Building Capacity & Improving Care

The Impact of the Kaiser Permanente Community Clinic Partnership

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PREPARED FOR:

KAISER PERMANENTE COMMUNITY CLINIC PARTNERSHIP

Kaiser Permanente Community Benefit Northern & Southern California Regions

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Preface

ACKNOWLEDGEMENTS

We begin this report by acknowledging the staff at Kaiser Permanente for their interest in and commitment to gathering and using information to improve their ongoing work. We would like to thank Jean Merwin for being our primary liaison in the evaluation of the Kaiser Permanente Community Clinic Partnership. We would also like to thank all the members of the Evaluation Advisory Committee for providing valuable guidance, input and support for this evaluation, specifically Angela Coron, Lucette DeCorde, Steve Graham, John Gressman, Rhonda McClinton-Brown, Jean Nudelman, Fredric Richmond, Christy Rosenberg, Cody Ruedaflores, Julie Schmittdiel, Mercy Siordia, Diane Strum and Judith Zitter.

We are extremely grateful to all who agreed to be interviewed and/or surveyed for this effort, each of whom contributed generously of their time, giving thoughtful consideration to our questions and information needs.

ABOUT BTW *informing change*

At BTW we are driven by our purpose of "*informing change in the nonprofit and philanthropic sectors.*" We work collaboratively with our clients, providing strategic consulting services to inform organizational effectiveness and learning. Our information-based services include program and organizational planning, theory of change development, evaluation, performance monitoring system design and applied research. We produce high-quality, easy-to-understand products that present useful information and are designed to be readily applied to practice.

Executive Summary

The Kaiser Permanente Community Clinic Partnership (the Partnership) is a collaboration of Kaiser Permanente (KP) in California and the state's system of community clinics. Supported by grants and in-kind resources, the Partnership strives to accomplish three main goals:

- To strengthen the capacity of community clinics and clinic networks to operate efficiently, enhance quality of care and improve access to care by supporting effective management infrastructure and systems;
- To enhance access to care for patients through collaboration among community clinics, clinic networks and KP; and
- To support the development of effective community-based systems of chronic disease management and prevention.

KP contracted with BTW *informing change* to examine the Partnership experience within KP, in the clinic networks and at the individual clinic level. BTW was asked to assess: 1) the accomplishments of the Partnership, 2) how the Partnership achieved these accomplishments and 3) the central lessons learned about the Partnership. The focus of the evaluation is on the Partnership's early years, its first phase of grantmaking and resource sharing between 2002 and 2005, and the resulting impacts.

ACCOMPLISHMENTS & IMPACTS OF THE PARTNERSHIP

A lot of rhetoric exists about partnership in philanthropy; however, reality doesn't often meet expectations. In this case, KP, community clinics and clinic networks have formed a true partnership that is not limited to grant dollars but has involved a significant exchange of non-cash resources in ways that have benefited all involved. KP, clinic and clinic network staff have demonstrated exceptional leadership in navigating cultural differences and calibrating expectations in order to build and maintain productive relationships. The Partnership has supported advances in clinical care, improved operational capacity and enhanced connections and collaborations among grantees, KP and other organizations in the health care field. Key reported accomplishments and impacts include:

- Increased access to and quality of clinical care, including chronic, primary and specialty care;
- Enhanced infrastructure, core operational practices and financial stability among clinics, clinic networks and the Regional Associations of California;
- More knowledge sharing, cross-learning and peer support among those involved with the Partnership;
- Stronger clinician leaders within their organizations and the health care field;
- New and strengthened connections, relationships and collaborations among KP and grantees;
- More effective advocacy for clinics and the needs of their patients and communities; and
- Increased visibility and credibility of the community clinics field.

SHAPING SUCCESS

Five years into the formal Partnership provides a well-timed opportunity to reflect on the lessons learned to date. Particular strengths of the Partnership model include the following:

- As a health care delivery system, KP is able to offer a broad range of high-quality support and expertise that goes beyond grants and is uniquely applicable to the needs of clinics and clinic networks.
- KP features a responsive, flexible and tailored approach in the way it issues grant funding and other support.
- The Partnership provides KP, clinic networks and clinics the opportunity for mutual learning and benefits.

The Partnership model has achieved much of its success due to the rich interplay of resources, both capital and intellectual, that the partners provide to one another; the mutual respect born of shared missions and patient populations; and joint planning and learning. These strengths will be critical elements for the Partnership's sustainability. As the Partnership matures and changes, it will be important to:

- Regularly review Partnership goals, strategies and intended outcomes, and adjust them as needed.
- Carefully plan for and nurture leadership succession.
- Build on successes to expand and deepen connections between KP and the community clinics field.

- Explore additional opportunities to leverage the Partnership's influence and reach through ongoing communication with key stakeholder groups.

The success of the Partnership provides numerous lessons that can prompt reflections as decisions are made about the Partnership's future. Going forward, it will be important for the Partnership to continue to embrace the key factors that led to its initial success and to document and share with others the best practices supported by this model. This will help to institutionalize the Partnership and support its replication elsewhere, for the ultimate goal of enhancing access to quality health care.

Introduction

The Kaiser Permanente Community Clinic Partnership (the Partnership) is a collaboration of Kaiser Permanente (KP), a health care delivery system serving more than six million California members, and California's system of community clinics, which provides care to nearly 2.5 million uninsured and underinsured patients each year.

The Partnership has three main goals:

- To strengthen the capacity of community clinics and clinic networks to operate efficiently, enhance quality of care and improve access to care by supporting effective management infrastructure and systems;
- To enhance access to care for patients through collaboration among community clinics, clinic networks and KP; and
- To support the development of effective community-based systems of chronic disease management and prevention.

The Partnership was initiated in the 1990s in response to increasing numbers of uninsured and underinsured individuals and growing health disparities among racial, ethnic and socioeconomic groups in California. California Senate Bill 697, passed in 1994, which required nonprofit hospitals to assess community needs and adopt a plan to meet those needs, also served as a catalyst for the Partnership by prompting closer alignment between private, nonprofit hospitals and community organizations addressing the ever-growing health care needs in their communities. The Partnership was codified in 2003, formalizing long-standing relationships between KP and the community clinics field at the statewide, regional and local levels. The participating organizations have similar missions and share commitments to comprehensive, affordable, high-quality health care.

Key Players in the Partnership[1,2]

To understand the Partnership requires some familiarity with both KP and the community clinics field in California. KP is a cooperative endeavor of physicians and nonprofit organizations comprising the Health Plan and hospitals which together organize, finance and deliver health care services to members on a prepaid basis and to non-members through charity care, self-pay or fee-for-service. With national headquarters located in Oakland, California, KP operates in eight regions across the U.S., two of which are in California: Northern California and Southern California. Three separate but collaborative organizations make up each regional entity: Kaiser Foundation Health Plans (a nonprofit, public benefit corporation), Kaiser Foundation Hospitals (a nonprofit, public benefit corporation) and the Permanente Medical Groups (for-profit professional organizations of physicians). Each region includes multiple medical centers (which include in-patient hospital facilities), medical offices and other facilities.

In 1996, KP's approach to community service was organized into the Direct Community Benefit Investment (DCBI) program, which has since evolved into the current Community Benefit Program. This program works towards meeting communities' needs for accessible, affordable and high-quality health care. The national Community Benefit grant program allows KP to work with organizations and agencies that span multiple regions of the U.S. However, most of KP's Community Benefit grants and in-kind resources to California are provided through the Northern California and Southern California Regional offices, as well as through KP's local staff in community benefit/community relations/public affairs offices in local service areas.[3]

The community clinics field in California is comprised of more than 600 nonprofit community clinics and health centers which provide comprehensive, quality health care services to primarily low-income, uninsured and underserved Californians. Fifteen clinic networks each provide a variety of supports to a group of member clinics with the ultimate intention of improving the health of their populations. The Regional Associations of California (RAC), a statewide collaborative body that is funded in part by KP, brings together clinic networks and their member clinics to develop leadership and strategy

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[1] Kaiser Permanente Website: *Structure of Kaiser Permanente*, retrieved September 7, 2007 from http://newsmedia.kaiserpermanente.org/kpweb/structurekp/detailpage.do?bodyContainer=/htmlapp/feature/123structurekp/About_us_national_page5.html

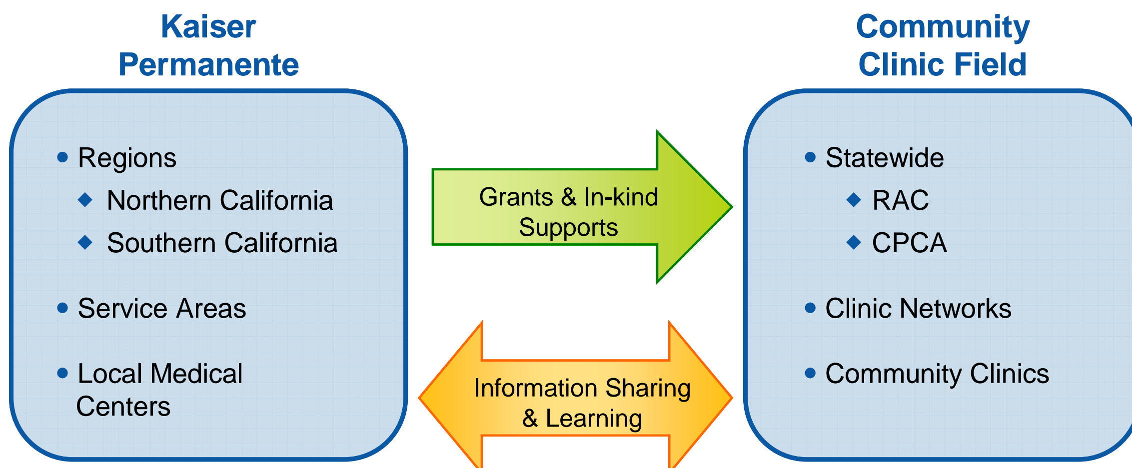
[2] Kaiser Permanente Website: *Kaiser Permanente Cares for Communities Grant Guidelines*, retrieved September 7, 2007 from http://newsmedia.kaiserpermanente.org/kpweb/entryPage.do?cfe=092.

[3] Unless otherwise noted, from this point forward the phrase Community Benefit Program (or Programs) in this report refers to one or both of KP's two regional Community Benefit Programs in California.

through trainings, technical assistance and leadership development. The California Primary Care Association (CPCA) also operates at the statewide level to represent the State's community clinics and strengthen its members through advocacy, education and services.

The key players both in KP and across the community clinics field in California have multiple opportunities for interaction and collaboration. Community clinics and clinic networks can access financial and in-kind resources from KP through the Regional Community Benefit Programs or from individual medical centers. Although community clinics and networks located outside of KP service areas are not able to access KP grants, they can benefit from KP support by participating in the RAC and utilizing KP in-kind resources such as trainings and care management protocols.

