BTW INFORMING CHANGE

MARCH 2011

Building Capacity to Promote Community Health

The Experience to Date of the Community Clinics Initiative's Networking for Community Health Program

PREPARED FOR:

Community Clinics Initiative
A joint project of The California Endowment and Tides

PREPARED BY:

Kim Ammann Howard
Regina Sheridan
Kris Helé
Tina Cheplick

Community Clinics Initiative
Strong Clinics, Healthy Communities

P.O. Box 29907
San Francisco, CA 94129-0903

(415) 561-7817
www.communityclinics.org

March 2011

Dear Colleague:

We are pleased to share with you an independent evaluation of our Networking for Community Health (NCH) program. The NCH program grew out of a planning process that engaged a number of long-time leaders in the community clinics field to think about the future of community clinics. The result was a program founded on the understanding that high quality, culturally competent health care services alone would not be sufficient to improve community health in traditionally underserved neighborhoods. Community clinic staff and partners need to work outside of their own four walls, beyond traditional boundaries, to build broad community partnerships to achieve the goal of improved community health.

The NCH program was designed to support clinics to expand and strengthen their working relationships with both traditional and non-traditional partners. Since 2008, the NCH program has supported projects across California working on a wide variety of issues, including improving access to nutritious food, engaging youth and coordinating health services, to name just a few.

This evaluation brief outlines the conceptual framework of the NCH program, presents initial evaluation findings from the first two program years and offers practical suggestions for funders and others interested in using partnerships to improve the health of their communities.

As you read the brief, we encourage you to think with us about the importance of capacity building both at an organizational level as well as the community and network levels. We also encourage you to consider the critical role that relationship building plays in our work to address persistent health issues.

Thank you,

Jane Stafford
Managing Director
Community Clinics Initiative

In a rapidly evolving health care landscape, how can California's community clinics leverage their strengths as health care providers to position themselves as leaders for community health?

INTRODUCTION

In 2007, a multi-sector group representing community clinics, health care agencies and community organizations came together for a series of conversations to address the above question posed by the Community Clinics Initiative (CCI), a joint project of Tides and The California Endowment ✉. CCI initiated these conversations to discuss the long-term future of California's clinics and to shape the vision for the next CCI funding initiative. Given clinics' expertise in providing clinical care and their long-standing connections to the communities they serve, the group particularly wanted to explore the potential leadership roles for clinics in addressing community-wide health issues.

Throughout this report, the envelope icon ✉ indicates that online readers can link to more information, stories, resources or learnings related to NCH projects.

Taking into account the changing demographics of California's population and movement toward health care reform, the group discussed how traditional models of care alone could not create and sustain healthy communities.[1] The group envisioned a program that would support deeper and more focused connections among clinics and other community organizations to share resources, services, information and data.

Out of these future-oriented discussions, CCI developed a grantmaking program to explore how clinics' connections with other community organizations could propel a new concept—centers for community health—and develop a greater capacity to serve the health needs of California's underserved populations ✉.[2] While CCI wanted to support a grantmaking program that addressed the future needs of clinics, it also wanted to build on previous CCI grantmaking efforts that had focused on enhancing clinics' capacity in a variety of areas, including information technology, capital projects and clinic leadership ✉. In 2008, CCI launched its Networking for Community Health (NCH) program with the first cohort of 26 grantees, followed by a second cohort of 32 grantees in 2010.[3]

"We believe that clinics are uniquely positioned to provide more than just a medical home for their patients. They represent an important voice for social justice for the underserved within the health care world."

–CCI staff

This evaluation brief is a summary of the launch of CCI's NCH program. It examines the ways in which the NCH program enhances the capacity of clinics and their partners to improve community health. Given the dynamic nature of the NCH program and the variety of projects, the evaluation focuses on identifying key process learnings and outcomes. In this brief, we outline the conceptual framework of the NCH program, present evaluation findings and offer practical suggestions for

1 In 2007, the future of federal health care reform was still being discussed.

2 See page 2 for description of "center for community health."

3 The term "project staff" refers to staff at clinics and/or partner organizations. The term "clinic staff," refers specifically to people working at clinics.

other funders and communities interested in pursuing a similar approach to improve community health.[4]

WHAT IS A CENTER FOR COMMUNITY HEALTH?

"The center for community health will provide a model of high quality care that also fulfills its mission of creating a healthier community by lifting up the collective voice of its constituents and building local power."
–CCI staff

CCI's concept for a center for community health builds on the strengths of clinics (e.g., commitment to the underserved, focus on culturally competent care), but expects that they will expand beyond their four walls and partner with others to tackle pressing community needs. As described below, CCI identified certain elements that characterize a center for community health; the extent to which clinics already reflected these characteristics at the start of their NCH grant varied greatly.

A true center for community health reaches beyond individually-based care or medical interventions and moves to a more population-based approach to care. This involves the medical field expanding its traditional view of health to a more holistic view that takes into account physical, mental, social and environmental determinants (e.g., availability of safe public spaces, housing conditions, access to nutritious food). To this end, centers for community health offer coordinated or integrated services, both medical and non-medical. CCI also envisions a role for centers for community health in empowering community residents, by providing opportunities and support for them to advocate for the health of the communities in which they live.

