technology or platform issues
- I don’t see how the content applies to my role
- I don’t feel invited or included
- Competing priorities at work
- Other (please specify): _____

**15. What makesyou feel most supported by or connected to other members?**
*Select up to two.*

- Feelingseen or heard
- Accesstorelevant resources
- Personalinvitations to participate
- Consistentcommunication
- Recognition or appreciation
- Shared values or purpose
- Other (please specify): _____

**16. What kind of community do you hope this becomes over time?**
*Open-endedresponse*

**17. If you could change one thing about how the community operates, what would it be?**
*Open-endedresponse*

**Practice**

*These questions focus on the shared activities, tools, methods, language, and knowledge that constitute the community's evolving practice.*

**18. Have you applied anything from this community in your work?**

- Yes, frequently
- Yes, occasionally
- Not yet, but I plan to
- No
- Not sure

*Optional: If yes, what have you applied and how? (open text)*

**19. What tools, resources, or processes have you found most useful here?**
*Open-endedresponse*
**20. How does participation in this community influence how you approach your work?**
*Select one.*

- It has changed how I think about problems
- It has changed how I act in my role
- It has influenced both my thinking and actions
- It hasn't changed how I work
- I'm not sure yet

**21. Are there tools or practices you'd like to share with the community?**

- Yes (please describe below)
- No
- Not yet, but I plan to

*Optional: What would you like to share? (open text)*

**22. What kind of learning or professional development formats work best for you?**
*Select all that apply.*

- Live webinarsor virtual events
- On-demand video or recorded sessions
- Written briefs, guides, or articles
- Interactive workshops or trainings
- Peer learning groups or cohorts
- Discussion boards or forums
- One-on-one mentorship or coaching
- Other (please specify): _____

**23. What areas ofyour work would you most like to improve or grow in?**
*Select up to three.*

- Leadershipor management
- Communityengagement
- Policy or advocacy
- Evaluation and data use
- Equity and inclusion
- Program design or implementation
- Cross-sector collaboration
- Clinical or technical knowledge
- Other (please specify):_____

**Part 2: Roles and Contributions**

*This section outlines how members currently participate in the community and the roles they envision themselves playing. Understanding these patterns enables us to design more responsive support, identify emerging leaders, and ensure that all forms of participation are valued.*

**Instructions:**

For each pairof roles below, indicate where you currently fall on the spectrum.

(1 = Fully leftrole, 5 = Fully right role)

**Where are you now?**

1. Imostly observe — 1 2 3 4 5 — I actively contribute
2. Iengage when I need something — 1 2 3 4 5 — I support others regularly
3. Ifocus on my own learning — 1 2 3 4 5 — I help guide community direction
4. Iapply ideas privately — 1 2 3 4 5 — I share tools or adapt ideas for others
5. Iwork locally — 1 2 3 4 5 — I connect across organizations or sectors

**Where would you like to be in the future?**

1. Iwould prefer to mostly observe — 1 2 3 4 5 — I would prefer to actively contribute
2. Iwould prefer to engage when I need something — 1 2 3 4 5 — I would prefer to support others regularly
3. Iwould prefer to focus on my own learning — 1 2 3 4 5 — I would prefer to help guide community direction
4. Iwould prefer to apply ideas privately — 1 2 3 4 5 — I would prefer to share tools or adapt ideas for others
5. Iwould prefer to work locally — 1 2 3 4 5 — I would prefer to connect across organizations or sectors

**Scoring Guide: Roles and Contributions**

**Step 1: Assign Scores**

Each of the 5 Likert questions produces a score from 1 to 5. Total the scores for:

- Current Role: Sum of all "Where are you now?" responses (5 questions)
- Aspirational Role: Sum of all "Where would you like to be?" responses (same 5 questions)

**Step 2: Calculate Averages**

- Current Score (C) = Total current score ÷ 5
- Aspirational Score (A) = Total aspirational score ÷ 5

**Step 3: Role Mapping Guide**

| Average Score | Role Category | Interpretation |
|---|---|---|
| 1.0–1.8 | Observer / Transactional Participant | Minimal engagement; draws value without contributing. |
| 1.9–2.6 | Peripheral / Occasional Participant | Passive but present; learning-focused, low visibility. |
| 2.7–3.4 | Active Member | Moderate engagement; contributes and learns, focused on local or individual use. |
| 3.5–4.2 | Applied Practitioner / Local Sponsor | Applies knowledge in context, may support others locally. |
| 4.3–5.0 | Core Member / Leader / Systems Connector | High engagement and cross-boundary influence contribute to strategy or coordination. |

**Part 3: Value Creation**

*These questions help us understand how participation in MRHA Connect (now The Causeway) is creating value for members—both in the short term and over time. Each section reflects one of the five value cycles in Wenger-Trayner's framework.*

For each statement, please rate your level of agreement using the following 1–5 scale:

**1 – Strongly disagree**

**2 – Disagree**

**3 – Neutral**

**4 – Agree**

**5 – Strongly agree**

**Immediate Value**

*Direct benefit from participation (learning, support, enjoyment).*

1. I gainuseful ideas, insights, or support each time I engage withthe community.
2. I feelencouraged or energized after participating in events or discussions.
3. I canfind quick answers or feedback when I need them.

*Optional:*
What recent experience in the community felt especially useful or meaningful to you?

**Potential Value**

*Accumulating knowledge capital for futureuse.*

4. I've built relationships or connections thatIexpect to be useful later.
5. I've discovered tools, frameworks, or ideasthat I haven't used yet but plan to.
6. Participation is helping me expand howIthink about my work.

*Optional:*
Have youdiscovered a new idea or resource here that you haven't applied yet but think you will?
**Applied Value**

*Using community knowledge in your context.*

7. I've applied something I learned from thiscommunity in my work.
8. I've adapted a tool, idea, or method fromthe community to fit my setting.
9. My work has improved because of something I've learned through this community.

*Optional:*
Can youdescribe a time you used something from the community in practice? What happened?
**Realized Value**

*Tangible outcomes or improved performance.*

10. I've seen measurable improvements in mywork, team, or organization as a result of participation.
11. My organization values my involvement inthis community.
12. The work I do has more impact because ofwhat I've gained here.

*Optional:*
What outcome or improvement would you credit to this community?
**Reframed Value**

*Shifts in thinking, purpose, or strategic direction.*

13. Thiscommunity has changed how I define success in my work.
14. I thinkdifferently about the challenges we face because of conversations here.
15. Mygoals or priorities have shifted as a result of this community.

*Optional:*
Has yourperspective or strategy changed because of what you've learned here? If so, how?
**Scoring Guide**

Each section includes three Likert-scale questions (e.g., Strongly Agree to Strongly Disagree). You can:

- Score each cycle (0–25 points)
- Visualize results as a radar chart or bar graph

**Part 4: Story Reflection (Optional)**

*This section invites you to share more of your experience in your own words. These stories help us understand how The Causeway s making a difference in members' work and lives. All responses are anonymous and will be used to inform program planning, evaluation, and storytelling.*

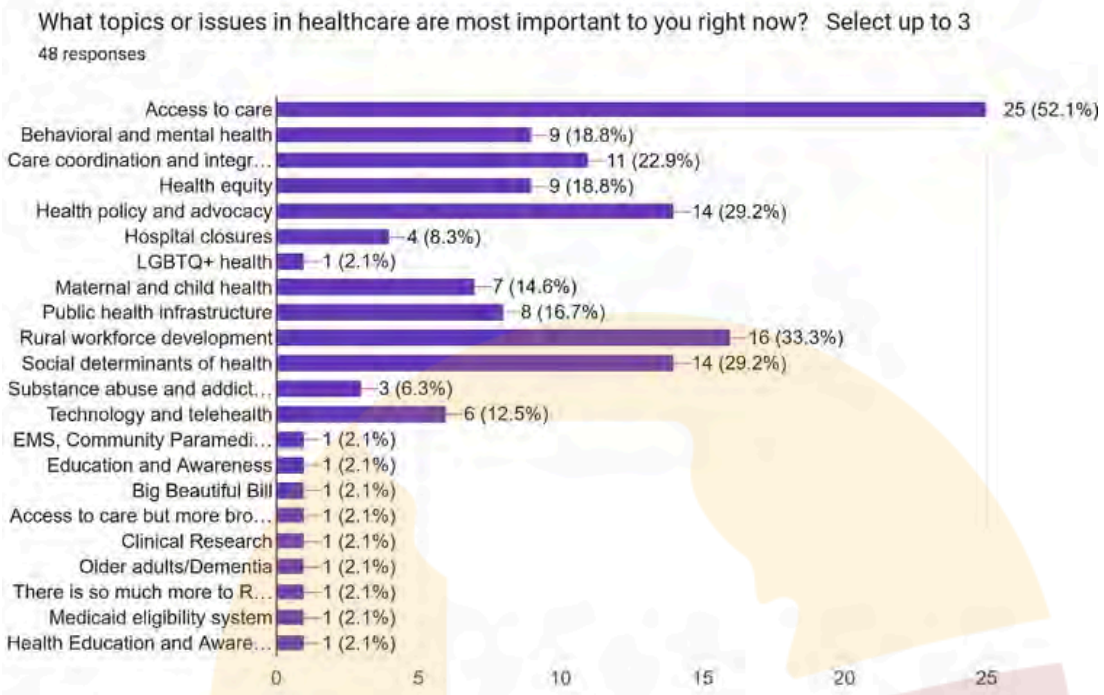
**Reflections on Your Lived Experience in Health Care**