Exhibit 1
Kaiser Permanente and Community Clinics Field Relationship in California



The Evaluation of the Partnership

The Partnership contracted with BTW *informing change* to examine the Partnership experience within KP, in the clinic networks and at the individual clinic level, and to seek answers to three key evaluation questions:

- What did the Partnership accomplish?
- How did the Partnership achieve these accomplishments?
- What are the central lessons learned about this collaborative Partnership?

The focus of the evaluation is on the Partnership's early years, its first phase of grantmaking and resource sharing between 2002 and 2005, and the resulting impacts. We specifically focus on grants and in-kind resources provided as part of the Partnership to community clinics and clinic networks through the Northern California and Southern California Regional Community Benefit Programs and resources received through other avenues within KP, such as the community relations/public affairs offices of local KP medical centers.

The data for this report were collected through a variety of methods from November 2006 through May 2007. BTW collected data to inform this evaluation through a review of secondary data, a grantee survey and interviews with key stakeholders involved with the Partnership. An evaluation advisory committee of representatives from clinic networks and KP staff guided the evaluation throughout its design and implementation. For a list of committee members and more detailed information about the evaluation methods, please refer to Appendix A.

This report describes the Partnership's formation and development, the nature of the Partnership's support, how grantees utilized this support and the Partnership's accomplishments and impact. The final section summarizes the Partnership's strengths and key lessons drawn from the evaluation findings. The Partnership hopes that this report will inform the broader community clinics field, the KP network within and outside of California, other health care organizations, funders and policymakers about promising practices and models for collaboration.

The Partnership's Formation & Development

"Everyone was giving money at different levels and it was scattered. We were interested in pulling it all together and talking about it as a community clinic partnership. A lot of people were involved and good at making relationships. It was a natural next step. Why shouldn't we be investing this way? We were doing it anyway. We just didn't think of it as a cohesive program."

—KP Staff

The Partnership grew out of KP's long history of active commitment to improving the health status of its members and the communities served by its medical centers. For more than a decade, as part of its community benefit activities as well as its tax-exempt requirements, KP has devoted millions of dollars to impact community health through various means, including providing charity or subsidized care to low-income families, participating in community health initiatives, disseminating health education and expertise and fostering clinician education. Through these activities, KP was developing and strengthening relationships with community clinics and clinic networks throughout California. This experience gave KP clinicians and staff insight about how to focus grants and provide in-kind resources for the community clinics field. Clinics, clinic networks and KP developed a sense of partnership in their work and recognized their commonalities—missions to improve community health, nonprofit status, overlapping patient populations and statewide systems of health care—as well as the tremendous potential for practical and mutually beneficial endeavors if they worked together. This formed the basis for the eventual creation of the formally structured Partnership.

Formalizing the Partnership

In the late 1990s, six clinic networks and CPCA were working together on health care issues and called their group the Urban Coalition of California. Each network had received grants from and had developed relationships with KP clinicians and staff on an individual basis. In 1999, the Coalition asked KP to increase its commitment to community clinics and clinic networks; the Coalition presented KP with a $10 million proposal to offset costs of caring for the uninsured and underinsured. KP offered to assist the Coalition in creating a more formal and intentional partnership that would go beyond a one-time grant and focus on developing and strengthening long-term partnerships with the community clinics field and KP throughout the state. The long-standing, successful partnership between KP, community clinics and community clinic networks in San Diego County served as a strong example for the emerging Partnership. Since 1986, the KP San Diego Medical Center had been partnering with the local network of community clinics and with clinics throughout that county to increase the availability of health care for those in need.

Champions of the partnership concept from KP and the community clinics field worked diligently to formalize the Partnership. While the Partnership made sense conceptually, these champions needed to generate buy-in and support from their peers. To accomplish this, Partnership advocates held conversations at many different levels, with a wide range of KP and clinic leaders, in formal and informal settings and sometimes behind the scenes. It was critical for KP and clinic stakeholders to:

- Create a common language to facilitate understanding about each other's needs, practices and target populations;
- Develop trust in one another and see one another as partners instead of competitors;
- Persuade KP clinicians and staff who were committed to giving back to the community that this particular way held exponentially more value for community clinics and KP;
- Overcome specific proprietary concerns about sharing KP practice models and tools; and
- Convince clinics and clinic stakeholders of the broad array of benefits beyond grants that could arise from such a partnership—expertise, technical assistance and in-kind resources.

Once the concept and commitments were in place for more structured relationships, the Partnership's founders began formalizing the arrangement. Key KP and clinic leaders jointly planned and negotiated the details of the agreement and drafted a "Statement of Partnership," which went through many iterations before reaching a final agreement. Representatives from KP, CPCA,

the California Family Health Council and clinic networks signed the document in 2003, formalizing relationships that had existed for decades. The full list of signatories appears in Appendix B.

The Implementation of the Partnership

During the early days of the Partnership, KP Regional Community Benefit staff focused on building and strengthening relationships with clinics and clinic networks. They sought promising ideas and input from clinic networks and community clinics on how funding and in-kind resources could best meet their needs and add value to their existing work. KP's early approach to grantmaking is generally described by KP, clinic network and clinic staff as relationship-driven, flexible and responsive. The greatest value of KP's experiences and expertise are reported to be in the areas of primary and preventive health service delivery and chronic care management.

While these initial defining characteristics still remain evident, over time the Partnership's support has become more focused, strategic and transparent, especially since the 2004 influx of more funding from KP grants. This has involved efforts to document and share grantmaking processes, to increase assessments of grantee readiness to undertake projects and to monitor grantee accountability. While continuing to provide core operating support, the Partnership has moved towards broader health initiatives—particularly in the areas of health disparities, quality improvement and health information technology (IT)—in order to have greater impact on the regional and statewide health care safety net[4] and its patient population.

"Overall the vision [of the Partnership] has stayed the same but it has become more strategic and defined."

—KP Stakeholder

The Partnership also developed an operating structure and processes for its ongoing work. Through regular KP-supported meetings, the Partnership's clinic network and KP representatives continue to meet regularly for joint planning, information sharing and mutual learning. Partnership members also meet in subgroups, in both ongoing and ad hoc committees, to focus on specific Partnership-related issues such as vision, evaluation and communications. Formal and informal communications facilitate the Partnership in achieving its goals between meetings.

[4] The safety net includes the wide variety of providers delivering health care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. This includes public hospitals and community clinics as well as teaching and community hospitals.

KP's Support & Its Recipients

This section of the report describes the nature of KP's support, the recipients of this support and the ways in which KP resources have been directed and utilized. Additionally, this section summarizes the major ways in which KP's support has changed over time.

WHAT SUPPORTS DID KP PROVIDE & TO WHOM?

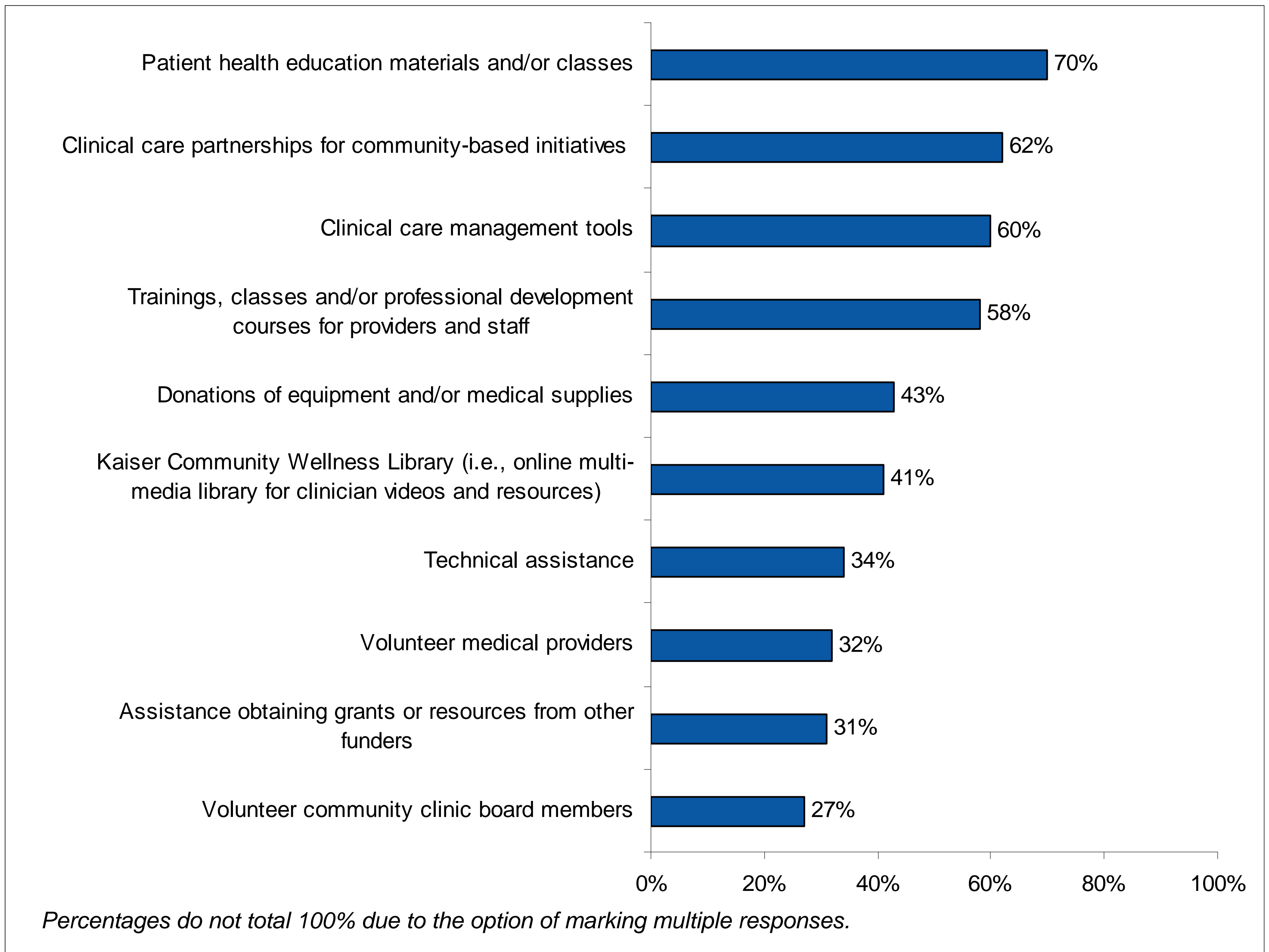
Between 2002 and 2005 KP provided grant funding as well as an expansive range of in-kind resources to 148 organizations. KP's Northern California Community Benefit Program distributed more than $8.8 million and the Southern California Community Benefit Program granted more than $15.5 million in this timeframe. The primary focus of this evaluation is the 80 community clinics and nine clinic networks that received funding totaling $50,000 or more; the largest amount of funding received by one organization was $1.29 million.

As a complement to its grant funding and to capitalize on its health care provider experience, KP offered grantees a wealth of health care expertise and resources related to clinical care, facilities, equipment and technology, and general organizational capacity. As demonstrated in Exhibit 2, grantees accessed different types of KP support to varying degrees. Grantees most commonly utilized health education materials and classes (70%), clinical care partnerships for community-based initiatives (62%) and clinical care management tools (60%).