Although CCI's grantmaking has traditionally focused on clinics, its vision of a center for community health does not require a clinic to be at the center. Rather, the vision demands a network of partnering organizations, one of which is a clinic. CCI realizes that the partnership structure will differ based on each individual community's needs and resources, and that a particular facility may or may not serve as the partnership's physical "center" ✉. Regardless of whether a clinic serves as a physical center, CCI believes that in these partnerships, clinics should function as significant "hubs" or "connectors" to resources on behalf of their community. In CCI's vision of a center for community health, clinics are key players with a leadership role in the development and maintenance of their networks.

[4] BTW *informing change* collected data from April 2009 through August 2010 to inform this evaluation. Key findings and learnings in this brief are based on 26 key informant interviews with clinic staff; a survey which was administered at a mid-point in the program, and then updated at the end of the program (the final survey was completed by 92% of the clinics and 75% of their core partners); observations at three meetings of the NCH learning community; two telephone focus groups concentrating on projects that engage community health promoters; and a review of materials including clinics' proposals, interim grant reports and final grant reports. The data presented in this brief are self-reported based on respondents' knowledge and perceptions of their NCH project; this evaluation did not collect standardized data to measure community impacts across projects.

WHY ARE NETWORKS AND PARTNERSHIPS IMPORTANT IN AN EVOLVING HEALTH CARE FIELD?

Over the past few years, California's health care safety net has faced increasingly complex challenges, including rising rates of chronic conditions, overuse of emergency departments and growing health care costs. While these issues are challenging for clinics trying to serve their communities, they also present opportunities to reconsider traditional models of care and examine new approaches for delivering cost efficient and high quality health services. One approach that is becoming more prevalent in the health field is moving toward a new model of care that requires partnerships among multiple organizations.

The recent passage of federal health care reform legislation has further motivated health care providers to pursue coordinated systems of care ✉.[5] The legislation promotes the creation of coordinated provider groups that deliver patient-centered care and utilize data and technology to improve health outcomes and reduce costs. This model to improve care is not new; health care leaders have discussed this concept for years, resulting in various definitions and terminology, including "patient-centered medical homes" and "health homes." While each term comprises slightly different elements, the overall intention is the same—to improve health care delivery and outcomes through the coordination, integration and availability of care.

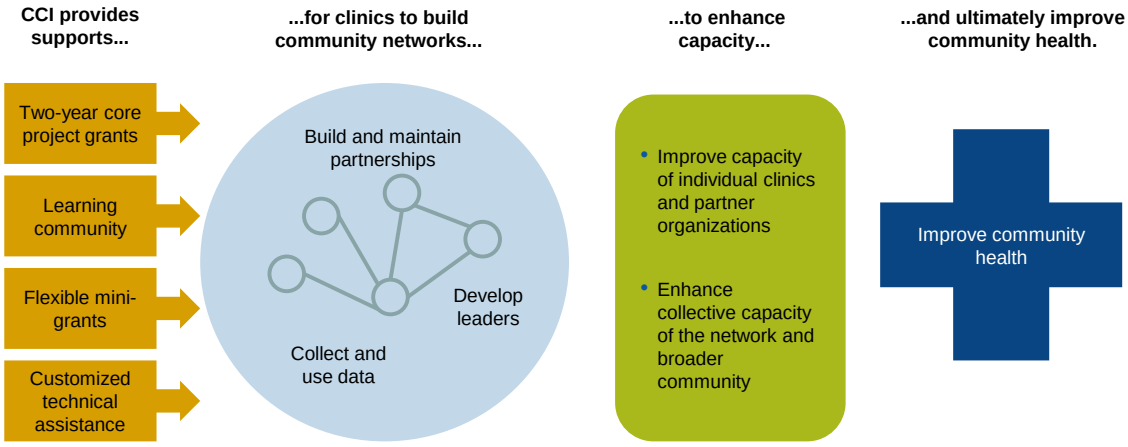
As clinics evolve toward this model, they will need to create and maintain networks with other providers, hospitals and service organizations to coordinate comprehensive and continuous care for their patients, while also addressing external factors that affect patients' health, such as environmental pollution or poor access to nutritious food. Also, as clinics increase their focus on prevention to combat chronic diseases, they will need to work with community members and agencies to identify health priorities, broaden their preventive strategies and conduct patient follow-ups in a customized way for their specific communities.

CCI'S NETWORKING FOR COMMUNITY HEALTH PROGRAM

To take on key leadership roles in community networks and emerge as true centers for community health, CCI understood that clinics needed a variety of supports, both monetary and non-monetary. CCI purposefully designed a flexible program structure to support clinics' creativity and to learn from a variety of partnership structures. Exhibit 1 and the text on the next page describe CCI's support for the first NCH cohort and their expectations for the NCH program.

[5] Federal health care reform legislation refers to the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act amendment.

Exhibit 1
Networking for Community Health Program Description



In the first cohort, CCI provided a range of supports to clinics and their project partners to build and maintain networks, develop leaders and utilize data to guide and promote the work of the network, including:

- **Two-year core grants.** The first cohort of 26 clinics received an average grant of $180,000 (range: $80,000 to $200,000) for projects implemented between July 2008 and June 2010.
- **Learning community.** Clinics and core partners participated in a learning community that met three times, providing opportunities to network; discuss project learnings and challenges with their peers, technical assistance consultants and CCI staff; and receive input and guidance on their projects.
- **Technical assistance.** Throughout the project, CCI assessed clinics and partners' needs for assistance. Based on these assessments, CCI decided to offer technical assistance in individual and group settings in the areas of network management, media advocacy, data tracking and evaluation.
- **Flexible mini-grants.** About half (54%) of clinics received a CCI mini-grant of up to $2,000 to address unanticipated project needs such as training and conference fees, transportation costs for community residents and funds to hire facilitators or consultants for specific NCH project needs.