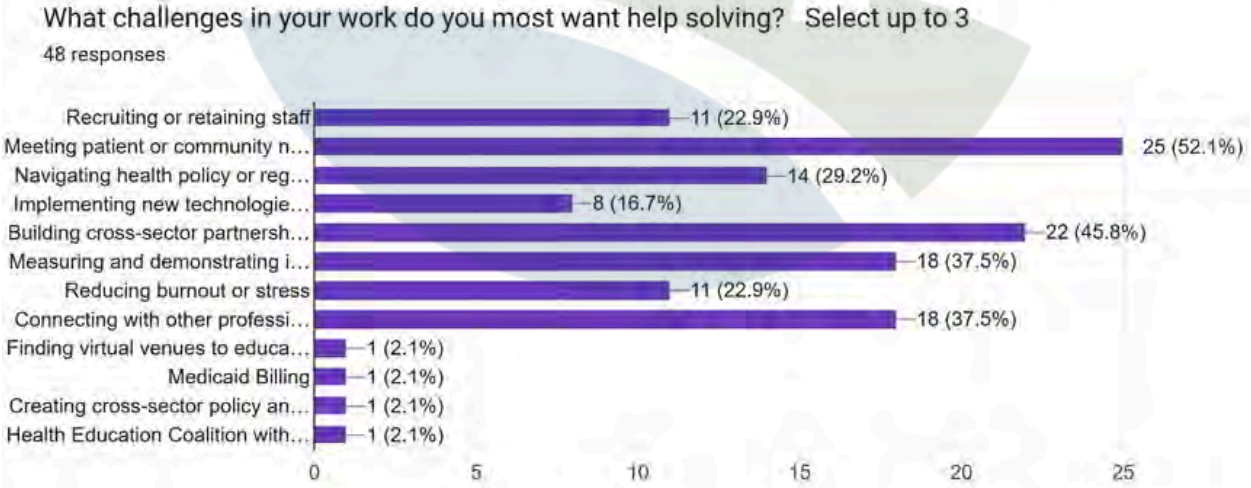
1. What is one challenge you face in your daily work that others in this community should understand better?
2. What does success look like in your role—and what makes it hard to get there?
3. Can you share a time you felt proud of your work?
4. What keeps you going during hard days?
5. What do you wish more people—inside or outside of health care—understood about your experience?

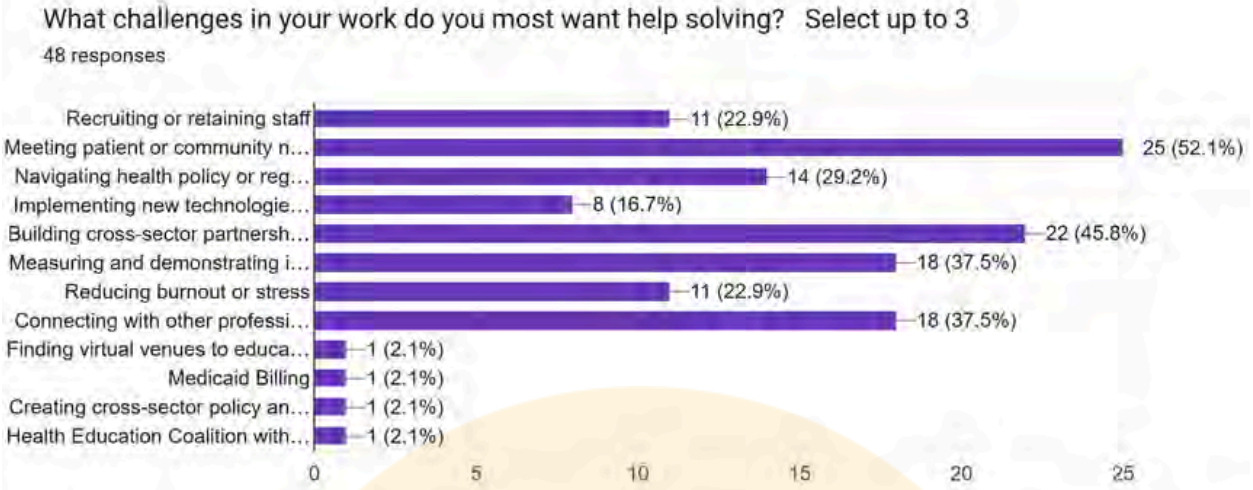
**Reflections on The Causeway**

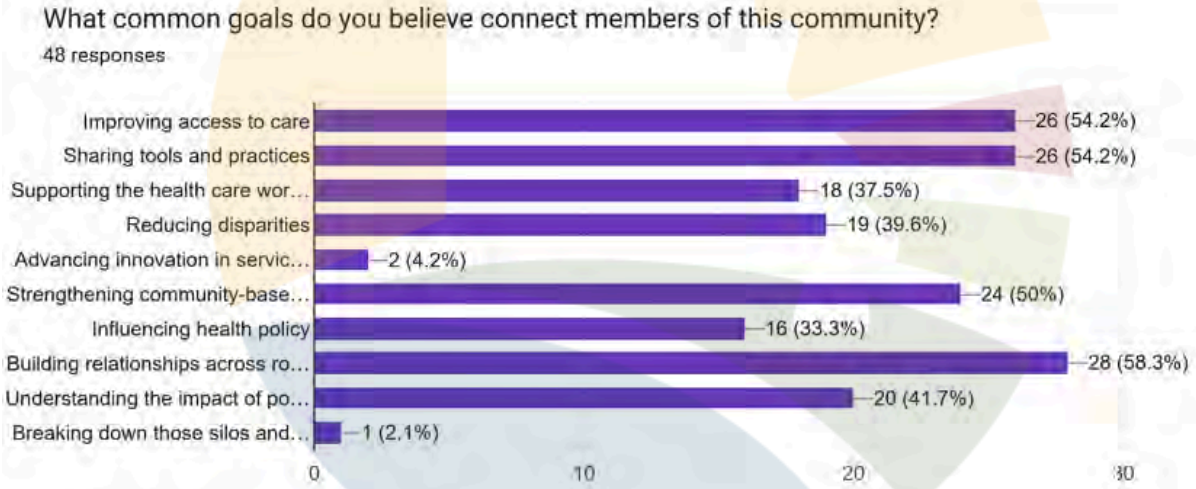
6. Can you describe a time when this community helped you learn something important or solve a real problem?
7. Have your goals, values, or way of thinking changed as a result of your participation here? If so, how?
8. What keeps you comingback—or what would make you want to come back more often?
9. What has been the mostuseful or meaningful part of this platform for you?
10. What would you mostlike to see this community become in the next year?

## Appendix C: Domain



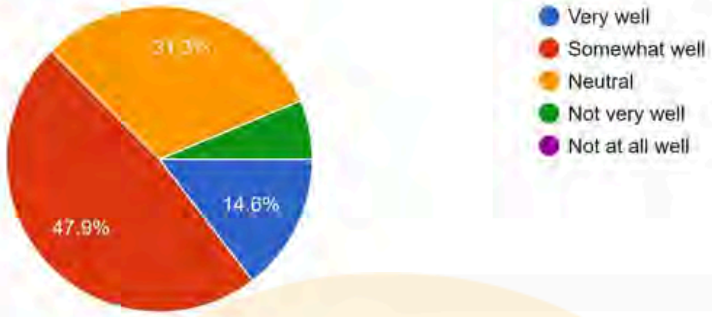




What challenges in your work do you most want help solving? Select up to 3
48 responses
Recruiting or retaining staff
11 (22.9%)
Meeting patient or community n...
25 (52.1%)
Navigating health policy or reg...
14 (29.2%)
Implementing new technologie...
8 (16.7%)
Building cross-sector partnersh...
22 (45.8%)
Measuring and demonstrating i...
18 (37.5%)
Reducing burnout or stress
11 (22.9%)
Connecting with other professi...
18 (37.5%)
Finding virtual venues to educa...
1 (2.1%)
Medicaid Billing
1 (2.1%)
Creating cross-sector policy an...
1 (2.1%)
Health Education Coalition with...
1 (2.1%)
0
5
10
15
20
25


What common goals do you believe connect members of this community?
48 responses
Improving access to care
26 (54.2%)
Sharing tools and practices
26 (54.2%)
Supporting the health care wor...
18 (37.5%)
Reducing disparities
19 (39.6%)
Advancing innovation in servic...
2 (4.2%)
Strengthening community-base...
24 (50%)
Influencing health policy
16 (33.3%)
Building relationships across ro...
28 (58.3%)
Understanding the impact of po...
20 (41.7%)
Breaking down those silos and...
1 (2.1%)
0
10
20
30

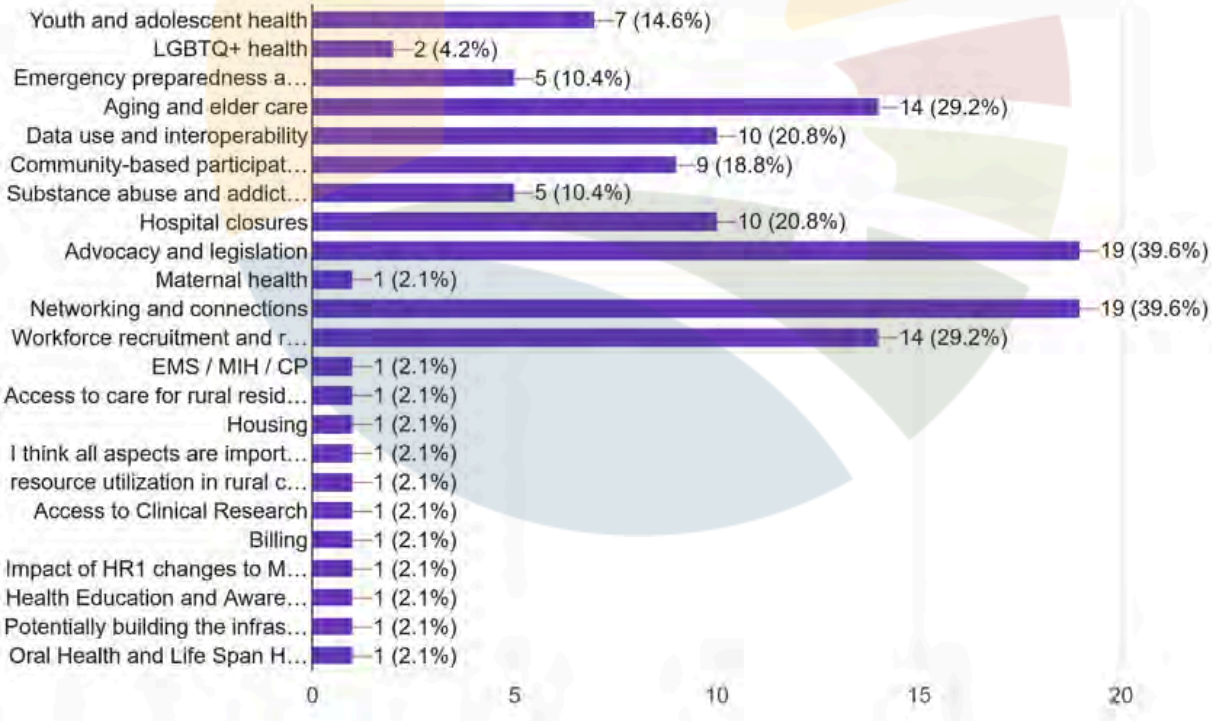
How well do you feel the current domain of this community reflects your priorities?