Exhibit 2

Top Ten Types of In-kind KP Resources Grantees Utilized from 2002 to 2005[5]

(N=74)



Percentages do not total 100% due to the option of marking multiple responses.

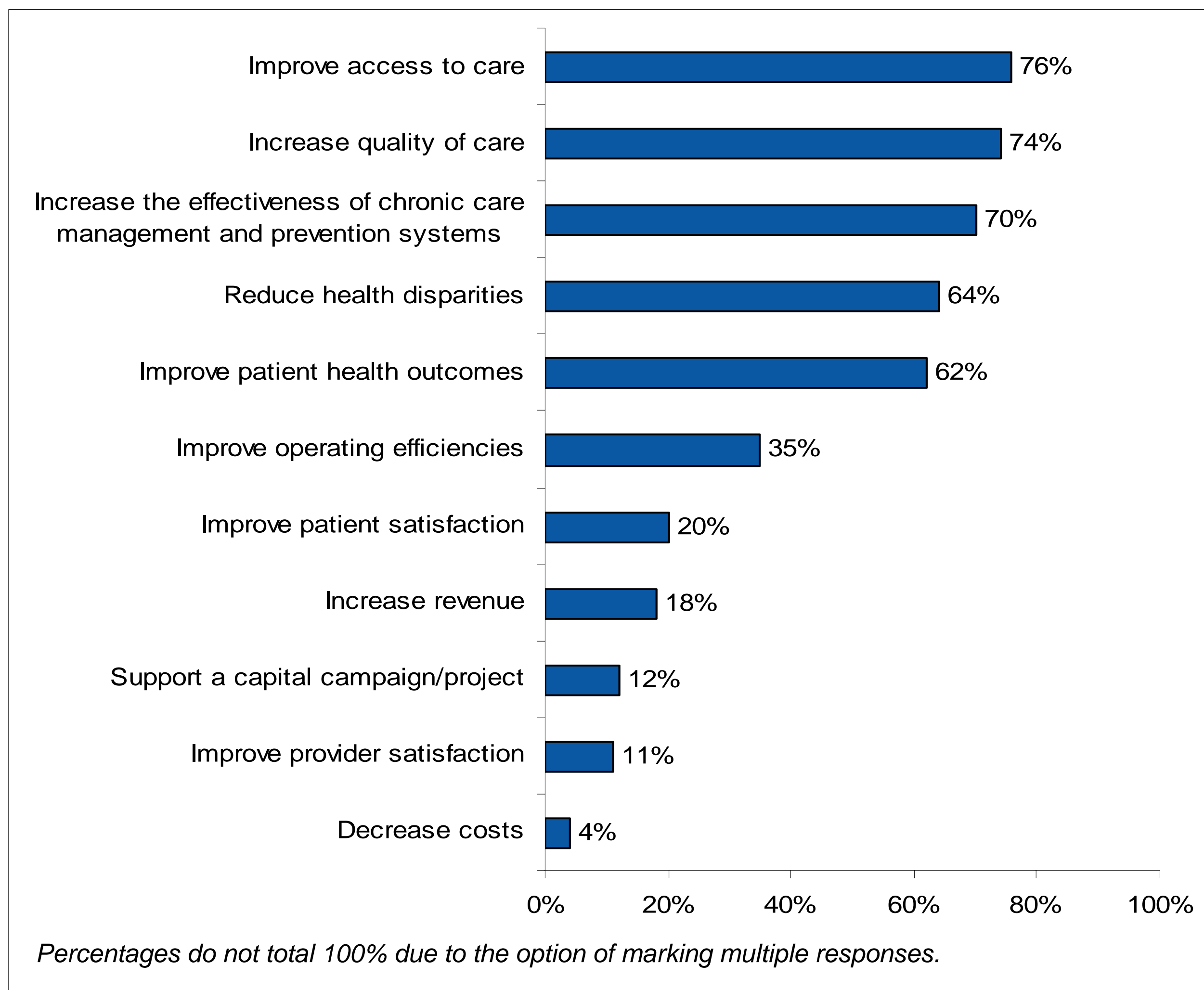
[5] The graph in Exhibit 2 shows only the ten most utilized types of Partnership support.

HOW DID GRANTEES USE KP SUPPORT?

With a combination of grant dollars and in-kind resources, grantees directed their KP-supported efforts towards a variety of objectives, specific health issues, target population groups and activities.

Grantees generally focused on clinical care and patient health objectives. As demonstrated in Exhibit 3, nearly three-quarters of grantees report that their primary KP-supported objectives were to improve access to care (76%), increase quality of care (74%) and increase the effectiveness of chronic care management and prevention systems (70%). A large portion of grantees also report objectives to reduce health disparities and improve patient health outcomes (64% and 62%, respectively).

Exhibit 3
Primary Objectives of KP-Supported Activities from 2002 to 2005
(N=74)



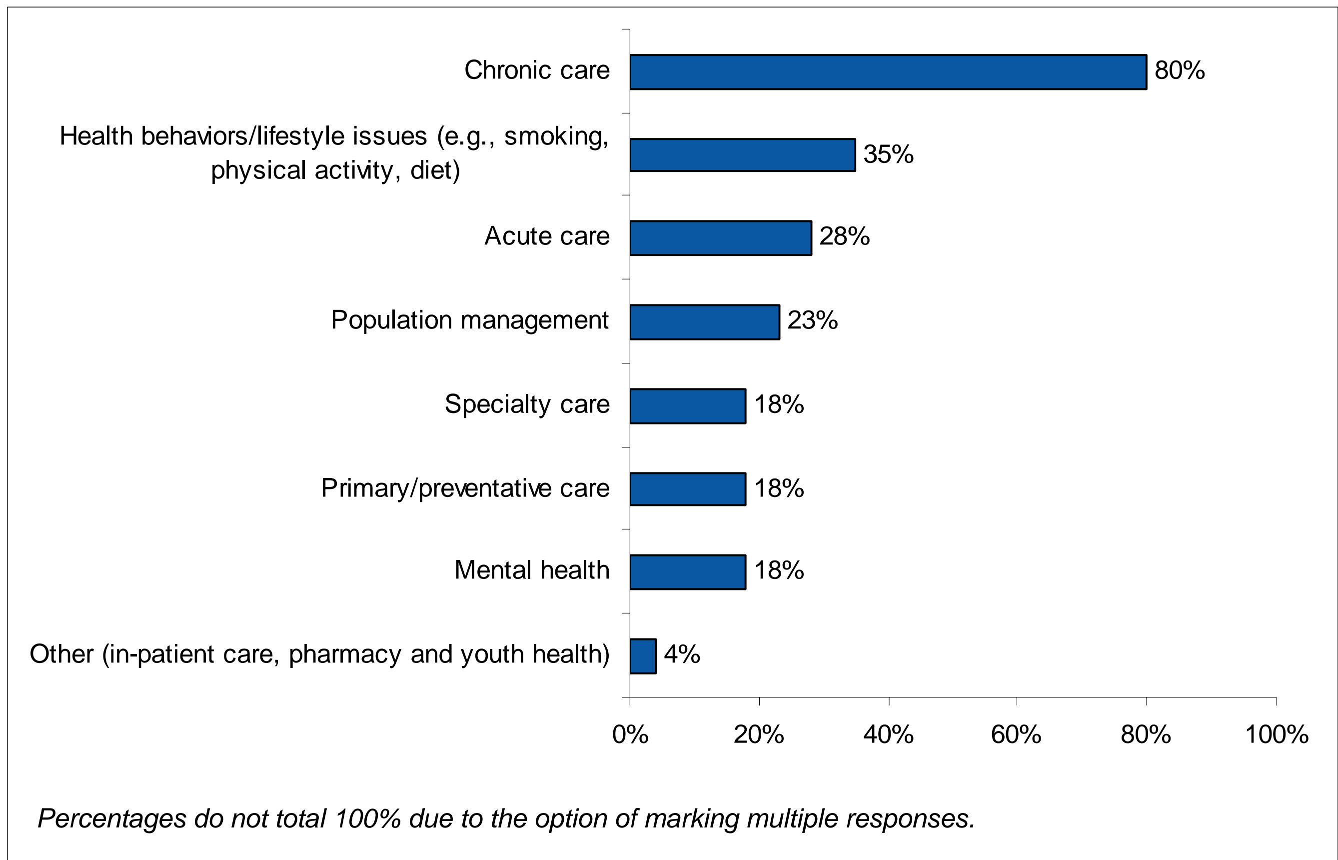
Percentages do not total 100% due to the option of marking multiple responses.

The majority of grantees (80%) addressed chronic care issues, most commonly diabetes. Other chronic care issues frequently addressed were cardiovascular/heart disease and associated risk factors (e.g., hypertension, cholesterol) and asthma. Approximately one-third of grantees directed KP resources towards health behaviors/lifestyle issues (35%). Other health issues addressed include acute care (28%) and specialty care issues (18%) such as psychiatry and ophthalmology (Exhibit 4).

Exhibit 4

Types of Health Issues Addressed with KP Support from 2002 to 2005[6]

(N=70)