CCI considers the first NCH cohort to be a pilot round and a "down-payment" investment to move clinics toward a model of care that will be most successful in the emerging health care landscape. Almost three-quarters of grantees received cohort two NCH grants in 2010 and are continuing to work on their community health projects. As a result of building these networks and implementing collaborative health projects, CCI expects clinics and partners to enhance their capacity—at both the organizational and collective levels—to improve community health.

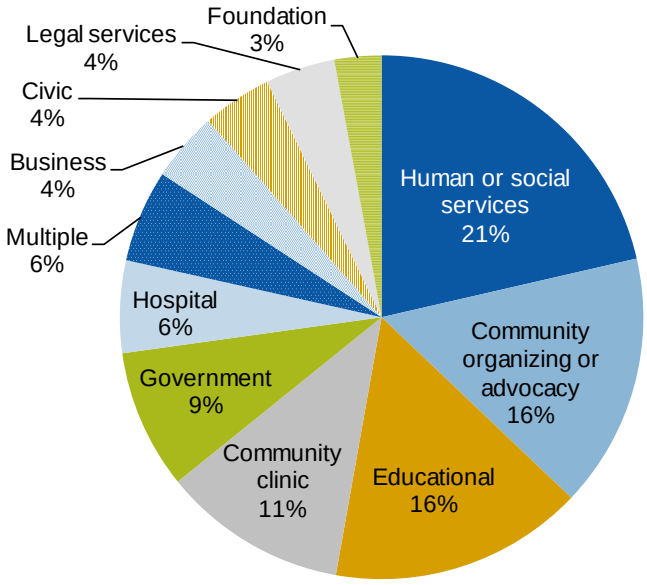
NCH PROJECTS & PARTNERS

All NCH projects build or strengthen clinics' partnerships with other community organizations. However, other than that common feature, the projects vary in terms of their types of partners, focus areas, project strategies and communities.

Partner Organizations

As required for grant funding, all NCH-funded clinics have formed or strengthened partnerships with other organizations to further their project goals. Clinics are working with a wide range of organizations, including allies in the health care safety net (e.g., other clinics, public hospitals) and community-based partners or agencies (e.g., human or social service providers, community organizing agencies, school districts, universities) (Exhibit 2). While clinics usually serve as the experts in providing clinical care, partners bring complementary strengths, including access to community groups and other project resources.

Exhibit 2
Types of Partner Organizations



Most clinics build on both existing and new relationships with partner organizations when they launch their projects. They typically have a few core partners that are integral to the projects' planning and/or implementation, with additional partners in more peripheral roles (e.g., conduct one-time trainings, provide venues for workshops, provide expertise at specific points in the project). Most clinics share some portion of their NCH funds with core partners; however, the amount that each core partner receives ranges widely (from $1,000 to $170,000) with an average allocation of $42,548 per core partner. Exhibit 3 lists project staff's key lessons learned about designing and implementing networks with partner organizations.

Exhibit 3
Clinics' & Partners' Key Lessons Learned About Designing or Implementing Networks to Improve Community Health

- Set expectations and create a work plan that can be revisited throughout the course of the project.
- Assess each potential partner's capacity.
- Be clear about decision-making processes and ensure that each core partner has a voice at the table.
- Clearly communicate with partners throughout the project.
- Distribute funds to match the expectations and efforts of each partner organization.
- Recognize when the network needs external assistance; however, ensure that it contributes to greater network capacity.
- Remember that networks are dynamic, not static. ✉

Focus Areas

CCI encourages NCH-funded clinics to focus on key health needs in the communities they serve. As a result, clinics' projects address a wide range of issues. Most grant projects ultimately aim to achieve one or more of the following four types of community health improvements:

- **Increased opportunities to engage in healthy activities.** Projects focus on empowering residents and providing them with opportunities to engage in healthy activities (e.g., eating nutritious food, providing safe spaces to exercise) that can help prevent chronic conditions.
- **Improved access to health homes and coordinated systems of health service delivery.** Projects focus on making referrals and coordinating services across agencies (e.g., primary care, behavioral health, social services) to provide patients with an organized system of care that is responsive to their various needs.
- **Higher quality care, services and resources.** Projects focus on increasing the availability and quality of care and services, often for specific populations (e.g., homeless, transgender, farmworker populations).
- **Increased advocacy for physical, social and economic environments that support health.** Projects focus on training and empowering residents to advocate for change related to substandard policies or environments in their community (e.g., poor housing, prolonged pesticide exposure, ocean contaminants).

Project Strategies

Together, clinics and partners determine specific strategies to address their particular community issues and needs. Exhibit 4 shows that a wide range of strategies are employed across projects; in almost every case, projects employ multiple strategies and tactics. For example, one project offers a community garden in tandem with healthy cooking classes; another project provides residents with skill building trainings (e.g., in communications, the legislative process, media relations), prior to launching advocacy activities.