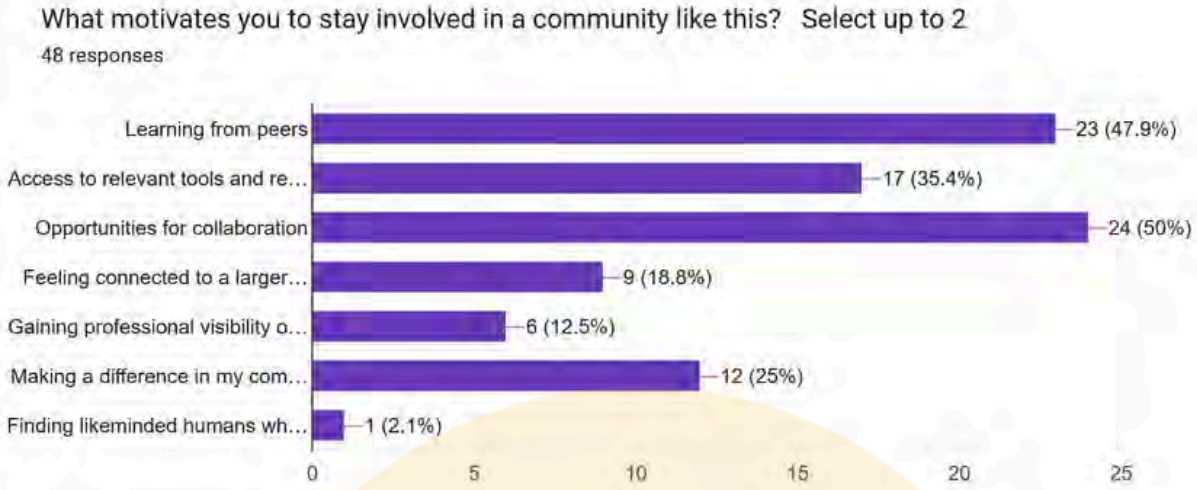
48 responses



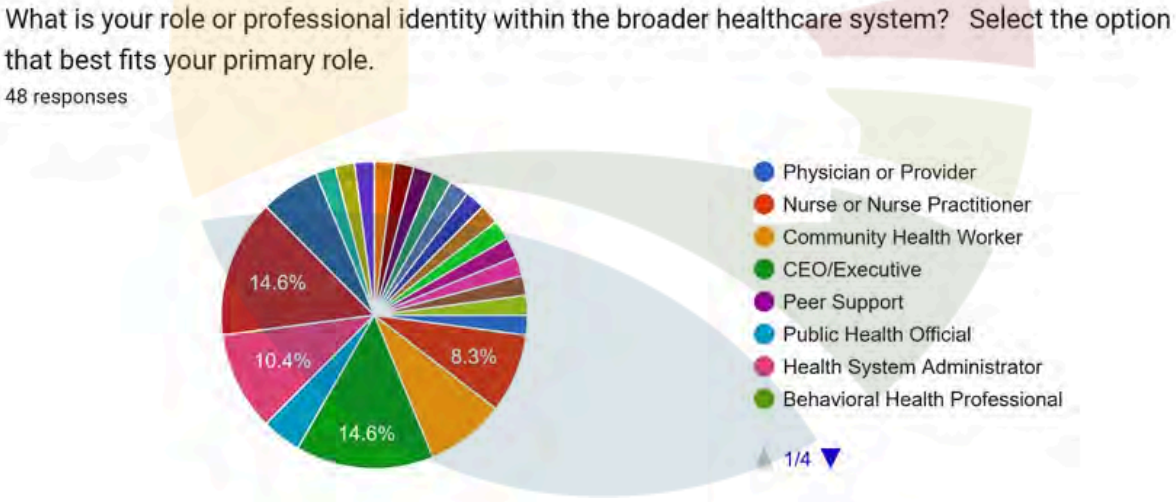

Are there emerging areas or themes you believe this community should focus on more intentionally? Please select up to 3

48 responses



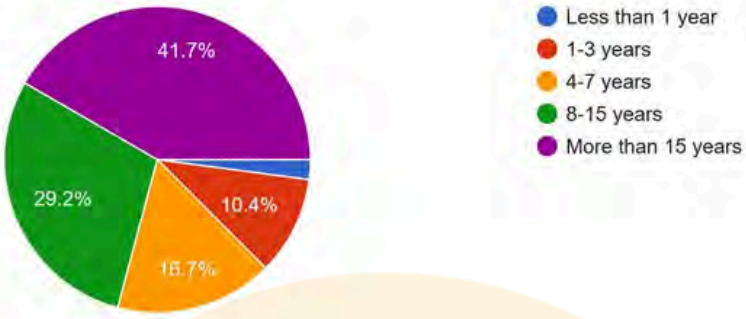



## Appendix D: Community



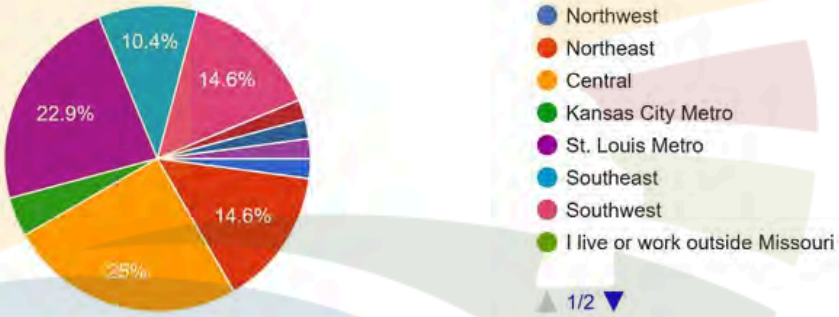
How long have you been involved in healthcare work?

48 responses



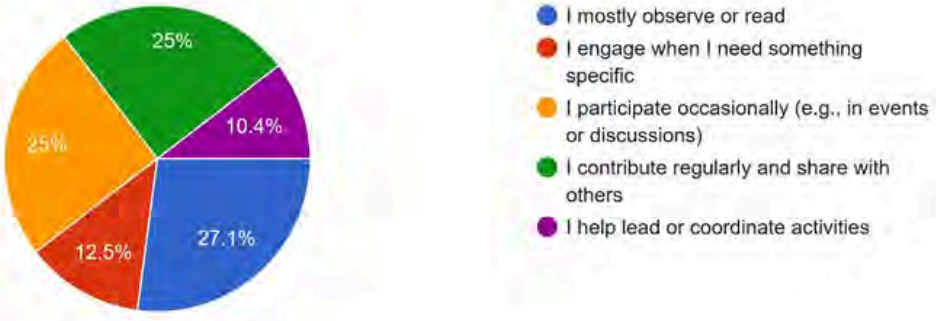

What part of Missouri best describes where you live and/or work?