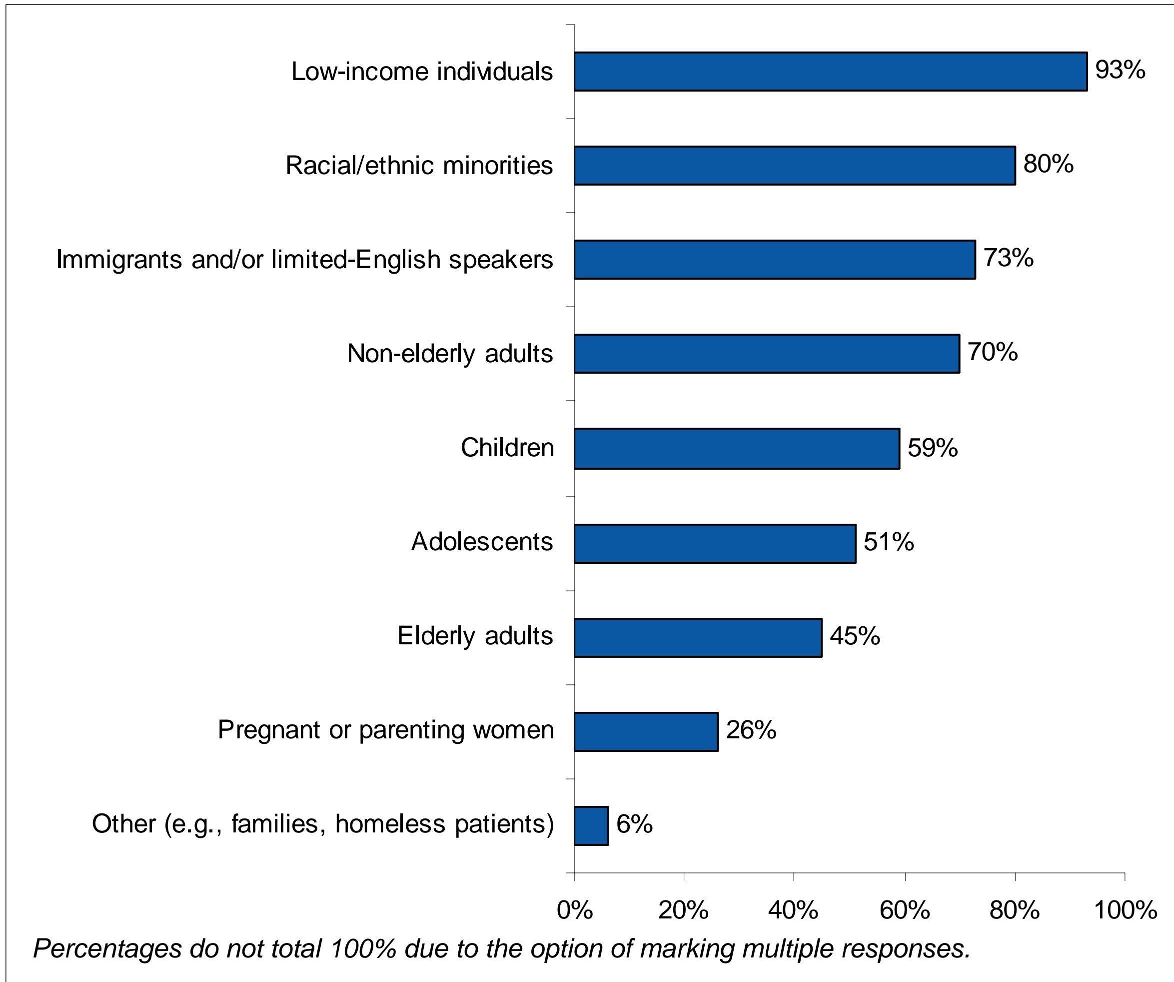


Percentages do not total 100% due to the option of marking multiple responses.

[6] The categories in this graph are not mutually exclusive. For instance, 18% of respondents reported addressing primary/preventive health care issues; however, it is likely that primary/preventative health issues are also subsumed under other categories such as health behaviors/lifestyle issues.

Grantees most commonly characterize the groups that they served as low-income (93%). Racial/ethnic minorities (80%) immigrants and/or limited-English-speaking populations (73%) were also frequent target populations for KP-supported work (Exhibit 5).

Exhibit 5
Target Population Groups for KP-Supported Activities/Work from 2002 to 2005
(N=73)



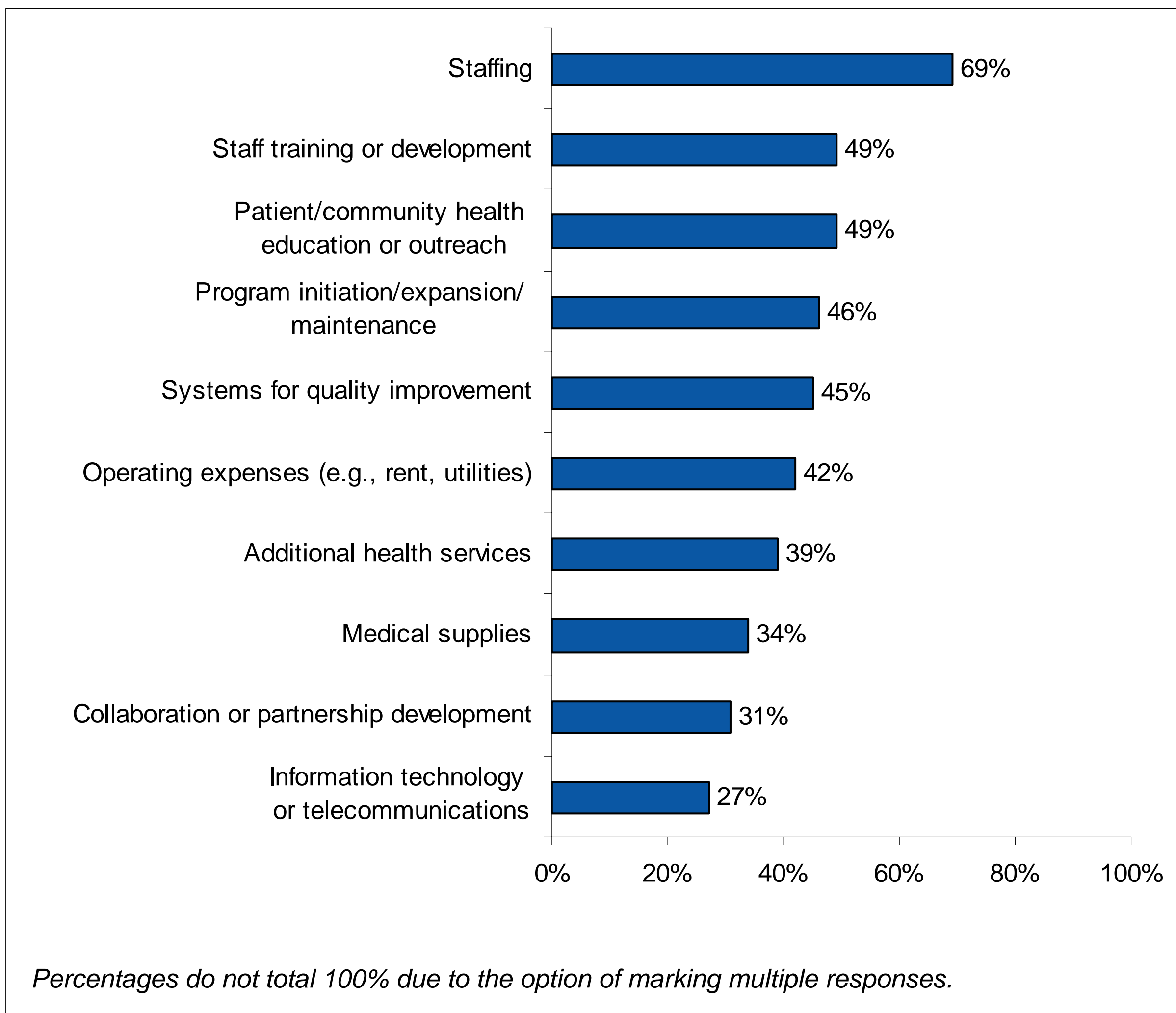
Percentages do not total 100% due to the option of marking multiple responses.

In order to meet their primary objectives within targeted health areas and populations, grantees pursued a broad range of activities with KP support. Grantees most frequently utilized KP's supports for staffing (69%) (e.g., to increase the number of staff or staffing hours) and for developing staff's knowledge and capabilities through training and other professional development opportunities (49%). In many cases, grantees directed KP's support towards activities closely linked to clinical care and patient health, such as health education/outreach (49%) and systems for quality improvement (45%) as shown in Exhibit 6.

Exhibit 6

Top Ten Types of Activities Pursued with KP Support from 2002 to 2005[7]

(N=74)



Percentages do not total 100% due to the option of marking multiple responses.

[7] The graph in Exhibit 6 shows only the ten most commonly reported KP-supported activities. Fewer than 20% of grantees report pursuing the remaining queried activities (e.g., facilities, evaluation, fund development) with KP's support.

Accomplishments & Impacts of the Partnership

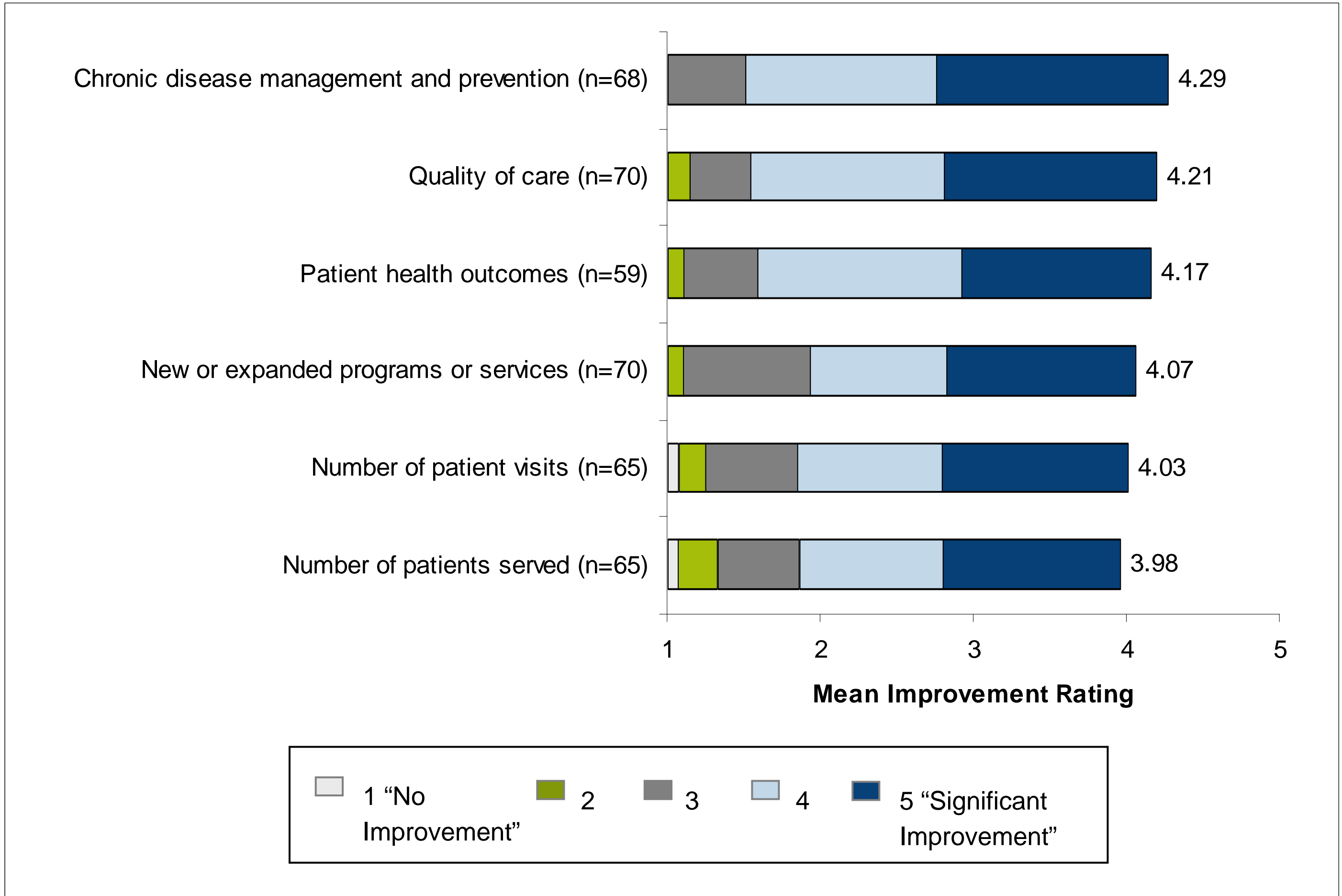
The Partnership has resulted in a variety of accomplishments and impacts for grantees including advances in clinical care; enhanced connections and collaborations among grantees, KP and other organizations in the health care field; and improved operational capacity. This section of the report describes the key impacts of the Partnership and provides examples and profiles of Partnership accomplishments.