Exhibit 4

Types of NCH Projects Strategies & Tactics

Strategy	Tactics
Partner	• Establish and/or strengthen partnerships with other agencies and individuals • Develop a shared vision and determine project goals • Create project work plans
Assess	• Conduct community health needs assessments • Collect and analyze data
Provide	• Establish community gardens or farmers markets • Provide health care services and education • Develop new resources (e.g., service directory, emergency plan)
Empower	• Provide skill building trainings • Establish project advisory committees • Engage residents in the project (e.g., community researchers, health promoters, gardeners)
Advocate	• Hold town hall meetings, press conferences or rallies • Engage in media advocacy campaigns • Conduct policy advocacy activities
Coordinate	• Make and accept referrals to/from other agencies • Connect individuals to primary care clinics • Share data with other organizations

Communities

NCH-funded clinics are located throughout the state of California with the largest proportion located in Los Angeles, Alameda and San Diego Counties ✉. NCH projects are most commonly working to make changes at a neighborhood or city level; however, some are focusing on a broader county, regional or state level. While NCH projects generally serve a variety of population groups, some focus their efforts on certain groups: 55% of projects focus on immigrants and/or refugees; 41% focus on populations with a specific health condition (e.g., diabetes, obesity, Hepatitis C) and 40% focus on a specific racial or ethnic group, most frequently Hispanics/Latinos.

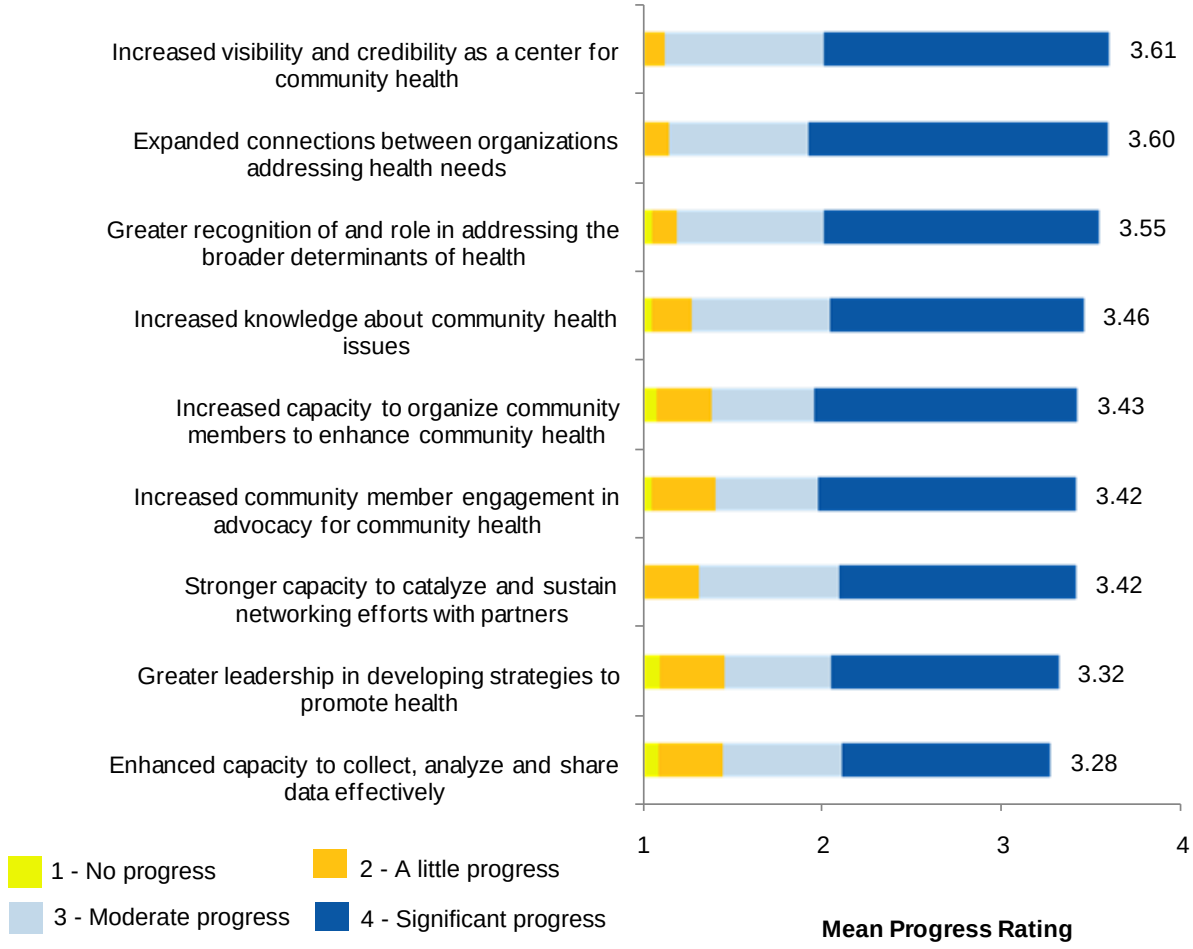
ENHANCING CAPACITY TO IMPROVE COMMUNITY HEALTH

The implementation of NCH projects enhances capacity in two key ways. First, clinics and partners strengthen their organizations' capacity in areas related to community health promotion. Second, communities' collective capacity grows as clinics and partners increase their ability to function as a group with a common vision and as community members work in tandem with clinics and partners collectively improve their abilities (e.g., gaining new knowledge, learning skills, sharing leadership responsibilities) to improve community health.

Overall, clinics and partners report progress toward enhancing their own and the communities' collective capacity. Exhibit 5 shows the extent to which clinics and their partners report improvements in a variety of capacity areas. As described earlier, it is important to note that projects vary widely in terms of partners, focus areas, strategies and communities served. Additionally, projects have different starting points. Some projects have already established partnerships or are continuing projects, while others launch new projects and partnerships when they receive the NCH grant. While each project did not necessarily address or focus on each capacity area listed in Exhibit 5, these findings illustrate how capacity is being enhanced, at an organizational and a collective level, throughout the overall NCH cohort.