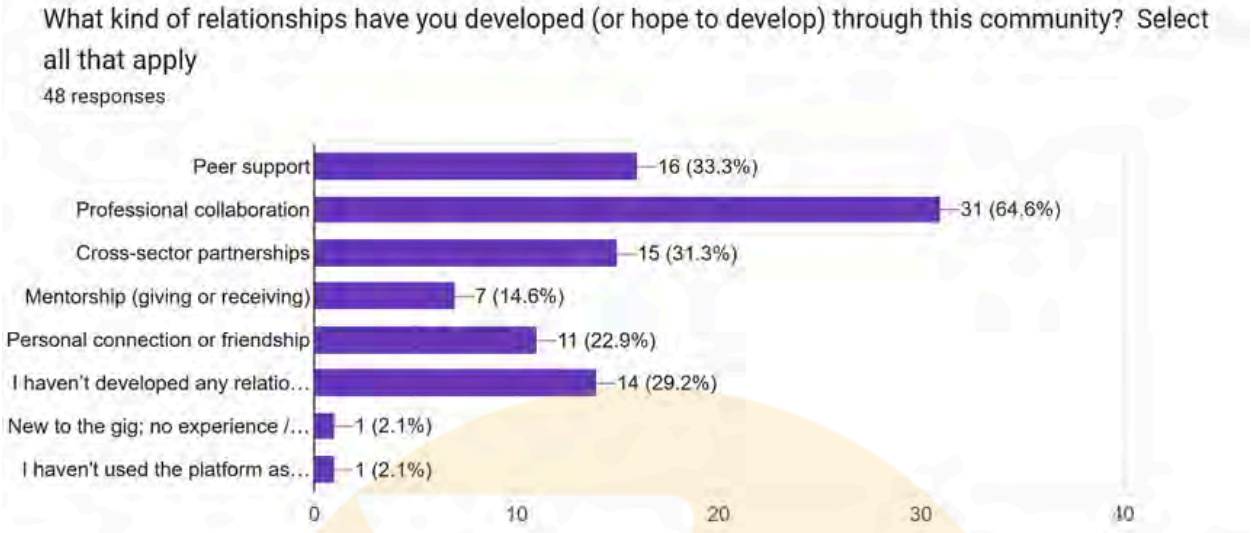
48 responses

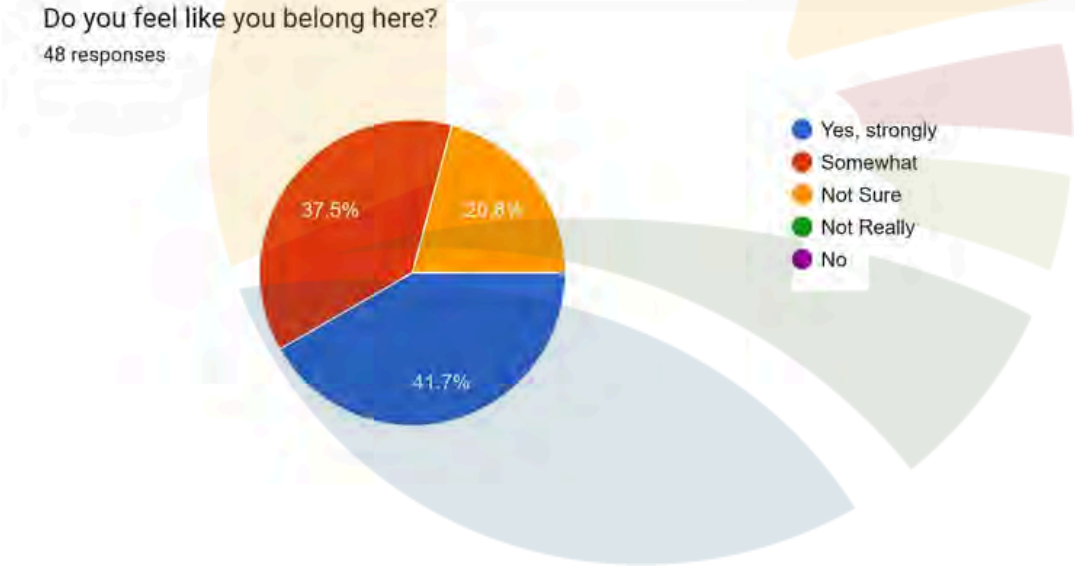


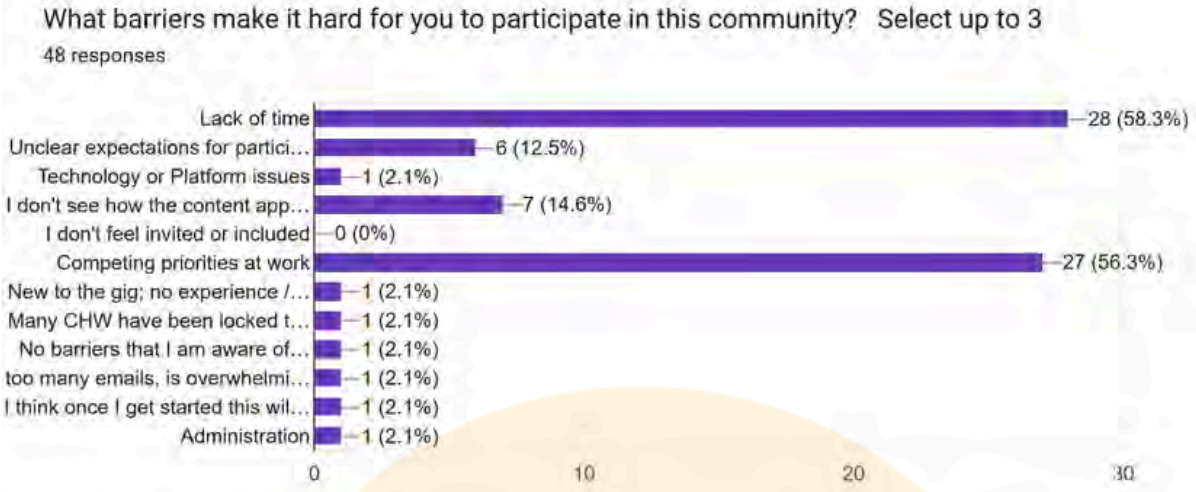

How would you describe your level of participation in the community?

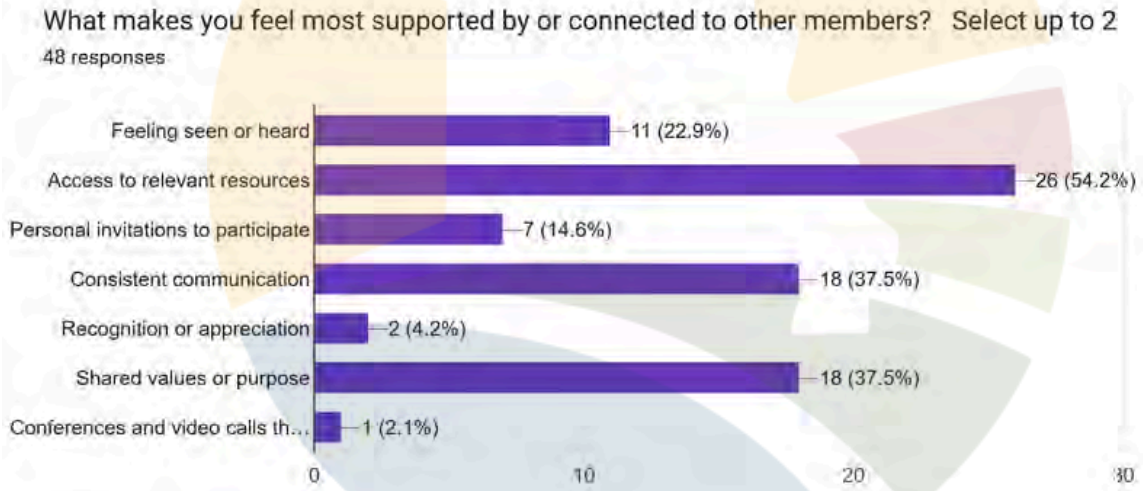
48 responses




What kind of relationships have you developed (or hope to develop) through this community? Select all that apply
48 responses
Peer support
16 (33.3%)
Professional collaboration
31 (64.6%)
Cross-sector partnerships
15 (31.3%)
Mentorship (giving or receiving)
7 (14.6%)
Personal connection or friendship
11 (22.9%)
I haven't developed any relatio...
14 (29.2%)
New to the gig; no experience /...
1 (2.1%)
I haven't used the platform as...
1 (2.1%)
0
10
20
30
40


Do you feel like you belong here?
48 responses
37.5%
20.8%
41.7%
Yes, strongly
Somewhat
Not Sure
Not Really
No

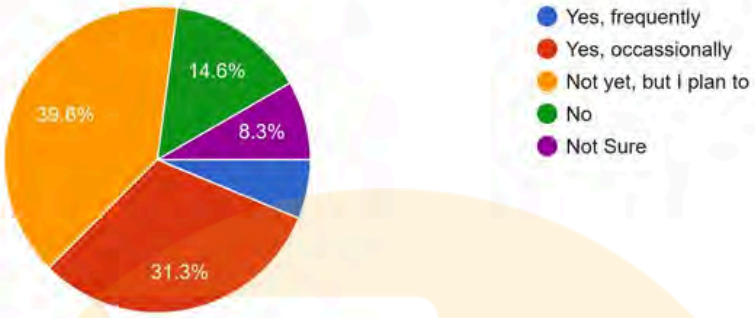

What barriers make it hard for you to participate in this community? Select up to 3
48 responses
Lack of time
28 (58.3%)
Unclear expectations for partici...
6 (12.5%)
Technology or Platform issues
1 (2.1%)
I don't see how the content app...
7 (14.6%)
I don't feel invited or included
0 (0%)
Competing priorities at work
27 (56.3%)
New to the gig; no experience /...
1 (2.1%)
Many CHW have been locked t...
1 (2.1%)
No barriers that I am aware of...
1 (2.1%)
too many emails, is overwhelmi...
1 (2.1%)
I think once I get started this wil...
1 (2.1%)
Administration
1 (2.1%)
0
10
20
30


What makes you feel most supported by or connected to other members? Select up to 2
48 responses
Feeling seen or heard
11 (22.9%)
Access to relevant resources
26 (54.2%)
Personal invitations to participate
7 (14.6%)
Consistent communication
18 (37.5%)
Recognition or appreciation
2 (4.2%)
Shared values or purpose
18 (37.5%)
Conferences and video calls th...
1 (2.1%)
0
10
20
30

## Appendix E (Practice)

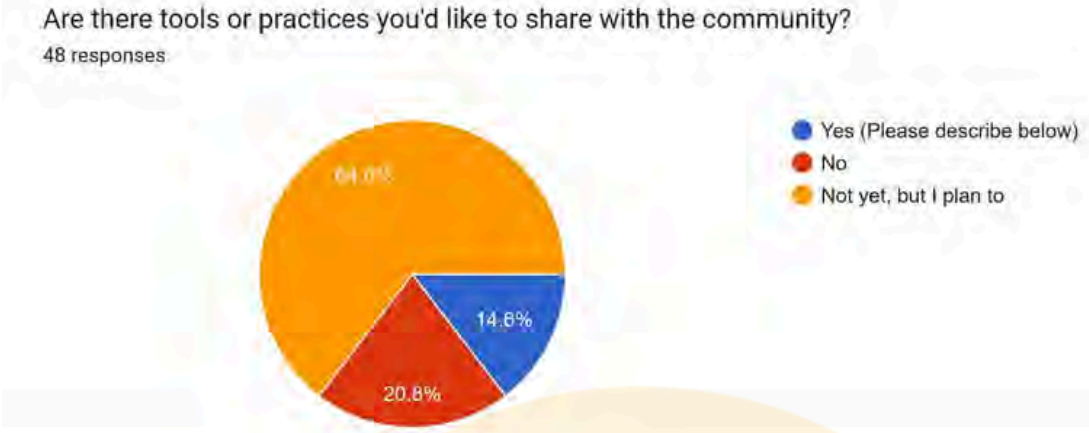
Have you applied anything from this community in your work?