CLINICAL CARE

As a result of the KP support that they received, grantees report improved access to and quality of clinical care, including chronic, primary and specialty care. As demonstrated in Exhibit 7, grantees report considerable progress in all of the queried clinical care areas. On a scale of 1 to 5 with 1 indicating "no improvement" and 5 indicating "significant improvement," grantees report the greatest extent of improvement in chronic disease management and prevention (mean of 4.29), followed by overall improvements in the quality of care (mean of 4.21).

Exhibit 7

Grantees' Mean Ratings of Clinical Care Improvements as a Result of KP's Support from 2002 to 2005[8]



The Partnership has been particularly successful in increasing grantees' engagement in chronic care activities and initiatives. Many grantees were able to benefit from KP's expertise and focus on chronic disease prevention and management, particularly related to diabetes. For instance, the Partnership facilitated the Redwood Community Health Coalition's (RCHC) involvement in a federal diabetes collaborative, even though many of RCHC's member clinics did not meet the collaborative's eligibility requirement of being a federally-qualified health center. By taking part in the disease collaborative, RCHC clinics benefited from knowledge-sharing and technical support on diabetes issues, which they would not have been able to do without KP's intervention.

[8] This exhibit represents respondents' mean ratings of the extent of specific clinical care improvements made at their organization due to KP support; it also breaks down the approximate percentage of specific answers that respondents marked on the survey. The scale ranges from 1 to 5, with 1 indicating "no improvement" and 5 indicating "significant improvement."

Enhancing Diabetes Care Management in Santa Clara County

Diabetes afflicts 10% of Santa Clara County's population.[9] In an effort to address this staggering statistic and with prompting and support from KP, in 2002 the Community Health Partnership of Santa Clara County (CHPSCC) partnered with The Health Trust and the Diabetes Society of Santa Clara Valley to form the Diabetes Coalition of Santa Clara County. The Coalition convened a group of community health providers, hospitals and other stakeholders to discuss options to address this growing problem. Rhonda McClinton-Brown, CEO of CHPSCC, reflects that, at the time, "there was a diversity of level of care to diabetes patients among our clinics." Some clinics referred diabetic patients to other providers for care while others managed diabetic conditions on site, and without countywide clinical practice guidelines. One year after the Coalition formed, the group chose to tailor a comprehensive approach to monitoring and managing diabetes patient care across the county health system.

McClinton-Brown reports that "through dialogue, KP let us know that they had many resources beyond cash" to support diabetes care management efforts. In addition to grant funding, KP provided community clinics with diabetes care management trainings and associated tools and materials. Nancy Moline, Regional Diabetes Program Coordinator of KP Northern California who orchestrated and customized these trainings, participated in the Coalition on KP's behalf. KP's experience and expertise in dealing with large-scale populations with chronic diseases established KP as a leader in chronic care management and made KP a valuable resource to the community. McClinton-Brown reports that KP's assistance increased clinic capacity in the county to manage diabetes as well as other chronic diseases. Community clinics were not the only organizations to benefit from KP's assistance and resources. The county health system also participated in the care management trainings and adopted KP's risk stratification methods for their care management program.

"We're learning how to assess ourselves, implement change in our own organizations and train our staff to be agents of continuous quality improvement."

—Clinic Grantee

The Partnership has helped to enhance the culture of and infrastructure for quality improvement among grantees. KP support accelerated grantees' work in assessing their existing practices, identifying and prioritizing areas for improvement, becoming more sophisticated and systematic in their quality improvement efforts and enhancing the number of people engaged in and/or championing these efforts.

KP increasingly supported technology-enabled quality improvement. Projects ranged from support to help clinics with their readiness assessment for IT endeavors to the installation and use of patient scheduling systems to enhance efficiencies in staffing and care. A few grantees with greater IT capacity developed and implemented data management systems and registries to track clinic patients and their outcomes at individual clinics; in some cases grantees undertook efforts to connect such systems across clinic sites and the broader safety net.

[9] *Behavior Risk Factor Survey 2004*, Santa Clara Department of Public Health, Health Assessment and Quality Improvement Division.

Connecting Across the City to Improve Care

The San Francisco Community Clinic Consortium (SFCCC) has undertaken a massive information technology (IT) project intended to establish a patient management system that links community clinics to other health care providers in the region. In 1998, SFCCC linked their first computer to the San Francisco Department of Public Health's electronic medical records. Since then, the IT infrastructure has been expanded to link all eleven SFCCC clinics, four satellite sites, three community hospitals and other city systems together on one system. Dr. Lisa Pratt, Medical Director of SFCCC, acknowledges that they have "created something that hasn't existed in California—a regional patient information system for the safety net."

This integrated system helps clinics operate more efficiently by providing access to patients' medical histories. If a SFCCC patient visits another doctor within the city's healthcare safety net, the primary care physician has easy access to the patient's medical record. Giving providers a more complete picture of a patient's history improves patient care and reduces duplicate testing, saving time and money and minimizing patients' discomfort. Dr. Pratt says, "There is no health system that can look at this and not be inspired that so many inefficiencies can be eliminated by just a simple tool of communication. That's really what this is. I think this absolutely will have national implications." KP supports SFCCC's IT infrastructure integration efforts through grants and by sharing KP's own expertise and lessons learned from implementing IT programs of this magnitude. KP hopes to see this model of system integration spread nationally. Recently, the Health Resources and Services Administration (HRSA) showcased SFCCC's work at a national meeting of their grantees.

Engagements between KP medical centers and local community clinics help to increase the quality of and access to primary and specialty care. For example, KP physicians in Los Angeles donate time and services to provide free pediatric specialty care consultation and treatment to 100 patients each year from the Eisner Pediatric and Family Medical Center. The Department of Radiology at the KP Los Angeles Medical Center reads up to 2,000 images annually for three clinics located in Skid Row, an area populated primarily by homeless and indigent individuals. The KP Los Angeles Medical Center Family Medicine Physician Residency Program provides medical residents with volunteer opportunities at the Venice Family Clinic and community clinic rotations at the Asian Pacific Health Care Venture and the Los Angeles Free Clinic. Through engagements such as these, patients benefit from quality, in-kind care from KP medical residents; clinics receive in-kind service and benefit from KP best practices; and KP residents gain awareness about the needs of the uninsured and underinsured.

Increasing Access in Orange County

In December 2004, KP awarded the Coalition of Orange County Community Clinics (COCCC) a grant to expand specialty care services for the county's uninsured population. At that time, Fred Richmond, former CEO of the Coalition, was also meeting with the Specialty Care Task Force, a committee of the Health Funders Partnership of Orange County, to explore how to address the county's specialty care needs. KP funds were used to study several nationwide specialty care access programs for possible modeling in Orange County. After debating the benefits and drawbacks of different models, the Task Force decided its first effort would be to replicate KP's partnership with Operation Access in the San Francisco Bay Area and explore the possibility of creating a multi-specialty care clinic hub in the future. For a year and a half, the Specialty Care Task Force developed the business model for implementing Operation Access in Orange County.

Operation Access began when Dr. Douglas Grey, chief of vascular surgery at KP San Francisco, and Dr. Bill Schecter, chief of surgery at San Francisco General Hospital, decided to volunteer their time on the weekend to perform surgeries. They wanted to help low-income people who do not qualify for state Medi-Cal coverage but cannot afford to purchase individual insurance. Since the first "Saturday Surgery Session" took place in San Francisco in 1994, the number of volunteers and hospitals involved has grown exponentially. In May 2007, Orange County facilitated its first "Saturday Surgery Session." KP donated its outpatient center, along with nine surgeons and 40 staff people to perform the surgeries. The program received 200 referrals for 15 surgery slots, demonstrating the great need for specialty care in Orange County. Fred Richmond reflects on the "Saturday Surgery Session," "It's heartwarming to see a community of altruistic individuals pulling together, transcending barriers. The patients, surgeon and staff volunteers, funders and family members felt a bond that day. It's a great model for improving access and closing health disparities." Richmond says that participating on the Task Force to implement Operation Access in Orange County has helped COCCC develop relationships with health funders, county government, local universities, the medical association and community clinics. The process has raised awareness about the Coalition, as well as the "state-of–the-art" clinics that fill a pressing need for primary and specialty care services.

CONNECTIONS & COLLABORATION

"The grants opened a lot of doors and made a lot of difference. Now, the interactions between our [KP] people and their [clinic/networks] people are about increasing impact. It is the combination of the [grants and interaction] that makes the difference."