Exhibit 5

Clinics and Partners' Mean Ratings of Progress Towards Capacity[6]



[6] If an impact area was not an intended goal of the NCH project, survey respondents were not asked to report on its progress. The number of clinic and partner respondents for each variable ranges from 73 to 78. Only NCH-funded clinics, not core partners, were asked to report on the impact of the NCH grant on their "visibility and credibility as a center for community health." As a result, there are 23 clinic respondents for this variable.

Organizational Capacity

Project staff are increasing their capacity to create and nurture a network of partners. Clinics and partners note that project staff develop competencies in forming, managing and maintaining partnerships. While the network of partners is key to making progress in their NCH projects, most project staff acknowledge the challenges of working across organizations, including the time and labor needed to ensure healthy and productive partnerships. For example, they note that getting initial involvement of certain organizations (e.g., local government, schools) is challenging; however, when successful, this is considered a great achievement. Exhibit 6 also shows key characteristics of a strong network of partners. Overall, project staff from clinics and partner organizations report that their partnerships exhibit elements of a strong network.[7]

Exhibit 6
Key Elements of a Strong Network of Partners

- Organizational vision aligns with project vision.
- Project is guided by effective leaders.
- Project has clearly defined goals and objectives.
- Leaders at each partner organization express commitment to the project.
- Partners freely share project information with all partners.
- Partners trust each other.
- Partners have an appropriate combination of resources for project implementation.
- Each partner is accountable for their contribution to the project.
- An agreed upon decision-making process exists.
- Partners address barriers in a timely and constructive way.
- Partners share decision making.
- Each partner's areas of responsibility are clear and understood.
- Project has a plan for sustainability.

[7] Between 72 to 79 project staff from clinic and partner organizations responded about their level of agreement for each element of a strong network. While there is a range in individual responses (1.00 to 4.00), overall project staff positively rated their networks' strength.

"Our project offered a vehicle for the community to personally air their health concerns and help us identify their needs."

–Project staff

Project staff are enhancing their ability to collect and use data effectively. A distinguishing factor of this grant portfolio is the key role that data play in most NCH projects. Data-related activities range from conducting needs assessments to mapping healthy food outlets to developing shared databases with partner agencies. By collecting and using data, project staff develop a better understanding of their communities' health needs. They can more effectively design, implement and assess their projects' impacts and obtain more compelling information to use in their advocacy and education efforts. For example, St. John's Well Child and Family Center's project is expanding upon their pre-existing project to create a shared data system with their partners to help them identify, address and track health issues (e.g., asthma, elevated lead levels) related to substandard housing conditions; this project ultimately plans to lead a community organizing campaign to target large-scale slumlords in Los Angeles ✉. NCH clinics that have collected data through their projects are also sharing, or planning to share, the data and learnings with others in hopes that they will utilize the information for their own work and mobilize the community toward action. For example, projects share data with city departments, schools and other organizations to prompt them to address specific health conditions, implement environmental clean-up activities and plan for emergencies. When faced with challenges or experiencing successes during their projects, staff identify key lessons learned for effectively collecting and utilizing data (Exhibit 7).

Exhibit 7
Clinics' & Partners' Key Lessons Learned About Collecting or Utilizing Data

- Conduct research or a community needs assessment prior to launching the project.
- Before collecting any data, clarify the purpose and plans for collecting and using the data.
- Consider the culture, age, literacy and skill levels of the community when collecting and utilizing data.
- Plan appropriately for pilot testing data systems and processes. ✉

"The project has had a big impact on our clinic as a whole. Our staff can get out of their usual routine of seeing patients in a clinic setting. Even though the work is not happening under the roof of our clinic, this project helps us to connect to our mission."

–Project staff

While developing and implementing community-wide health strategies, project staff are enhancing their knowledge and leadership abilities. NCH projects provide opportunities for staff to develop knowledge, skills and expertise that further enhance their ability to lead projects, collaborate with others and mobilize community members. For example, project staff enhance their knowledge about multiple determinants of health and develop skills such as facilitating networks, managing multiple partners and giving presentations to elected officials. As one project staff member reflects, "through this project, we have developed the skills and leadership of the project staff. Our program administrator's leadership has grown enormously."

Clinic staff are more connected to their organization's mission. While this was not an overt goal of the NCH program, it has surfaced as an important one. Clinics describe how their NCH project has helped them reconnect to the grassroots mission of their clinic—improving the community's health. By conducting community outreach beyond their patient population, they build connections, support and trust with the broader community and increase their ability to engage residents in various community health issues and activities. Clinic staff are reinvigorated by these projects, calling them a "shot of energy in the arm."

Clinics are gaining greater visibility and credibility in their communities. NCH projects increase the visibility of clinics in the community through a variety of public activities and events, such as community health forums, town hall meetings, farmers markets and media campaigns. For example, numerous projects, including the one led by Winters Healthcare Foundation, have been featured in news reports or articles ✉. In many cases, clinic staff are being invited to take part in opportunities outside of the clinic as a result of the enhanced community presence and credibility developed through their NCH projects. For example, clinic staff report that they have joined government advisory groups, been invited to take part in expert forums (e.g., an environmental health forum, Filipino health summit) and participated on community coalitions dedicated to advocacy or policy change.