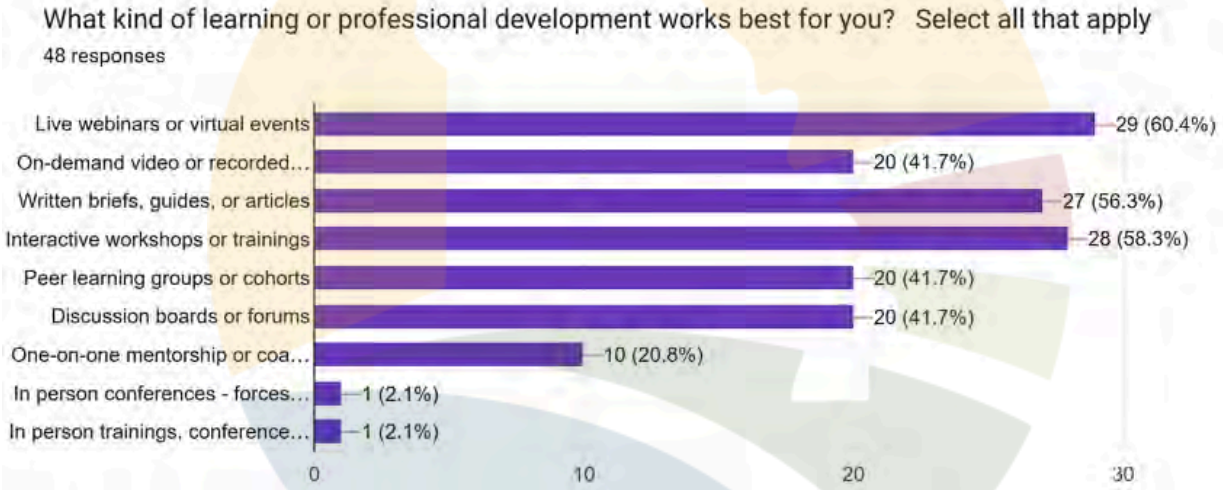
48 responses

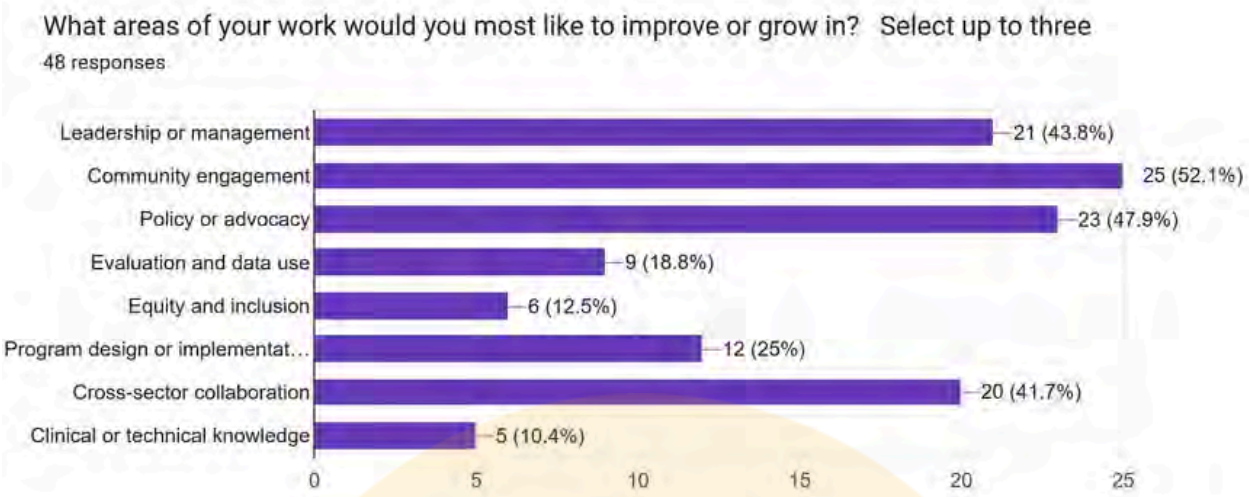



How does participation in this community influence how you approach your work?

48 responses


Are there tools or practices you'd like to share with the community?
48 responses
Yes (Please describe below)
No
Not yet, but I plan to
64.6%
14.8%
20.8%


What kind of learning or professional development works best for you? Select all that apply
48 responses
Live webinars or virtual events
29 (60.4%)
On-demand video or recorded...
20 (41.7%)
Written briefs, guides, or articles
27 (56.3%)
Interactive workshops or trainings
28 (58.3%)
Peer learning groups or cohorts
20 (41.7%)
Discussion boards or forums
20 (41.7%)
One-on-one mentorship or coa...
10 (20.8%)
In person conferences - forces...
1 (2.1%)
In person trainings, conference...
1 (2.1%)
0
10
20
30

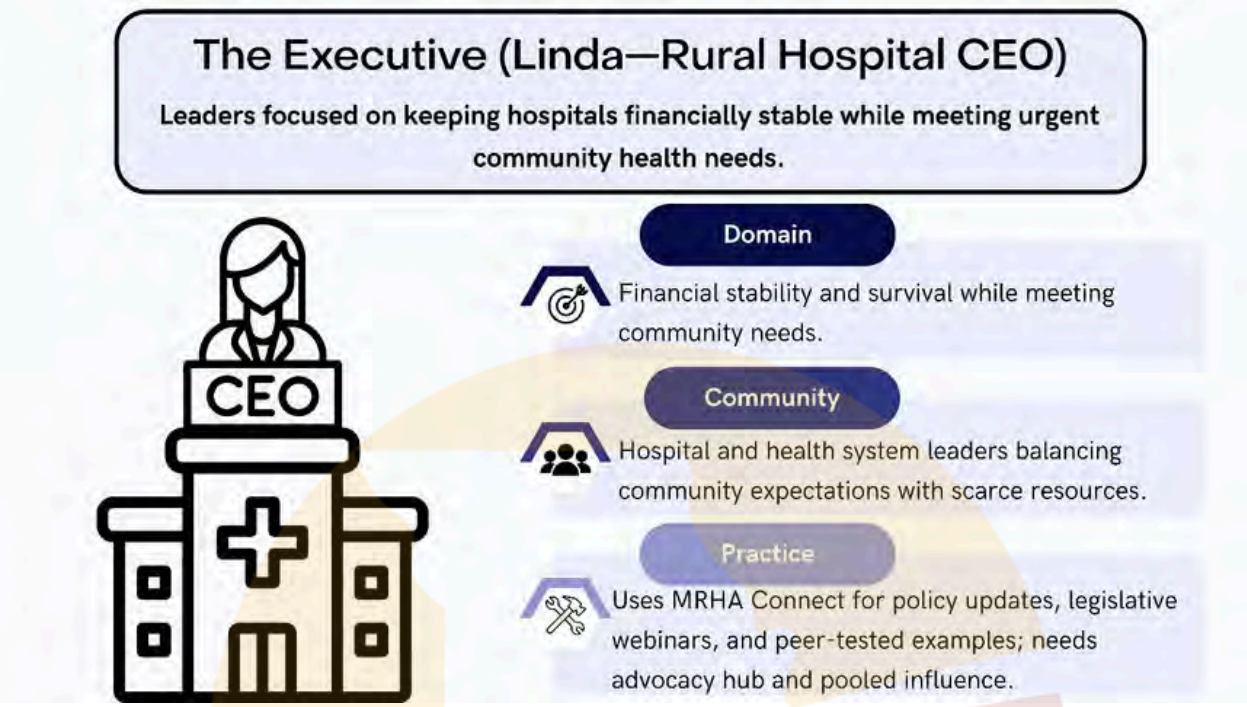

What areas of your work would you most like to improve or grow in? Select up to three
48 responses
Leadership or management
21 (43.8%)
Community engagement
25 (52.1%)
Policy or advocacy
23 (47.9%)
Evaluation and data use
9 (18.8%)
Equity and inclusion
6 (12.5%)
Program design or implementat...
12 (25%)
Cross-sector collaboration
20 (41.7%)
Clinical or technical knowledge
5 (10.4%)
0
5
10
15
20
25

## Appendix F: Archetypes

Members of The Causeway represent a broad spectrum of Missouri's healthcare workforce. Survey responses and narratives consistently converged around five recurring archetypes: the Executive balancing financial survival with community needs, the Policy Advocate pressing for systemic change, the Community Connector navigating frontline burdens, the Educator striving to reach dispersed audiences, and the System Builder ensuring that healthcare systems and programs function behind the scenes. These archetypes capture not just professional roles but the shared challenges and motivations that shape how members experience the platform. They were derived by synthesizing quantitative survey patterns with open-ended narrative responses, providing a structured approach to interpreting common mindsets that extend across organizations, regions, and disciplines.

Taken together, the archetypes provide more than descriptive categories—they illustrate how Connect creates value across diverse contexts while revealing gaps where deeper support is needed. Each highlights a distinct dimension of engagement, ranging from policy advocacy to grassroots service delivery, demonstrating how members derive meaning and utility from participation. By grounding abstract measures of domain, community, and practice in the lived realities of participants, these archetypes establish a human-centered framework for assessing The Causeway's current impact and guiding its growth as a statewide infrastructure for collaborative learning and coordinated action.