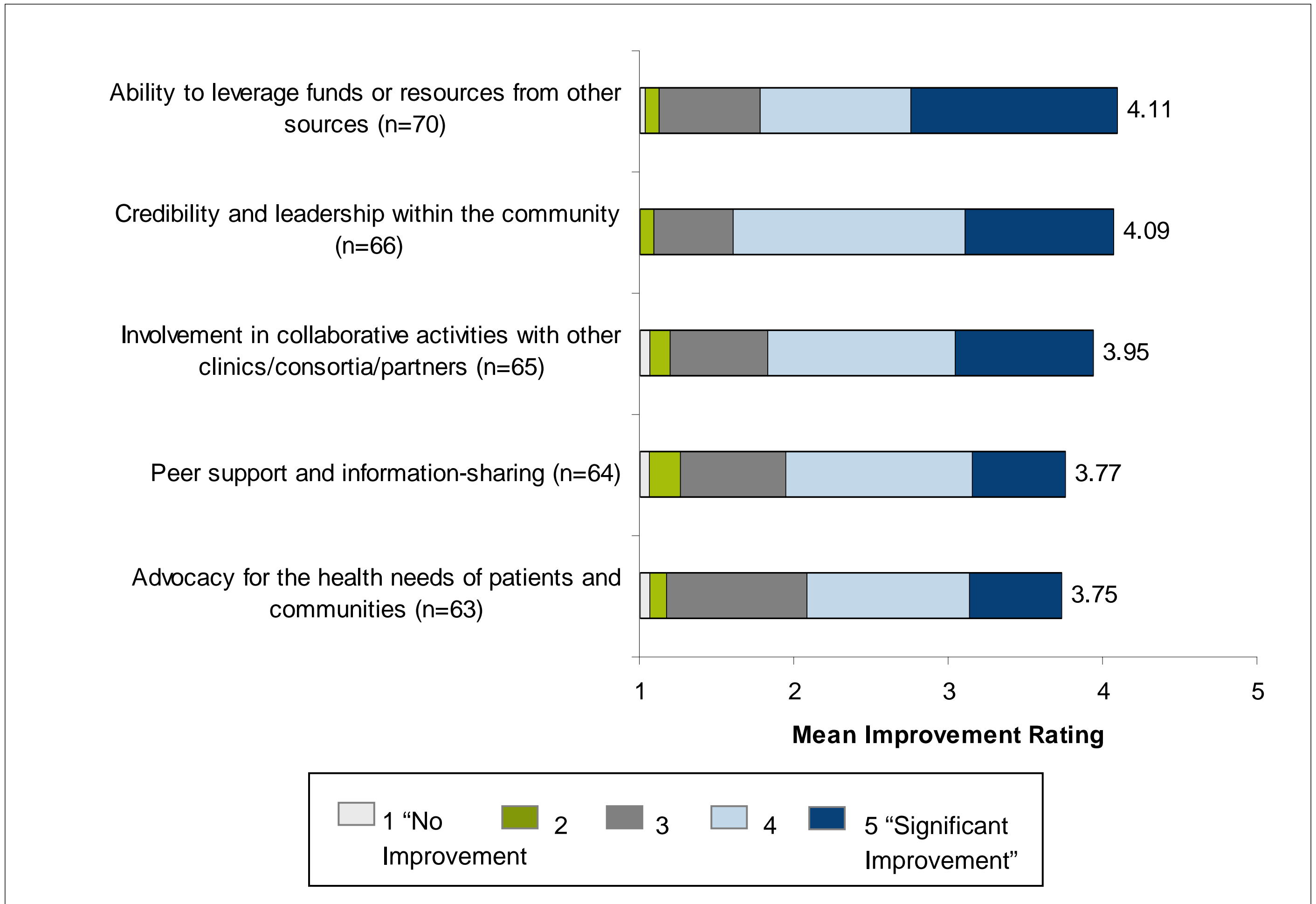
—KP Staff

Connections and collaboration continue to be key tactics to achieve the Partnership's goals and are important outcomes in their own right. Stakeholders strongly express pride and a sense of accomplishment—as well as a fair amount of surprise—about the breadth and depth of the relationships that have developed out of the Partnership. Personal relationships laid the groundwork for the Partnership and, according to its stakeholders, the Partnership continues to be characterized by trust, mutual respect, peer support and members who are willing to be honest with one another.

The Partnership's strong relationships open doors to many opportunities for collaboration and learning; they promote community clinic and clinic network visibility among funders and the broader community. As shown in Exhibit 8, where the scale ranges from 1 to 5 with 1 indicating "no improvement" and 5 indicating "significant improvement," grantees report the greatest extent of improvement in their ability to leverage KP resources (mean of 4.11) and in their credibility and leadership within their community (mean of 4.09). For example, the Community Clinic Consortium reports that KP funded the establishment of their Safety Net Council in Contra Costa County. This group of community clinic and county health system leaders now convene regularly to discuss issues and share information concerning the health care safety net. Recent Council discussions led to a series of trainings conducted by the county for clinic staff on referral processes to county systems. The foundation of longstanding relationships and successful collaboration through the Partnership also contributed to KP's health care reform plan being unveiled at a CPCA meeting in fall 2006. KP's plan, which prominently featured the role of safety net providers in the health care delivery system, informed California Governor Arnold Schwarzenegger's health care reform plan.

Exhibit 8

Grantees' Mean Ratings of Improvements in Connections and Collaboration Due to KP's Support from 2002 to 2005 [10]



KP's investments in developing clinician leadership have enhanced clinicians' roles within their organizations and the health care field. KP's support of coaching, peer support and professional development opportunities such as conferences and trainings for community clinic physicians produces physician leaders who are more connected to their peers, are more closely linked to best practices and have a greater role in policy and advocacy work. In addition, these supports have helped carve out a role for medical directors on clinic networks' staff.

[10] This exhibit represents respondents' mean ratings of the extent of specific connection and/or collaboration improvements made at their organization due to KP support; it also breaks down the approximate percentage of specific answers that respondents marked on the survey. The scale ranges from 1 to 5, with 1 indicating "no improvement" and 5 indicating "significant improvement."

Promoting the Value of a Clinic Network Medical Director

Steve Graham, past Community Health Partnership Manager of KP's Community Benefit Program in Northern California, strongly believed that the San Francisco Community Clinic Consortium (SFCCC) needed a medical director to provide leadership in medical quality and facilitate relationship building among physicians. John Gressman, CEO of SFCCC, reflects back on his initial resistance to the idea: "When Steve started talking to me about a medical director on the network level, I could not imagine what the role and responsibilities would be. Although I had run a clinic and the medical director was integral in our work, I could not see how such a position would work in a network…. I also had tremendous fear that the network medical director would have conflict with clinic-based medical directors and be perceived by clinics as a network trying to be prescriptive on clinic practice or clinical issues." However, with enough prompting by Graham, Gressman's thinking shifted. With support from KP, he created the position and hired Dr. Lisa Pratt, a physician with community clinic experience.

Dr. Pratt remarks on the value of her position: "There's another world of communication and collaboration that comes from physician-to-physician relationships and contact. In order to position the Consortium in that world, SFCCC needed to have a physician to be that liaison." She elaborates that CEOs of clinics have many operational and business concerns to address to ensure that their organizations are run properly. A clinic network medical director is in the unique position of being able to highlight the important issues for patient care and clinical issues. Gressman no longer needs convincing of the importance of such a position: "Our medical director is core to our thinking on a minute-by-minute, strategic and ongoing basis. She represents providers in all our planning and activities, bridges a voice of the clinics to the SFCCC Board and leadership and serves as a critical representative to other health care providers and their systems—places where only a medical director would or could go. She reminds us constantly about keeping patients as our focus." After seeing the value that accrues to networks with a medical director, many other networks have since created a similar position in their organizations.

"Because of the reputation and position that KP holds, its endorsement of clinics has been incredibly valuable in elevating the perception of [safety net providers]. Clinics have turned the corner from being the underdogs to having a more robust leadership role in the health care delivery system."

—Network Grantee

Because KP is such a large, powerful and respected entity in the health care field, its endorsement of, commitment to and investment in clinics and clinic networks increases their credibility and attracts other investors' interest. Partnership grantees as well as other stakeholders report how KP's partnership with the community clinics field signals to other funders, government agencies and health care organizations that the clinic safety net provides high-quality care and is a critical piece of the health care delivery system. With confidence in and respect for KP's due diligence, funders and organizations are motivated to follow suit and invest resources or build their own relationships with clinics and networks. The Partnership has had a significant role in facilitating clinics' and clinic networks' collaboration with county health agencies, helping to build trust, negotiate organizational culture gaps and support health IT and other projects.

The Partnership also reinforces that KP cares about community health. The Partnership gives KP credibility and legitimacy with regard to caring for the uninsured and underinsured and counteracts perceptions that KP redirects poor patients or shifts the burden of indigent care to public hospitals. The

Partnership has also created allies who are willing to publicly defend KP. One grantee notes, "There have been times when we [a clinic network] have been able to say things that KP cannot say without sounding self-serving. Once we were interviewed by a radio call-in show about KP and the group was very anti-managed care. I was able to say that if managed care is done like [KP] does it, it is an ideal model."

The Partnership promotes knowledge sharing, cross-learning and peer support so that stakeholders can build on successes and minimize challenges. KP's transfer of knowledge and evidence-based practices to community clinics (e.g., sharing protocols on how to reduce mortality after heart attacks) allows grantees to benefit from KP's clinical experience in a way that directly contributes to quality improvements in health care as well as cost savings. In turn, KP gains valuable information to improve the application of its tools and practices with challenging and diverse populations such as the homeless, immigrants and patients with low literacy (e.g., improve cultural competence and readability/comprehension) and opportunities to build its relationships with safety net providers. An example of knowledge sharing among a broader audience is the KP-supported semiannual one-day gatherings of Partnership members from RAC with KP and other health care funders (e.g., Blue Shield of California Foundation, The California Wellness Foundation, Tides/Community Clinics Initiative, The California Endowment and the California HealthCare Foundation). Through these gatherings, funders and others have learned from KP and community clinic staff about the Partnership's efforts; sometimes that has led to funders adopting KP-supported practices with their own funds (e.g., chronic disease management programs).

"It's been really great for me to meet some of the physicians at KP who are doing the work, who are walking the walk and talking the talk and trying to improve chronic care. There's something about meeting people and hearing them share their experiences—it's very inspiring."

—Network Grantee

Developing a Statewide Infrastructure for Community Clinics

KP's support of the Regional Associations of California (RAC) has contributed to the development of a statewide affiliation of clinic networks that represents and advocates for the needs of community clinics throughout California.

KP's funds support the technical and logistical aspects of the RAC's work. This forum has allowed RAC members, who are the directors of clinic networks and state associations, to meet regularly to share successful programs and practices as well as strategize around challenges they face individually and collectively. Clinic networks outside of KP service areas, and therefore ineligible to receive KP grants, benefit from KP's support through their involvement in the RAC. Other staff from networks that participate in the RAC also benefit through their participation in special gatherings such as the RAC Best Practices Conference that shares best practices across networks and increases the capacity of networks throughout California.

David Quackenbush, CEO of Central Valley Health Network, reflects on the RAC gatherings: "The most significant [impact of the Partnership] is formalizing and stimulating the conversation between networks, getting everyone in the room and allowing relationships to develop.... Every health center in the state is represented at the same meeting."

RAC members also have the unique opportunity to sit down with funders. Every six months, six to eight major health care funders in the state join the RAC meetings. KP's involvement in the RAC has added credibility to the RAC and has helped bring these funders to the table. At these meetings, clinic network leaders discuss the major issues facing clinics and clinic networks, which guides funders about how to focus their grants to clinics to increase impact and scale and improve the health care safety net as a whole. One participating funder noted, "KP was a real leader in bringing other funders to the table—not for joint funding, but how various funders can play a role in the community-based health care delivery system.... I've never had such openness between and among funders and recipients of those funds. It is really a unique model."

The Partnership has led to new collaborations and strengthened existing ones. The opportunities to collaborate occur in many different forms among a variety of stakeholders, including community clinics, clinic networks, KP staff and other players in the health care arena. For example, KP's in-kind trainings on clinical care open up opportunities for clinics to network directly with KP clinicians and staff for relevant information, resources or volunteer opportunities. Examples of collaboration at the clinic network or regional level include the replication of programs/initiatives such as the ALL program (see Box on page 24) and Operation Access (see Box on page 18). More recently, the Partnership's activities have led to new partnerships for KP with other funders, including a collaboration with Unihealth Foundation on health IT readiness assessments for clinics and networks in Southern California and a health care funder learning community called Funders Fostering Technology for Quality.

Sharing KP Evidence-Based Programs with the Safety Net

KP's chronic care management model for reducing the incidence of strokes and heart attacks in at-risk patients is spreading throughout California, improving clinical effectiveness and reducing costs. In Southern California, the ALL Intervention (Aspirin, Lisinopril, Lovastatin) targets patients afflicted with chronic diseases such as diabetes, coronary artery disease and chronic kidney disease and aims to reduce their risk of suffering from a life-threatening emergency. The ALL Intervention manages this threat by setting guidelines to monitor risk factors, prescribe preventative medicine and advise lifestyle changes.