"The NCH project gave our clinic the opportunity to really shine in the community. We are now seen not just as a medical center, but as a center for community health."
–Project staff

Collective Capacity

Expanded connections among organizations are enhancing the community's collective capacity to address health issues. Some NCH-funded clinics built their network with uncommon partners to address community health issues. For example, Planned Parenthood Mar Monte formed a collaborative with farmworkers, labor organizations and agricultural businesses—partners that often have opposing priorities—to hold discussions and create an action plan to address pesticide-related illnesses among farmworkers. In another example, LifeLong Medical Care engaged in a project with a community-based organization and a private health care provider to increase access to care; other health care providers are very interested in the viability of this uncommon alliance. In most cases, the networks created through NCH projects have helped organizations come together around a common issue in a more cohesive and goal-oriented way than they had prior to the grant. Operating as a network, partners have been able to leverage one another's skills, expertise and resources to more effectively work toward improvements in community health.

"The NCH project has encouraged our organization to establish collaborative relationships that we otherwise wouldn't have pursued; these have significantly changed the culture of our organization, our approach to working with others and the nature of the work we are doing."
–Project staff

Involving community residents as project implementers, as well as project beneficiaries is enhancing the collective capacity of the community. The degree to which community residents are involved in projects is a unique aspect of the NCH program, as compared to typical clinic grants, and has resulted in key lessons learned about engaging community residents in health projects (Exhibit 8 on the next page). Community residents are involved in NCH projects in a variety of ways, including being part of community advisory boards that give input into the development and implementation of the project and playing key roles in participatory action research such as the creation and administration of community surveys or needs assessments. Many projects also engage residents as community health promoters, which is a particularly effective strategy for community health projects ✉. As residents, they are recruited and trained to apply their knowledge of the community and use their personal connections to advance health messages among their peers, engage residents in project activities and feed valuable information about community health needs back to the project staff. Many projects also provide focused trainings and workshops to develop community residents' skills (e.g., communication and presentation skills, policy advocacy, data collection and analysis) to enhance their ability to advocate for community change. Through NCH project activities like these, residents enhance their leadership abilities while providing valuable assistance to the project.

Exhibit 8
Clinics' & Partners' Key Lessons Learned About Engaging Community Members in Projects

- Identify community members who have a history of engagement and leadership in the community.
- Gather community input at the beginning of the project, but remain open to continuous feedback.
- Provide opportunities for community members to lead project activities.
- Be mindful of various barriers that prevent community members from actively engaging in the project.
- Pay attention to the marketing, branding and communication of project activities to community members or stakeholders.

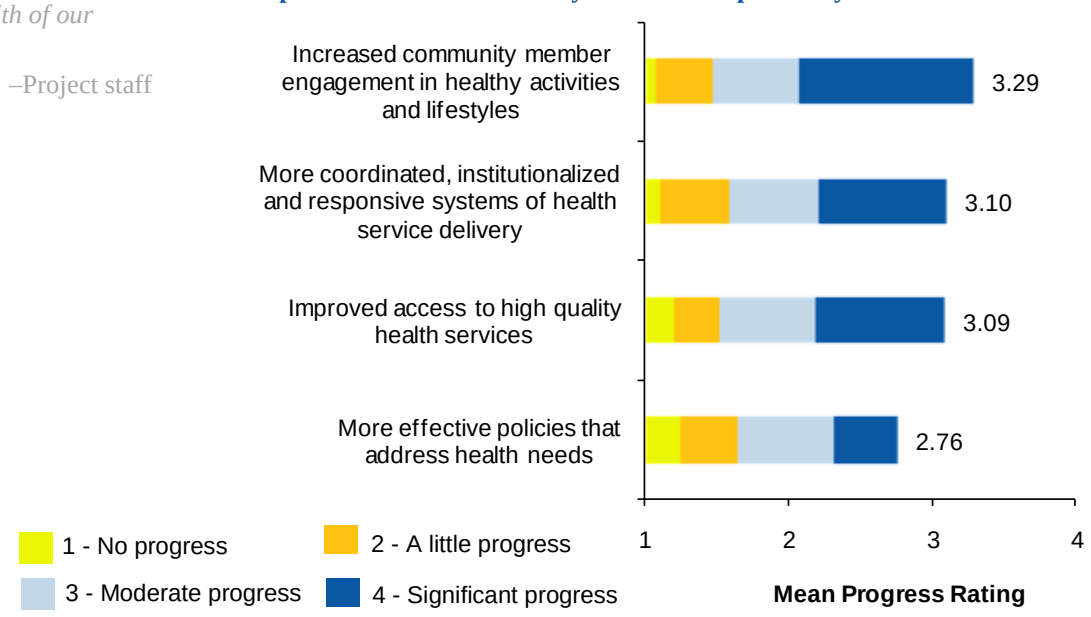
PROGRESS TOWARD IMPROVING COMMUNITY HEALTH

In most cases, NCH projects are laying the groundwork for further improvements in the health of their communities. As anticipated, much of the first two years of the NCH program focused on capacity building in the areas described above. To different extents, NCH projects are making progress toward broader community health improvements, as shown in Exhibit 9 and described in the following pages.

"This project has helped capture collective community energy to change policies that might detrimentally impact the health of our community."

–Project staff

Exhibit 9
Improvements in Community Health as Reported by Clinics and Their Partners[8]



[8] If an impact area was not an intended goal of NCH projects, clinic and partner survey respondents were not asked to report on its progress. The number of respondents for each variable ranges from 53 to 68.