**The Executive Archetype: "Linda, Rural Hospital CEO"**



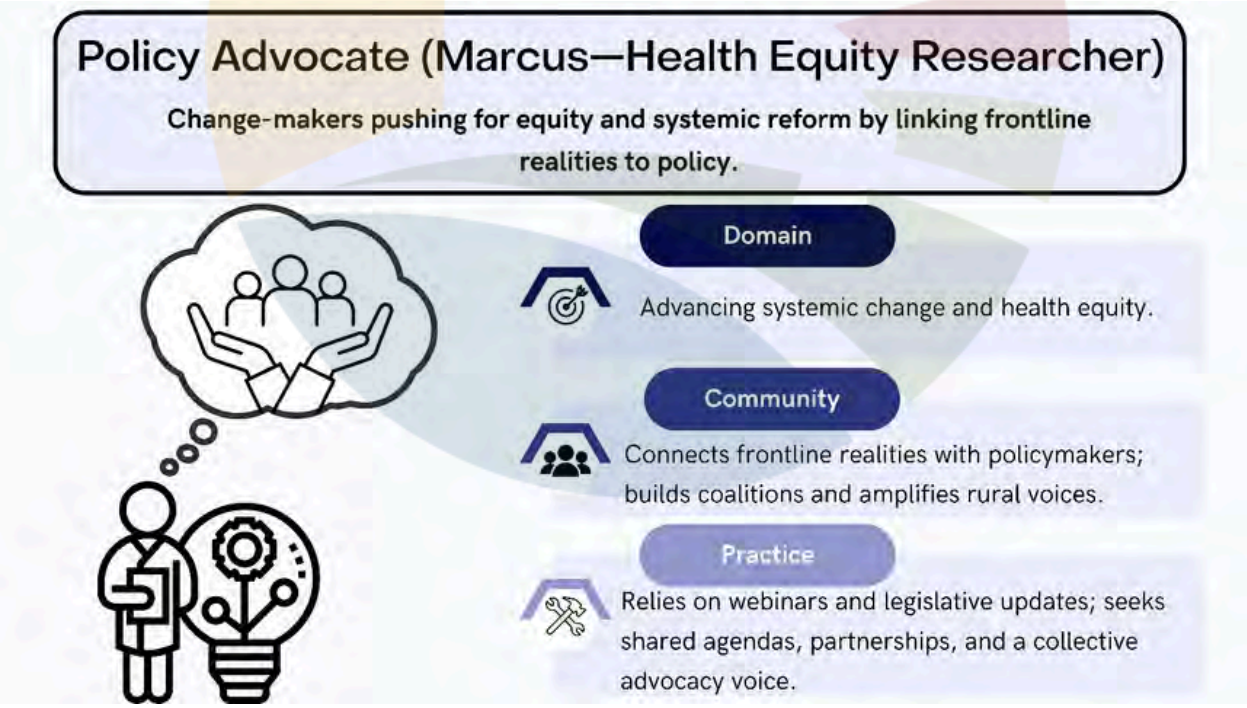

About 15% of respondents align with the Executive Archetype, represented here by *Linda*, a rural hospital CEO navigating constant strain. For leaders like her, the challenge is capacity: too few staff, too many demands, and limited resources to meet community needs that far exceed any single organization's reach. Success is defined as stability and survival—"running a financially stable hospital…while still providing quality care"—but the weight of workforce shortages, rising costs, and the lingering trauma of closures looms heavy. As one executive put it, "Our community had a hospital closure several years ago… it has had an impact on healthcare for our most vulnerable citizens."

Linda turns to The Causeway for policy updates, legislative webinars, and peer-tested examples that help her prepare for high-stakes conversations with boards and policymakers. The greatest promise she sees lies in collective advocacy and collaboration, described by one leader as "sharing the real healthcare issues of everyday people with policymakers."

**Key Characteristics**

- **Proportion of members:** ~15% of respondents
- **Motivation:** Financial stability and organizational survival while meeting community needs
- **Biggest Barriers:** Workforce shortages, hospital closures, escalating costs
- **Value in Connect:** Legislative webinars, policy updates, peer framing of issues
- **Future Needs:** A strategic advocacy hub with streamlined policy intelligence and opportunities for pooled influence

**The Policy Advocate Archetype: "Marcus, Health Equity Researcher"**




Roughly 15% of respondents align with the Policy Advocate Archetype, represented here by *Marcus*, a health equity researcher who works at the intersection of direct care, policy,

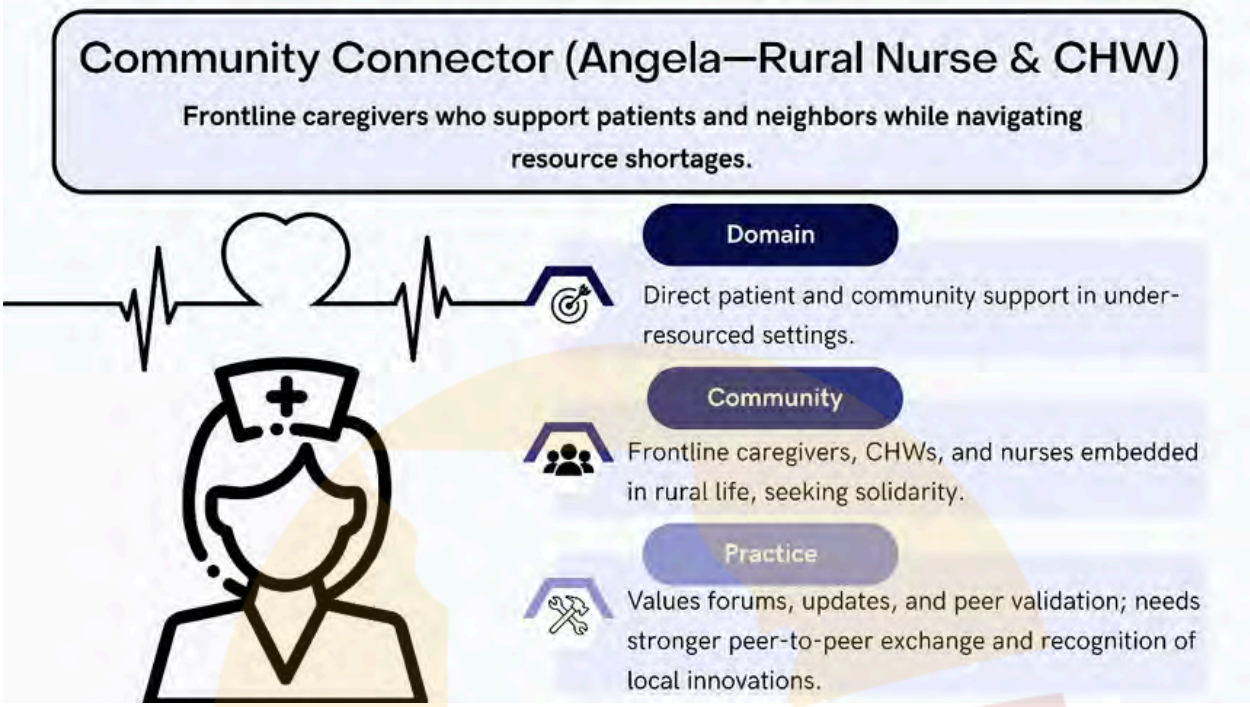
and systems change. Advocates like Marcus see their role as bridging scales—bringing the realities of frontline work into conversations about equity and reform. Success means advancing systemic change, though they recognize barriers: “Enhanced health equity is the goal. The barrier is the political environment in Missouri and the U.S.”

Policy Advocates rely on The Causeway for legislative updates and webinars that sharpen their voice in coalitionsand sustain their energy. As one member noted, “Having a sense of community that othersare working on similar topics helps reduce a sense of isolation that can come with changeleadership.”

**Key Characteristics**

- **Proportion of members:** ~15% of respondents
- **Motivation:** Equity, systemic change, and amplifying rural voices
- **Biggest Barriers:** Political climate, fragmented advocacy, lack of cross-sector coordination
- **Value in Connect:** Legislative updates, webinars, peer solidarity in advocacy work
- **Future Needs:** A structured vehicle for collaboration on advocacy—shared policy agendas, partnerships, and collective amplification of rural perspectives

**The Community Connector Archetype: *"Angela, Rural Nurse and CHW"***



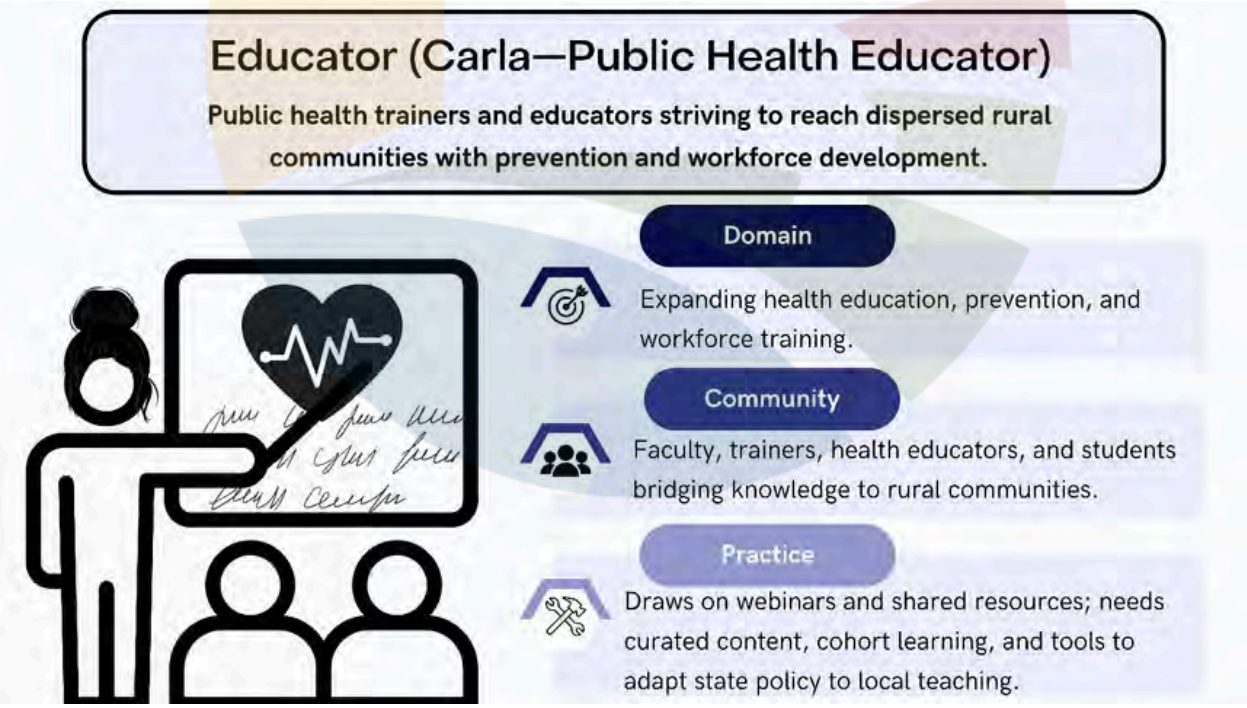

Roughly 15% of respondents align with the Community Connector Archetype, represented here by *Angela*, a nurse who also serves in a community health worker role in her rural town. These members are embedded in the daily realities of patients and neighbors, often juggling direct care, outreach, and case management with limited support. Their challenges are immediate and pressing: "There are never enough hands to do all of the duties." Yet they are driven by personal stories of impact, like helping a patient access free insulin so she no longer had to choose between medicine and groceries.