In 2005, KP awarded a grant to the Community Clinics Health Network (CCHN) in San Diego to implement the ALL Intervention in their clinics. CCHN selected two clinics to pilot test the program and monitored the changes in patient data. The initial outcome data from these two pilot clinics exceeded KP's expectations. Diane Strum, Director of Government and Community Relations of KP in San Diego, acknowledges this success, stating that, "KP sets a standard of care and a benchmark for the clinics, and in some cases clinics have surpassed it."

In 2006, the ALL program was replicated in Northern California as the PHASE Program (Prevent Heart Attacks and Strokes Everyday). Dr. David Shearn, Director of KP's Physician Education and Development and KP Northern California's physician liaison to Safety Net Initiatives, highlights the importance of sharing this model with community clinics. "It is well demonstrated that Northern California KP members have a significantly lower cardiovascular mortality rate than non-members. If it is good for our members, it is good for community clinic patients. There are opportunities to share our experience and improve health outcomes statewide."

The Partnership has improved the ability of KP, clinic networks and clinics to advocate for clinics and the needs of their patients and communities. For example, the Partnership has been working with the California state legislature to build coalitions to address diabetes. The Partnership's activities include promoting diabetes awareness campaigns and contributing to a public, online diabetes information resource center. Such activities position the Partnership to help increase the issue's visibility, coordinate resources and ultimately improve quality of care statewide. Clinics and networks not in a KP service area are unable to apply for grants, but have benefited from KP's advocacy to other funders on their behalf. For example, acknowledging these limitations on Partnership funding, The California HealthCare Foundation provided increased funds through their Accelerating Quality Improvement through Collaboration program to clinic networks outside KP service areas.

"The Partnership has helped [KP] understand the larger picture of challenges in health care today. Hopefully that helps us make better decisions—not only policy decisions but clinical care decisions."

—KP Staff

Generating Health Care Resources Through Policy Change

In 2004, 71% of Alameda County voters approved a measure containing a phrase that voters typically avoid—a new sales tax. Measure A authorized a 0.5% tax on sales and transactions to fund health providers in the County. Ralph Silber, CEO of Alameda Health Consortium (AHC), reflects on his organization's involvement in promoting this measure: "The core funding that we receive from KP to do local policy and advocacy work has been very significant.... With the new Measure A funding, the clinics have been able to provide more than 10,000 additional primary care visits for uninsured residents of Alameda County." Seventy-five percent of the revenue generated by Measure A is earmarked for the Alameda County Medical Center, which faced service cuts at the time of the vote. The remaining 25% is distributed at the discretion of the County Board of Supervisors to community clinics and hospitals serving low-income residents. Since Measure A's passage, AHC member clinics have received more than $6 million annually in revenue from this sales tax to support indigent care.

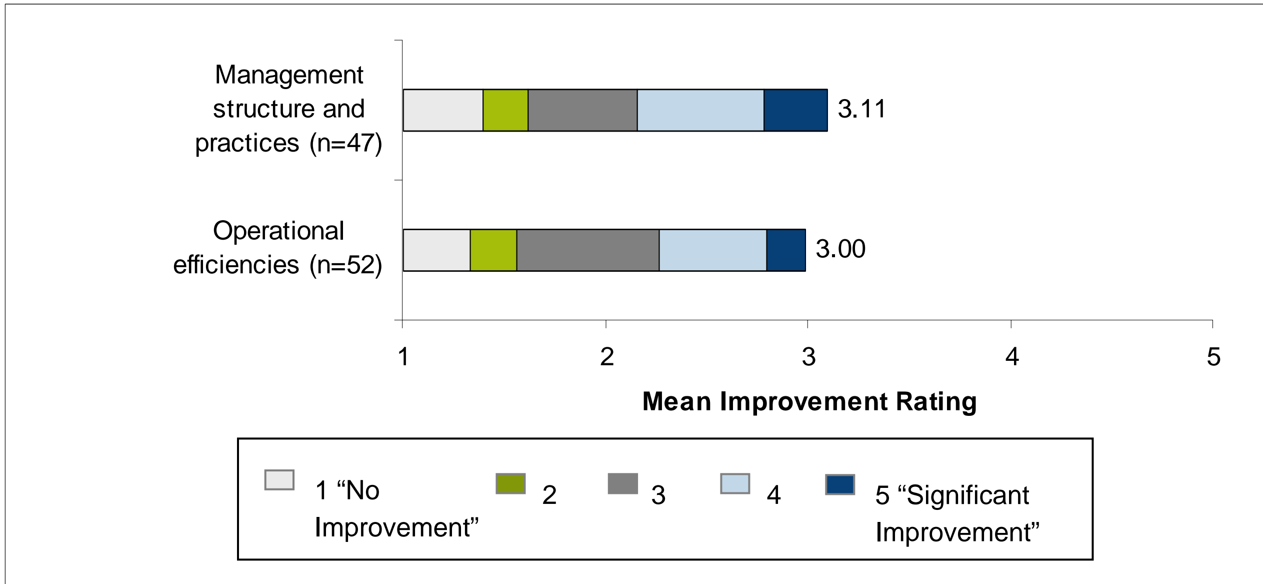
Beginning in 1997, the Community Clinic Association of Los Angeles County (CCALAC) and its member clinics engaged in a collaborative effort with the Los Angeles County Department of Health Services to restructure the County's health delivery system and direct federal indigent care funds to community clinics. The resulting Public-Private Partnership Program established the first formal linkages in the County between private and public health clinics and County hospitals. Over its first six years, the Program provided approximately 4 million primary, specialty and dental care patient visits to 1.3 million uninsured and underserved individuals. In order to extend the Program beyond the 2005 end date for federal funds, CCALAC utilized KP's core operating support to advocate for the continuation of the Program through alternative financing models, negotiate higher reimbursement rates for Program services and otherwise help shape the County's indigent care policy. Bolstered by KP's support to educate, convene and communicate with community clinic stakeholders and policymakers, CCALAC helped ensure the continuation of the Program—now a permanent line item in the County's general expenditures budget—and increase reimbursement rates by 12% in 2006. Gloria Rodriguez, CEO of the CCALAC, notes that continued KP funding "has been very critical because it has supported our staff's ability to maintain this program; the maintenance of effort to keep everyone informed and supportive of this program and partnership can't be undervalued."

OPERATIONAL CAPACITY

The Partnership has contributed to grantees' operational capacity, primarily by helping build infrastructure, maintain core operational practices and increase financial stability. One way KP has helped to improve grantee infrastructure is through their support of capital improvement projects. For instance, a clinic grantee described the invaluable technical assistance to design a new clinic facility, including the selection of an architectural firm and planning the size of exam rooms according to expected patient volume and staffing patterns. In addition, KP has supported grantees' overall capacity by providing support for new staff, professional development (e.g., meetings, trainings, conferences), research, data analysis and more. Although KP's support has had an important influence on grantee capacity, as shown in Exhibit 9, grantees' perceived improvements in the areas of operations and management are more moderate than those related to clinical care and connections and collaboration (as shown previously in this report in Exhibits 7 and 8).

Exhibit 9

Grantees' Mean Ratings of Improvements in Organizational Operations and Management Due to KP's Support from 2002 to 2005[11]



"The cost of doing business continues to rise while fee-for-service reimbursements remain constant. The Partnership's core support helps keep the doors open to low-income, uninsured populations."

—Clinic Grantee

KP's core operational funding has contributed to the financial viability and security of many clinics and networks. This has been especially important given an environment of unpredictable and generally insufficient health care funding. Grantees find this willingness and commitment to fund core operations to be extremely valuable, as it allows them to shift their attention from economic survival to a focus on providing quality care to their target populations and working towards other organizational and capacity improvements.

Despite comparatively lesser impacts on clinic and clinic network operations overall, KP support has had a monumental impact on the development of the RAC and a few of the clinic networks.[12] KP funding and resources helped clinic networks build and strengthen their infrastructure and position them to enhance their own capacity and better serve their clinic members, ultimately helping clinics to increase access to and quality of care among their patient populations. For example, KP provided the Community Clinic Consortium (Contra Costa County) with seed money to establish the organization and offered ongoing core support for capacity development, including establishing a leadership role in a regional asthma coalition, developing a white paper on clinic workforce development, developing a customer service training for clinic staff and engaging in clinic publicity campaigns.

[11] This exhibit represents respondents' mean ratings of the extent of specific operations and management improvements made at their organization due to KP support; it also breaks down the approximate percentage of specific answers that respondents marked on the survey. The scale ranges from 1 to 5, with 1 indicating "no improvement" and 5 indicating "significant improvement."

[12] See box on page 23 for information about RAC's development.

Strengthening the Organizational Capacity of Clinic Networks

KP has supported the Community Clinic Association of Los Angeles County (CCALAC) from its infancy. CCALAC was founded in 1994 as a project of the Los Angeles-based National Health Foundation (NHF) and received its non-profit status in 1996. The NHF Report *Closing the Gap,* which documented the extent of the uninsured problem in California, coupled with Los Angeles County's threatened dissolution as a safety net provider and the pending implications for the local community clinics system, catalyzed CCALAC's formation.

Early in the organization's formation, KP funded a study to explore models of clinic partnership and networking. KP hoped to see CCALAC's clinic partnership model replicated in counties around the state, so it nurtured the development of the network through core operating grants. Mandy Johnson, former CEO of CCALAC, remembers, "Core support was the hardest money to get, but KP understood why it was important. KP wanted to see strategic initiatives implemented, but they also wanted to see the survival of the consortium."

KP's partnership with CCALAC goes beyond grantmaking; the relationships that formed out of this partnership have added value for both CCALAC and KP staff. Johnson benefited from having a KP administrator mentor her on how to support the development of a clinic association. As an advisor to the organization, Judith Zitter, Community Health Manager for KP Southern California, heard first-hand about the current issues facing clinics. Johnson noted how productive the relationships were for both parties: "KP gave me a new viewpoint on some of the things I was worried about … and I was able to help them shape KP strategy by helping them understand what is really a driver for clinics."

Shaping Success

Overall the story of the Partnership is one of significant progress and accomplishment. Shaped by a relatively small group of individuals, the Partnership was built on KP's rich history of commitment to the communities it serves and the relationships it has developed with community clinics and clinic networks over many years. Over time the Partnership has expanded in size and scale to become a significant source of support for the community clinics field in the state. In addition to KP's grants, community clinics and clinic networks have been able to access a broad range of unique in-kind resources and technical assistance. All participating parties, within KP and in the community clinics field, have realized significant benefits, from stronger leaders to enhanced organizational capacity and improvements in clinical care. The bridges that have been built strengthen the work within and among community clinics, clinic networks, KP and the broader safety net and hold potential for more important impacts in the years ahead.

Five years into the formal Partnership provides a well-timed opportunity to reflect on lessons learned, for the purpose of informing the Partnership's future direction. Such reflection can inform other health care organizations, clinics or clinic networks across the country that may be considering adopting the Partnership model or some of its components.