Community residents are beginning to engage in healthier activities. Personal practices and behavior changes are some of the most difficult outcomes to achieve for any health project. Even when information and infrastructure are available, many individuals have difficulties altering familiar and long-held habits. Some NCH projects are developing strategies to address poor community conditions that hinder residents from engaging in healthy activities, such as a lack of access to healthy food and safe outdoor spaces. In tandem with these strategies, projects usually provide health education, such as nutrition classes or cooking demonstrations, to further encourage healthy behavior. For example, Community Health Clinic Ole's project is working to improve residents' health status by developing a community garden to improve access to healthy food, providing nutrition education and prompting residents to participate in group exercise classes ✉. Clinics report that these project activities, especially those implemented in a group setting, help build participants' sense of empowerment and interest in broader community change as they work on personal health improvements. Community members participating in these project activities receive messages about health promotion and prevention that complement information that they receive from other sources (e.g., their doctors), providing multiple inputs to support their positive behavior change.

"Residents initially come to our project's walking group feeling isolated. However, once they become a part of the group, they develop a strong support network for change. They leave feeling empowered to take control of their own health and the health of their family members."

–Project staff

More coordinated and responsive systems of health service delivery are being developed to increase access to care and services. Some NCH projects are working to coordinate care or services among project partners. While the types of care and services they are coordinating vary, most are working toward creating a central point where patients or community residents can access or learn about a range of services and/or resources. For example, Venice Family Clinic's project is collaborating with two hospitals and a social service agency to establish a referral system for homeless patients to receive respite care. As homeless clients are discharged from hospital emergency rooms, the project connects them to primary care at the clinic, as well as temporary or permanent housing and social services through a homeless social services agency ✉.

The quality of health care services is improving, especially of those focused on prevention. Some projects use their network of partners to focus on improving the quality of care for underserved populations. These projects train clinicians in preventive measures related to environmental or social issues (e.g., recognizing pollution- or pesticide-related illnesses during patients' regular exams, providing competent care to transgender people, delivering comprehensive Hepatitis C monitoring and treatment). They also, as mentioned earlier in this brief, engage community health promoters to deliver culturally and linguistically appropriate health messages and services to hard-to-reach populations. For example, Santa Cruz Women's Health Center's project is working in collaboration with two family resource centers to recruit, train and engage community health workers to hold individual and group sessions on a variety of health topics (e.g., blood sugar testing, substance abuse, nutrition).

"For advocacy work to be successful, whatever you do, it must be connected to how people are living every day. It has to be connected to their reality."

–Project staff

Projects are leveraging community residents' enhanced skills and mobilizing them to advocate for changes in policies and practices. Projects are building on the new knowledge and leadership abilities of community residents and mobilizing them to take action about their health concerns. These residents attend rallies and town hall meetings, testify at city council meetings, collect petition signatures, register

people to vote, participate in letter writing campaigns to policymakers and get involved in local policy groups. While NCH projects are at different stages of pursuing their advocacy agendas, a few have already experienced tangible successes. For example, Golden Valley Health Centers' project collected almost 1,000 signatures from residents to successfully advocate for city improvements to a dangerous intersection.

CONSIDERATIONS FOR SUPPORTING NETWORKS

The evaluation of the first cohort of NCH clinics has generated important lessons for funders who support multi-organizational community health projects. The section below offers considerations for funders or others who design and support grantmaking efforts intended to enhance capacity to improve community health. We draw on examples from the NCH program's first two years.

Approach to Capacity Building

View capacity building as more than a means to an end. While CCI had an implicit focus on capacity building during the initial program planning, this became a more explicit and important outcome as the program evolved. In many community health improvement initiatives, the focus is on project activities and their impacts, with minimal attention given to assessing capacity improvements among staff, within organizations and in the community. In addition, capacity building grants are rare for many grantmaking programs, and when they do exist, they are typically separate from programmatic grants. The result creates artificial boundaries that do not mirror the day-to-day work in clinics or other nonprofit organizations.

Expect community capacity building to take time and be aware that there will be different trajectories across projects. The process of building capacity to improve community health usually precedes health impacts, and the broader the project's scope of desired change, the longer it usually takes (e.g., empowering a large group of residents usually takes more time than empowering a dozen community health promoters). As CCI was reminded during the NCH program, it is important for both funders and grantees to hold realistic expectations about the timeline to build networks for community health, especially allowing adequate time to establish and cement relationships.

Capacity Design Elements

Look for multiple ways to weave capacity building into projects. When supporting multi-organizational community health projects, it is important to proactively think of ways to spread capacity building efforts to all of those involved and "touched" by the project. Opportunities to enhance capacity can take place in a variety of ways across key project strategies (e.g., leadership, data, partnerships) and audiences (e.g., project staff, clinic and partner organizations, the network, broader community). During the first cohort of NCH, CCI encouraged cross-project sharing activities, such as written or visual documentation about the cohort and group discussions. This type of "weaving" and other activities (e.g., "train the trainer" approach) are especially important given inevitable turnover among project staff and partners and the large number of individuals and groups involved in projects as both recipients and implementers.

Assess capacity needs throughout the project. It is important in any grantmaking program to solicit input from grantees about their challenges and technical assistance needs. In the first cohort of the NCH program, CCI looked to clinics and partners to determine what types of support or training will be most helpful for their projects. Clinics were asked about their capacity needs in a variety of ways, such as surveys, informal feedback and reports on challenges during the grant. CCI also monitored the cohort as a whole to identify supports that clinics and partners may not be aware that they needed. For example, CCI wanted clinics and partners to view their projects from a broader "prevention lens" as opposed to implementing narrowly defined activities focused on existing health problems. To support this shift, CCI is providing the second NCH cohort with trainings and resources about prevention.