For Community Connectors, The Causeway provides solidarity and practical sharing. Forums and weekly updates act as reminders to engage, while peer validation offers encouragement: "Seeing others so engaged and connecting is really great to see." They value the wins that come from collaboration, whether housing a client, coordinating holiday events, or applying for grants surfaced on the platform.

**Key Characteristics**

- **Proportion of members:** ~15% of respondents
- **Motivation:** Direct support for patients and communities, solidarity in frontline roles
- **Biggest Barriers:** Limited staffing, lack of compensation or recognition, overwhelming workloads
- **Value in Connect:** Forums, weekly updates, resource-sharing, and peer validation
- **Future Needs:** Stronger peer-to-peer exchange, visibility for CHW and provider innovations, and structured networks that expand reach beyond clinic walls

**The Educator Archetype: "Carla, Public Health Educator"**




Roughly 12.5% of The Causeway participants fall into the Educator Archetype, represented by *Carla*, a public health educator and academic. These members include faculty,

trainers, researchers, and students who focus on workforce development, health education, and prevention. Their main challenge is reach—finding effective ways to connect with dispersed and often hard-to-reach rural populations: “Identifying the most effective strategies to reach and engage the public on health topics, such as substance use prevention and tobacco-free living, is difficult.” Success comes when repeated outreach pays off and communities begin to engage with programs and initiatives.

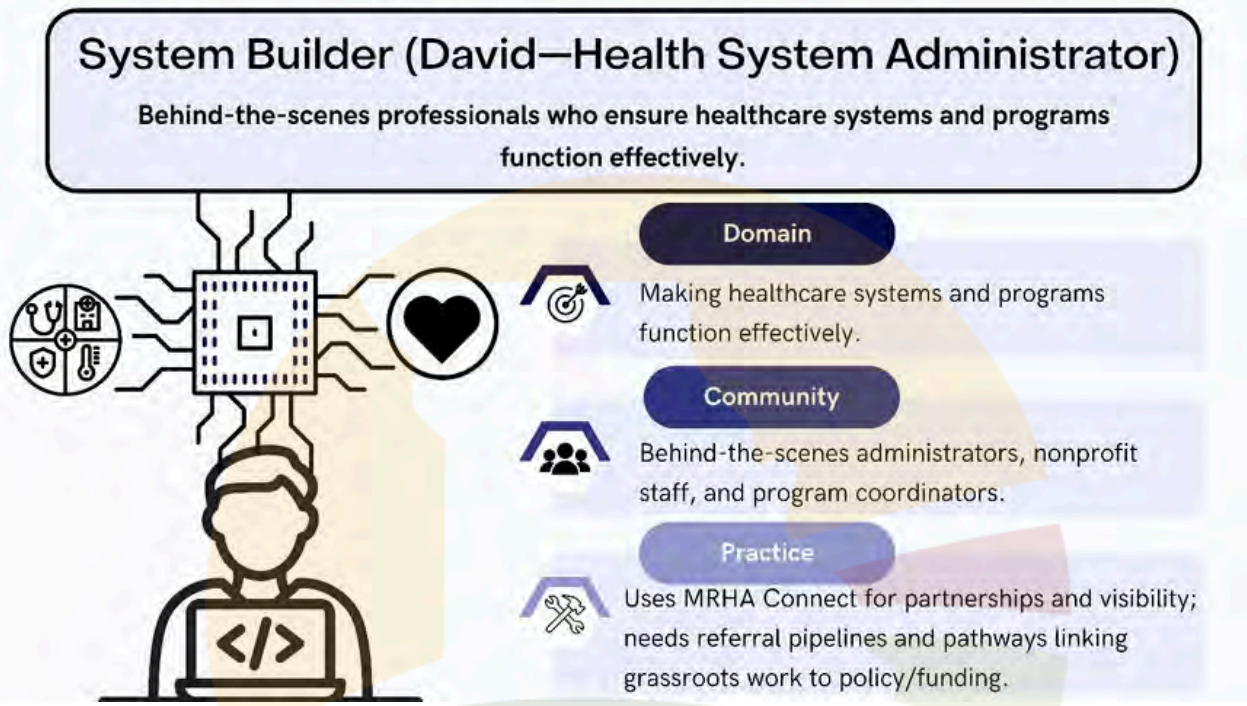
Educators use The Causeway both as a **content hub** and an **inspiration hub**, turning to webinars, articles, and legislative updates for resources they can adapt and share. The platform also motivates them by exposing the work of peers across Missouri, which helps reduce isolation and spark new ideas. However, many also report challenges in navigating the volume of information, sometimes feeling overwhelmed by emails or unsure of what resources are available. They envision a more formalized structure for learning, such as cohort-based groups where like-minded educators can collaborate directly.

**Key Characteristics**

- **Proportion of members:** ~12.5% of respondents
- **Motivation:** Expanding public health education, prevention, and workforce training
- **Biggest Barriers:** Limited reach in rural settings, information overload, lack of structured cohorts
- **Value in Connect:** Webinars, legislative updates, shared resources, exposure to peer initiatives

- **Future Needs:** Curated resources, cohort-based peer learning, and tools to translate statewide policy into local teaching strategies

**The System Builder Archetype: "David, Health System Administrator"**




Roughly 12.5% of The Causeway participants align with the System Builder Archetype, represented here by *David*, a health system administrator whose work focuses on coordination, billing, and operational support. Members in this group include nonprofit program developers, administrators, and staff who make healthcare systems function behind the scenes, often with limited visibility and few resources. Their central challenge is recognition: "Our biggest challenge is letting others know that we exist and are able to help the uninsured have access to free medication." Success, for them, is straightforward—expanding reach so that more people can access services and resources that otherwise remain hidden.

System Builders use The Causeway to expand partnerships, share resources, and gain visibility for their organizations, though some note that collaboration often happens informally and outside the platform. They return for practical content, peer exchanges, and the chance to see "key people in the key roles that help to support rural communities." Their vision for Connect is a platform that amplifies their work, builds referral pipelines, and connects grassroots solutions to larger policy and funding conversations.

**Key Characteristics**

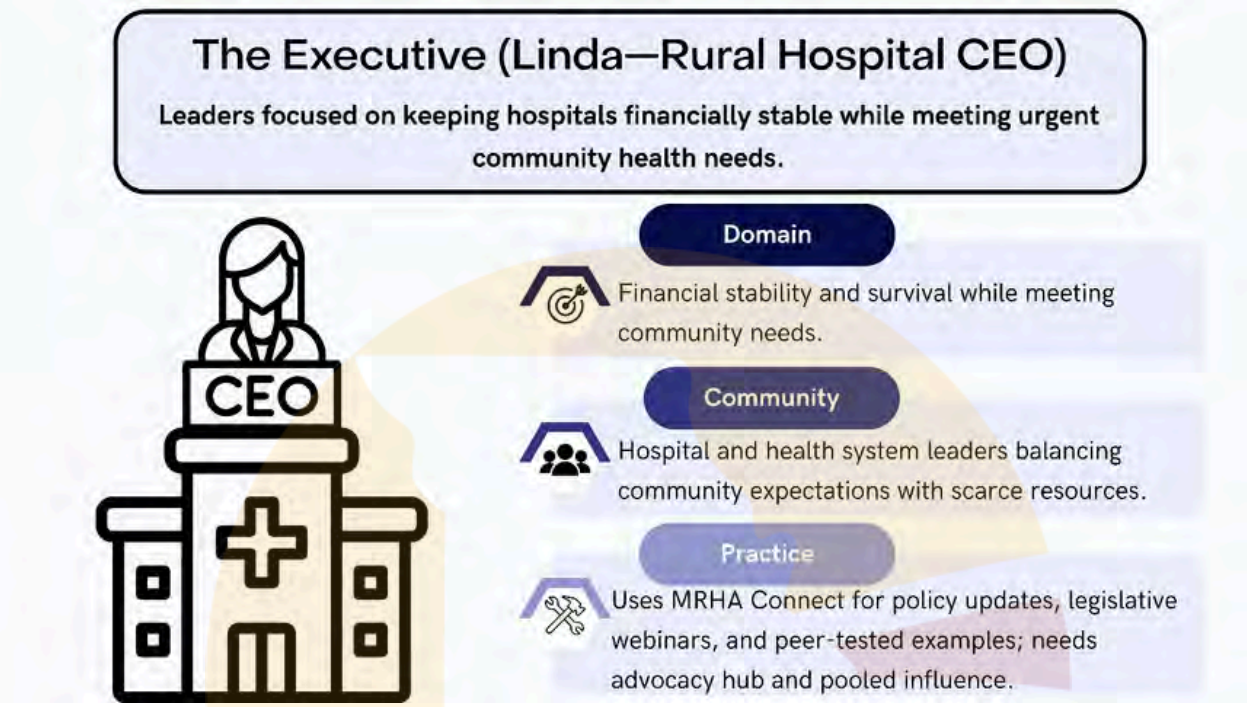
- **Proportion of members:** ~12.5% of respondents
- **Motivation:** Expanding reach, visibility, and impact of essential but often overlooked services
- **Biggest Barriers:** Limited recognition, fragmented networks, lack of sustainable funding
- **Value in Connect:** Practical articles, resource-sharing, peer connections, visibility of key actors
- **Future Needs:** Stronger referral pipelines, amplification of innovative models, and structured pathways linking grassroots work to policy and funding

Taken together, these five archetypes illustrate how The Causeway's members experience both the promise and the limits of the platform. The Executive (15%), focused on financial stability and collective influence; the Policy Advocate (15%), pursuing equity and systemic change; the Community Connector (15%), depending on solidarity and shared resources in frontline roles; the Educator (12.5%), turning to peer-driven learning and outreach; and the System Builder (12.5%), working behind the scenes to make fragmented systems function. Each

group brings distinct motivations, barriers, and needs, but all converge on the value of collaboration, knowledge exchange, and advocacy in addressing Missouri's rural health crisis. By linking these lived realities to the broader measures of domain, community, and practice, the archetypes provide a human-centered framework for evaluating The Causeway's current impact and identifying the investments needed to strengthen engagement, streamline access, and expand collective influence.