In the following section we summarize the key lessons from these evaluation findings. First, we discuss the key strengths of the Partnership model. Second, we identify four recommendations for the Partnership, or others involved in similar efforts, to consider when making plans to move forward.

STRENGTHS OF THE PARTNERSHIP MODEL

As a health care delivery system, KP is able to offer a broad range of high-quality supports and expertise that goes beyond grants and is uniquely applicable to the needs of clinics and clinic networks. Unlike many funders, KP has first-hand experience providing clinical care and has accrued a great deal of empirically based and hands-on expertise that it shares with grantees. By choosing to fund areas in which KP can share evidence-based practices and internal resources (e.g., tools, clinic practice guidelines, etc.), KP is able to leverage its own grantmaking dollars and experiences providing health care to benefit a wider audience beyond KP's own staff and members. KP's dual role, as funder and health care provider, allows a richness and depth of partnership that transcends the traditional grantee-grantor relationship and is clearly acknowledged and valued by the grantees.

The Partnership model features a responsive, flexible and tailored approach in the way it issues grant funding and other support. Despite KP's size and organizational complexity, it has been able to tailor the processes for grantmaking and providing in-kind resources to meet a wide range of grantee priorities, fuel grantees' growth and sophistication, and promote innovation. Close partnerships between KP and the community clinics field facilitate quality matching of KP grants and in-kind resources with the changing needs of clinics and clinic networks as they pursue their grant objectives and face organizational or broader context challenges or opportunities.

The Partnership provides KP, clinics and clinic networks the opportunity for mutual learning; this mutual learning makes the Partnership a "two-way street." More recently, this "two-way street" has facilitated KP's sharing of evidence-based practice with clinics and KP's modification of tools and practices based on grantee feedback. Overall, given the mix of organizations in the Partnership, there have been ongoing opportunities to teach and learn from one another about the similarities that bring Partnership organizations together (e.g., improving the quality of health care) and the differences that are beneficial (e.g., expertise with different population groups and chronic care practices).

GOING FORWARD

Factors that led to the success of the Partnership will remain important for its institutionalization and sustainability. The box below lists the key elements in the formation and formalization of the Partnership as well as in its implementation and resulting achievements and accomplishments.

Then and Now: Elements of the Partnership's Formation That Continue to Build Sustainability

- Common language for planning & collaboration
- Trust among partners
- Open dialogue
- Buy-in from partner organizations' leadership & senior staff
- Joint planning & decision making
- Long-term commitments of money, time & space
- Relationship-building for deeper understanding as well as new connections & new perspectives
- Mutual learning, peer support & collaboration
- Communication about the Partnership
- Access to & use of in-kind resources that complement grants & KP expertise

As the Partnership matures and changes, it will be important for it to regularly review its goals, strategies and intended outcomes and adjust them as needed. Given the sizable number of new individuals becoming involved in the Partnership from both the community clinics field and KP, the significant increase in KP funds for grants since 2004 and the broadening of the Partnership's work to include more safety net members, new and old members could find themselves with different expectations or mixed understandings of the Partnership's intentions. The initial joint planning process that occurred when the Partnership was formed clarified group expectations and documented key decisions; that process and documentation can serve as a guide for reflection, refinement and recommitment to the Partnership.

The Partnership needs to carefully nurture leadership succession. The Partnership's leaders and champions laid a firm foundation for the Partnership's work. Since personal connections were an important part of the groundwork and initial building blocks of the Partnership, a challenge at this stage of development is to sustain these important connections as leaders transition out of their roles. Roles for new and emerging leaders can be defined to support bringing in new talents and connections while maintaining useful connections established by their predecessors. It will be important to strike a balance between holding the history of the Partnership and honoring former relationships and collaborations while articulating new directions and priorities.

The Partnership is in a good position to expand and deepen connections between KP and the community clinics field. A systematic approach to identifying and involving key partners would help to leverage and expand the Partnership's work. One specific area of growth is to increase and deepen local KP medical center involvement with Community Benefit grantees. By increasing engagement of local KP facilities and medical groups in the Partnership—not just as resources but as active, dedicated participants—grantees could have better access to resources, local staff and facilities would be able to learn from grantees, and the infrastructure and leadership for the Partnership would be expanded and strengthened.

The Partnership should explore opportunities to leverage its influence and reach through communications with key stakeholder groups. The work of the Partnership should continue to be documented and communicated to a wide audience through a variety of mechanisms. This includes information about the purpose of the Partnership, KP's grantmaking practices (e.g., focus, timelines, etc.), and the story of the Partnership and its impact. While this could be shared through multiple mechanisms, at a minimum it should be available through the KP website and intranet and shared with key groups within KP, the community clinics field and other funders and policy makers. The Partnership should actively explore opportunities with health care organizations and networks to showcase its work and share successful practices.

CONCLUDING THOUGHTS

The success of the Partnership has provided numerous lessons to prompt reflections as decisions are made about the Partnership's future. The accomplishments of the past and the promise of the future have emerged from a model of resource sharing. This model has been characterized by a long-term commitment to a mutually beneficial approach for productive sharing and learning and a rich array of in-kind resources that complement more traditional grantmaking.

Going forward, it will be important for the Partnership to continue to embrace the key factors that led to its initial success and document and share them with new Partnership members, recipients of Partnership benefits and others with whom the Partnership collaborates. This will help to institutionalize the Partnership and the successful practices supported by KP grants and in-kind resources.

Appendices

Appendix A: Kaiser Permanente Community Clinic Partnership (KPCCP) Evaluation Advisory Committee Members, Evaluation Methods & Limitations

Appendix B: Kaiser Permanente Community Clinic Partnership (KPCCP) Statement Signatories

Kaiser Community Clinic Partnership (KPCCP) Evaluation Advisory Committee Members, Evaluation Methods & Limitations

The Kaiser Permanente Community Clinic Partnership (KPCCP) evaluation was informed by a review of secondary data, a survey of Partnership grantees and interviews with key stakeholders. Below we briefly describe each of these methods and list the members of the Evaluation Advisory Committee who provided input and reflection into this evaluation.

EVALUATION ADVISORY COMMITTEE MEMBERS

- Angela Coron – *Director of Community Benefit, KP Southern California Region*
- Lucette DeCorde – *Safety Net Group Leader, KP Community Benefit Northern California Region*
- Steve Graham – *Community Health Manager, KP Northern California Region*
- John Gressman – *President & CEO, San Francisco Community Clinic Consortium*
- Jean Merwin – *Consultant, Merwin & Associates*
- Rhonda McClinton-Brown – *Executive Director, Community Health Partnership of Santa Clara County*
- Jean Nudelman – *Director of Community Benefits, KP Northern California Region*
- Fredric Richmond – *CEO, Coalition of Orange County Community Clinics*
- Christy Rosenberg – *Director of Quality and Population Health, Council of Community Clinics*
- Cody Ruedaflores – *Project Manager, KP Community Benefit Southern California Region*
- Julie Schmittdiel – *Research Scientist, KP Division of Research*
- Mercy Siordia – *Project Manager, KP Community Benefit Southern California Region*
- Diane Strum – *Director of Government & Community Relations, KP Southern California Region*
- Judith Zitter – *Community Health Manager, KP Southern California Region*

METHODS

Secondary Data Review

BTW received background materials from the Kaiser Permanente Northern and Southern California Regional Community Benefit Programs at the launch of the evaluation in November 2006, which included grant reports, a Partnership communications plan, requests for proposals, workplans and meeting notes. BTW reviewed these materials to gain an understanding of the KPCCP and to help inform the development of the survey and interview protocols.

Grantee Survey

BTW launched an online survey to 91 Kaiser Community Benefits grantees on February 5, 2007. The survey was in the field for approximately five weeks and achieved an 81% response rate. Of the 74 organizations that responded to the grantee survey, 86% are clinics, 11% are consortia

and 3% are foundations, fiscal intermediaries or other types of organizations affiliated with the health care safety net. The grantees included in the survey met the evaluation advisory committee's criteria of having received a total grant amount of $50,000 or more during the 2002 to 2005 time period, excluding grantees that only received funding for sponsorships or conferences. The purpose of the survey was to help Kaiser better understand the degree to which their support of community clinics and consortia strengthened capacity and enhanced access to and quality of care. The survey also evaluated the grantees' level of satisfaction with the funding and support they have received from Kaiser. The evaluation advisory committee provided input into the development of the survey instrument.

Key Informant Interviews

From March through May 2007, BTW conducted 52 interviews with key stakeholders involved with the Partnership. These stakeholders identified by the evaluation advisory committee included grantees (n=23); non-grantees including CEOs from Northern Sierra Rural Health Network, Alliance for Rural Community Health and Planned Parenthood of California (n=3); Kaiser staff in the north (n=8), south (n=8) and national offices (n=2); and private and government funders (8). The evaluation advisory committee also provided input on the development of the interview protocols for both the grantees and Kaiser staff.

Please contact BTW informing change at (510) 665-6100, if you would like a copy of the survey instrument or interview protocols.

Evlauation Limitations

BTW used a combination of data collection methods to ensure that the findings did not rest upon one source. However, when reviewing these findings it is important to note some limitations. First, the data collected for this evaluation is self-reported by those who were surveyed and interviewed. Second, the grantees received different levels and types of support and are in various stages of completing their grant projects.[1] Third, this evaluation focused on the time period of 2002 through 2005; however, it is not always clear the degree to which grantees reported only on this time period in their responses.[2] Fourth, it is not always clear the degree to which grantees distinguished Partnership support from other Kaiser support or other funding sources. Fifth, we did not collect information from all individuals who received Partnership support or who were involved in the Partnership; as a result, caution is warranted in generalizing findings to other consortia or clinics that did not participate in the evaluation.[3]

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[1] When considering the implementation and impact of Partnership support during the 2002 to 2005 period, this evaluation uses a broad definition of support including grant funding, technical assistance and in-kind resources.

[2] Although this report may include some outcomes or insights that have been realized in 2006 or 2007, the evaluators have included such findings only if they appear to have resulted from the support of the Partnership during the 2002 to 2005 period.

[3] At a later date, the Partnership expects to sponsor an evaluation of its grantmaking from 2006 onward. In the second phase evaluation, the Partnership intends to address its relationship with public hospitals; however, this report does not include data about the Partnership's grants to public hospitals from 2002 to 2005.

Kaiser Permanente Community Clinic Partnership (KPCCP) Statement Signatories

- Alameda Health Consortium
- California Family Health Council
- California Primary Care Association
- Central Valley Health Network
- Coalition of Orange County Community Clinics
- Community Clinic Association of LA County
- Community Clinic Consortium (Contra Costa County)
- Community Health Partnership of Santa Clara
- Council of Community Clinics
- Kaiser Foundation Health Plan & Kaiser Foundation Hospitals, Northern and Southern California Region
- Planned Parenthood Affiliates of California
- Redwood Community Health Coalition
- San Francisco Community Clinic Consortium
- Southern California Permanente Medical Group
- The Permanente Medical Group, Inc.