Provide a variety of supports to address a range of capacity needs. In many grant programs, the extent to which grantees can implement different program strategies varies greatly. It can be challenging for funders to assess needs and provide adequate support, especially when grantees' projects are diverse in focus and context. CCI realized that a "one-size-fits-all" approach to support was not appropriate for the diverse NCH cohort. Therefore, CCI experimented with a range of technical assistance approaches that built on grantees' existing expertise, leveraged resources and learning that took place among grantees, and provided external experts to address needs that could not be met within the cohort of NCH grantees.

- **Baseline technical assistance for all grantees.** CCI brought experts to a learning community meeting to provide an introduction to forming partnerships and supported an introductory media advocacy training; all NCH-funded clinics and partners were eligible to participate.
- **In-depth technical assistance to select grantees.** CCI offered a selection of clinics supplemental assistance on an as-needed basis. For example, interested clinics were invited to attend a more advanced training module that built on the introductory media advocacy training. Also, CCI pilot tested a technical assistance model to assist a limited number of clinics with project evaluation, and then developed a more formal technical assistance process that is being implemented in the second cohort.
- **Practical tools and resources.** Clinics and partners received a variety of resources and tools to assist them with their projects. For example, to help form and manage their network partnerships, clinics received a book that provides guidance for launching network, *Networks that Work*, and an assessment tool, The *Network Health Scorecard* ✉.[9] Clinics and partners also received guides and exercises related to media advocacy.

[9] Vandeventer, P. and Mandell, M. (2007). *Networks that Work*. Community Partners.

Accounting for Change

Balance room for project creativity with specific grant requirements. While CCI allowed first cohort NCH grantees room to be creative in their approach to their projects, it became evident that certain requirements could push or assist grantees in clarifying and reaching their project goals. It is important for funders to balance this need for flexibility in grantmaking programs with a set of clear requirements that can benefit both the grantees and the funder. For example, CCI found that it was helpful to require grantees to:

- **Share funding across partners.** During the first NCH cohort, CCI realized the importance of having grantees distribute some portion of grant funds to their partners to increase and/or retain their investment in the project. The ideal distribution of funds took into account the contributions of each partner as well as the structure of the network.
- **Submit a work plan.** In the second NCH cohort, CCI found it helpful to require a more detailed work plan with measurable project objectives once grantees and their partners were a few months past their project launch. The timing of this request allowed for work plans that better reflected realistic expectations and provided clarity about each partner's roles and responsibilities. The work plans also pushed grantees to think about what data to collect, which was particularly helpful given the substantial use of data in the NCH projects for various purposes (e.g., planning, advocacy, evaluation).

Reserve a portion of program funds to provide small, flexible grants that can address unanticipated project needs. Establishing a strong network of community partners can be a difficult process; many NCH projects faced expected and unexpected challenges. Since this type of work is dynamic and evolutionary, CCI set aside a small reserve of funds to assist grantees with discrete aspects of their projects. For example, CCI provided resources to grantees to hire a consultant to conduct data analysis trainings, send community health promoters to a conference and hold a strategic planning retreat with partner organizations.

After an initial pilot phase, assess if grantmaking strategies need to be adjusted or more narrowly focused. At the launch of the first NCH cohort, CCI provided broad guidelines in their request for proposals to see what types of projects would be submitted. This pilot phase of the program was beneficial for CCI to get a better sense of "the state of the field," understand the types of projects that are most needed in target communities and promote creativity among grantees. However, after this initial phase, it was helpful to determine specific areas for desired change, such as increasing access to healthy food. More tightly focused grantmaking initiatives have advantages, such as promoting greater clarity among grantees about the intentions of the program, making it easier to deliver targeted technical assistance and organize groups for peer learning and support, and using similar measures to assess impact across the cohort.

MOVING FORWARD

At the end of the two-year grant program, NCH-funded clinics and partners were well positioned to build on their program experience. Almost all clinics applied for the second round of NCH funding, with CCI re-granting almost three-quarters of the projects for an additional two years.[10] These projects are currently strengthening their clinics' relationships with partners, expanding their networks to involve additional organizations, increasing the community engagement and community organizing components of their work, and making further progress on improving health outcomes. A few clinics have expanded or shifted their project focus to new populations or geographic areas. As NCH-funded projects continue to move forward, it will be important to continue assessing and addressing project processes and progress, as well as the opportunities and challenges that impact their success. While the addition of new NCH-funded clinics to the second cohort will provide an opportunity to expand cross-project learning, support and collaboration, it may also necessitate the adjustment of project expectations and CCI's supports.

The NCH program's focus on strengthening networks and enhancing capacity positions clinics and partners to improve community health beyond the life of the grants. Most importantly, clinics have formed or strengthened relationships with others in their community, which they can leverage in the coming years as various aspects of the Affordable Care Act are implemented and clinics continue to move toward networked models of health care delivery. As the NCH program moves forward with its second cohort, it will be important to continue identifying lessons learned and sharing them with NCH grantees as well as other funders and organizations that are supporting or pursuing similar efforts.

[10] CCI selected an additional 13 clinics to fund that were not part of the first cohort for a total of 32 grantees in the second cohort.

2550 Ninth Street, Suite 113
Berkeley, CA 94710
tel 510.665.6100
fax 510.665.6129

www.btw.informingchange.com