## Appendix G: Narrative Examples

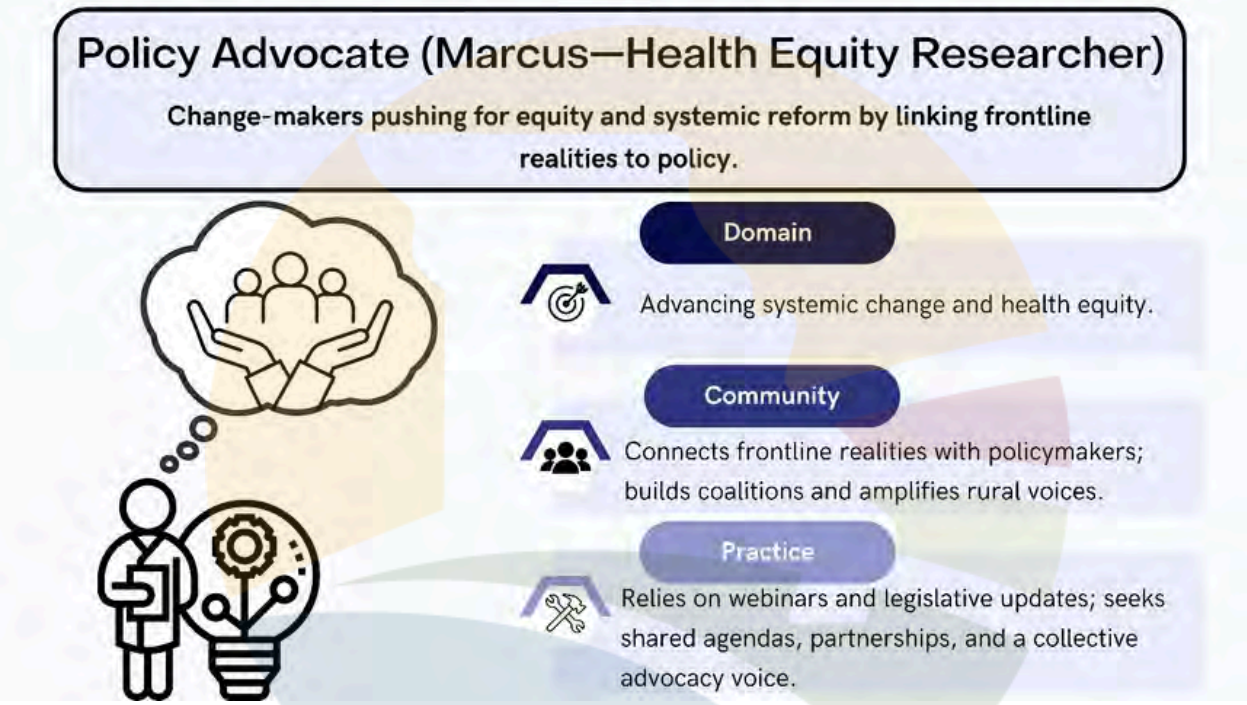
### Linda, The Executive




Consider Linda, a rural hospital CEO who embodies the executive archetype. Linda carries the weight of maintaining financial stability while meeting the expansive health needs of her community, all against the backdrop of workforce shortages and the looming risk of hospital closures. Her onboarding begins in the newcomer cohort, where she is introduced to the platform's tools, including how to access policy resources, post in discussions, and join relevant communities. From there, she is placed in the executive community, where hospital and clinic leaders share strategies for managing organizational survival, preparing for board meetings, and framing rural challenges in ways that resonate with policymakers. Linda also remains part of the primary feed for statewide announcements and chooses to join the XYZ niche community (to be defined), which reflects her interest in shaping long-term workforce and financial stability. Over time, Linda becomes a mentor, lending her experience to both the newcomer cohorts and the

executive group, helping less experienced leaders navigate the complexities of rural healthcare management. For her, The Causeway is not just a source of information but a collective voice—an advocacy hub where the real issues of everyday rural hospitals can be amplified to influence policy and protect community health.

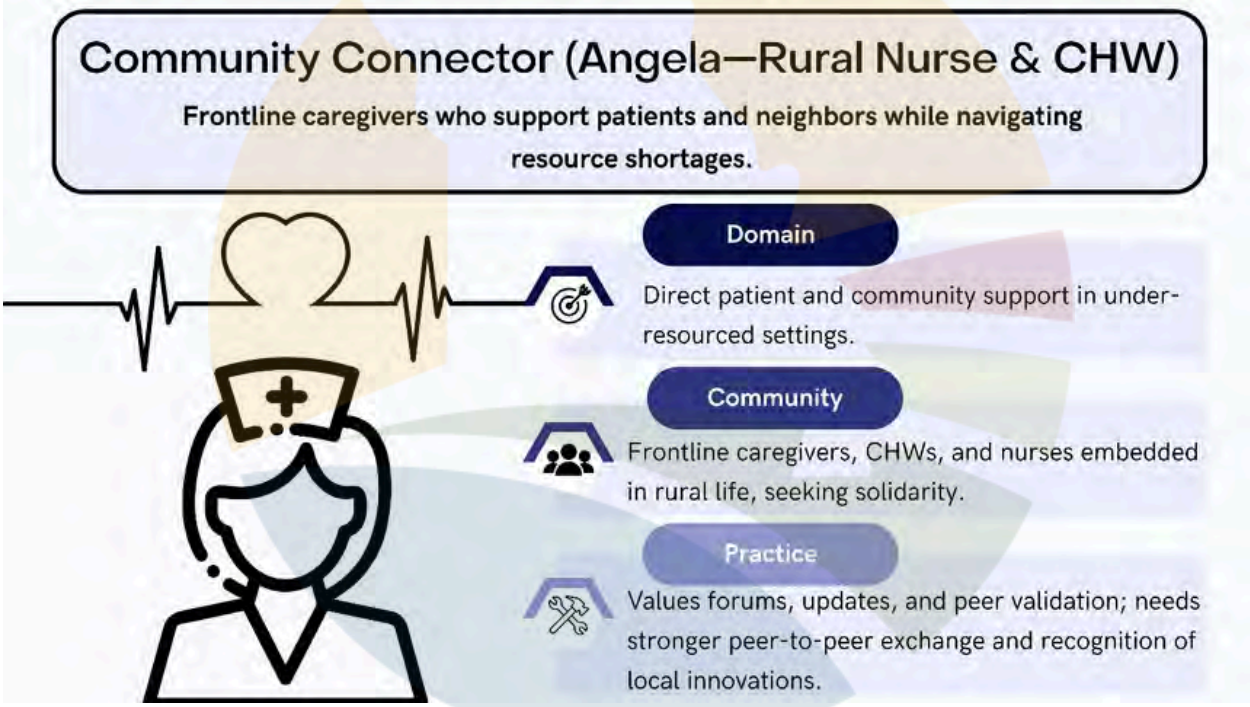
**Marcus, the Policy Advocate**




For example, consider Marcus, a health equity researcher who represents the policy advocate archetype. Like many advocates, Marcus works at the intersection of direct care, policy, and systems change, with a strong motivation to amplify rural voices in statewide conversations. His onboarding begins in the newcomer cohort, where he learns how to post in discussions, access the resource library, and connect with peers. During this process, Marcus is placed in the policy advocate community, a space designed for members focused on legislative updates, advocacy strategies, and coalition-building. He also remains part of the primary feed, where statewide announcements and resources are shared, and chooses to join the workforce

development niche group, reflecting his interest in addressing rural workforce shortages. This layered onboarding ensures Marcus is both grounded in the basics of The Causeway and embedded in spaces aligned with his professional role and advocacy priorities. Over time, his contributions in policy discussions and workforce initiatives position him to serve as a mentor, helping other advocates navigate the challenges of political fragmentation while sustaining their energy through a sense of solidarity and shared purpose.

**Angela the Nurse Practitioner**




Consider Angela, a nurse practitioner who also serves as a community health worker in her rural hometown. Angela represents the community connector archetype, balancing clinical responsibilities with outreach and case management, often with limited staffing and support. Her onboarding begins in the newcomer cohort, where she learns how to navigate The Causeway post in forums, and explore the resource library. As she completes this orientation, Angela is placed in the community connector group, where frontline providers share tools, encouragement,

and practical strategies for supporting patients and neighbors. Like all members, she remains connected to the primary feed for statewide announcements and updates, but her personal interests draw her into the maternal health niche group, where she engages with peers addressing challenges she frequently encounters in her patients, such as prenatal care access and postpartum support. This layered structure ensures Angela is not left isolated but instead finds solidarity, encouragement, and practical resources to help her manage the overwhelming demands of her role. Over time, as she contributes her own insights—such as new approaches for coordinating care or connecting patients with housing and transportation—Angela's experience positions her to serve as a mentor for other community connectors, providing the same validation and support that once sustained her.