BTW INFORMING CHANGE

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Strengthening Partnerships to Improve Community Health

The Experience of CCI's Networking for Community Health Program

PREPARED FOR:

Center for Care Innovations
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Dear Colleague,

As the Networking for Community Health program concludes, CCI and BTW *informing change* are pleased to share the findings from BTW's evaluation, "Strengthening Partnerships to Improve Community Health." The Networking for Community Health program originally 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. With generous support from The California Endowment, CCI developed the program to help community clinics increase their capacity, relevance and sustainability to respond to upcoming shifts in the health care landscape.

As we reflect on the years since the program's inception in 2008, we are struck by the immense changes that have provided both opportunities and challenges for those working in the health care safety net. The passage of the Affordable Care Act, the economic recession and advances in technology—to name a few—all influence how we approach our day-to-day work in ensuring health care for the underserved in California. During these years, community clinics have strived to adapt to new circumstances and changing conditions.

Overall, the evaluation has found that the Networking for Community Health program enabled clinic grantees to go beyond their four walls, strengthen community relationships and build the capacity of local organizations and residents to make positive changes for community health. While building capacity and strengthening partnerships are not always seen as exciting topics that result in dramatic health outcomes, they are vital ingredients for successful community change. As a result of the Networking for Community Health program, networks of clinics, local organizations and community members are better connected and positioned to work on community health issues as a united front rather than a single entity. Even though these efforts can sometimes be difficult and resource intensive, enhancing capacity at multiple levels—organizationally, among community members and collectively as a network—is worth the investment.

As you read this report, we encourage you to think about the multitude of ways that community clinics can partner with other agencies and individuals in their communities to build capacity and address complex, multifaceted community health issues. We would love to hear your feedback and response to this program.

Thank you,

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Introduction

Five years ago, before the passage of the Affordable Care Act, California's community clinics and other key players in the health care system faced an uncertain future. Though it was clear that major changes were needed to address increasing rates of chronic diseases and spiraling costs of care, most were unsure of what exactly would change and how these changes would roll out.

Around the same time, the Community Clinics Initiative (CCI) was determining how to commit its remaining grant funds (see side bar). Sensing opportunity within the ambiguity in the health care field, CCI convened a group of forward-thinking clinic leaders, community representatives and funders to brainstorm scenarios for upcoming changes in the health care landscape and explore ways clinics could proactively increase their capacity, relevance and sustainability. Ultimately, the group agreed that community clinics needed to evolve toward a new model of care. They envisioned the clinics of the future functioning as "centers for community health" (see box below), going beyond the provision of medical services to develop strong community partnerships that could more effectively address persistent community health issues. From this concept, the Networking for Community Health (NCH) program was born.

ABOUT CCI

CCI originated in 1999 as the Community Clinics Initiative. Created by The California Endowment, CCI worked to enhance the capacity of California's community clinics.

CCI grew into a $113 million grantmaking initiative that responded to the needs of the clinics field by providing grants and capacity-building assistance in a range of areas including health information technology infrastructure, major capital projects, clinic leadership and community networks.

In 2012, CCI became the Center for Care Innovations. With a new name and an expanded focus, CCI works with multiple funders on projects to bring people and resources together to accelerate innovation in the health care safety net.

WHAT IS A CENTER FOR COMMUNITY HEALTH?

CCI considers a "center for community health" to be an organization that reaches beyond its four walls to play a central, leadership role within a dynamic network of organizations and community members to improve community health. A center for community health goes beyond individually-based medical interventions to embrace a population-based, preventive and holistic approach that takes into account physical, mental, social and environmental determinants of health.

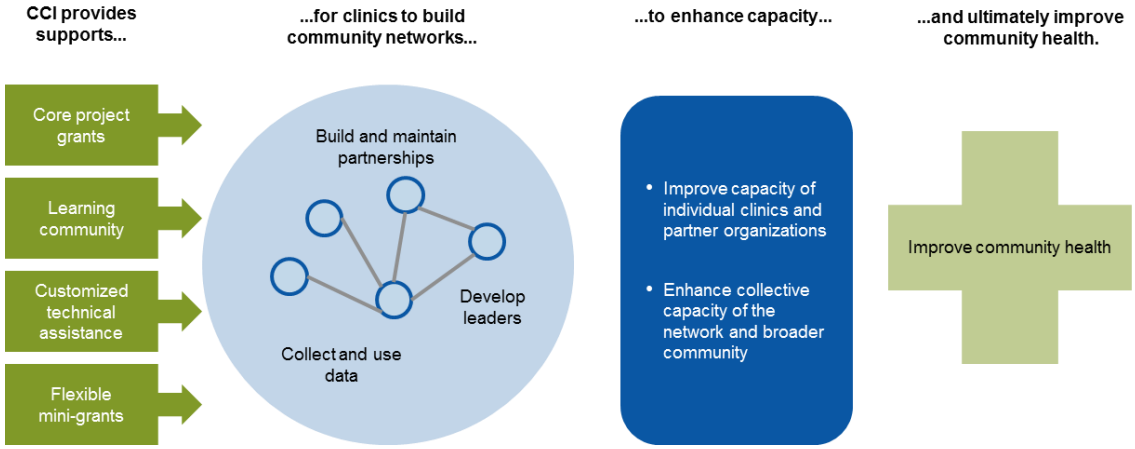
Throughout the report, this icon indicates that additional resources and reports are available for online readers through hyperlinks.

THE NETWORKING FOR COMMUNITY HEALTH PROGRAM

Launched in 2008 and concluded in 2012, the NCH program included a variety of monetary and non-monetary supports to help clinics build community networks and enhance the capacity of those working within the networks (e.g., clinic staff, representatives of other community agencies, residents) to improve community health. CCI identified three key elements that they deemed necessary for clinics to become a true center for community health: robust partnerships, strong leadership at the clinic and community level, and the dexterity to collect and use data (Exhibit 1).

Exhibit 1

The NCH Program Theory of Change



Over the four-year NCH program, CCI distributed approximately $10 million in core grants to a total of 39 clinics across California.[i] Almost two-thirds of the grantees received four years of funding, while the other grantees received two years of funding either in the first cohort or second cohort.[ii] On average, grantees received $260,000 (ranging from $71,000 to $380,000) to implement their networking projects. CCI intended for the grants to act as a "down-payment" investment for clinics to take new approaches in the emerging health care landscape. The range of other NCH supports included the following.

- **Learning community:** CCI convened clinics and their core partners to share learnings and improve their practice in multiple ways including periodic all-grantee meetings, the Community Clinic Voice online forum and specialized convenings for smaller groups working on common issues or strategies. These convenings also provided an opportunity for CCI staff to learn about projects' progress and emerging needs and how they could be addressed.
- **Ongoing technical assistance:** Based on feedback from grantees, CCI partnered with other organizations to help grantees with data-related efforts, media advocacy and partnership building.[iii] These opportunities were open to all NCH grantees, but participation was not mandatory. CCI also conducted a series of webinars that highlighted the work of select NCH projects and supported one grantee, Open Door Community Health Centers, to host a two-day conference where other grantees and partners could learn about their community garden and wellness project.

THE NCH PROGRAM

Click on the image below to watch a video that explains the purpose of the NCH program.

- **Flexible mini-grants:** As a supplement to core grants, CCI distributed $97,000 in "mini-grants" to approximately two-thirds of NCH grantees at the mid-point of their projects. Grantees applied for these small grants of $2,000–$3,000 to obtain project-specific assistance for problems or opportunities they encountered during the course of their work. For example, grantees used the funds to send staff to trainings, visit other clinics doing similar work, hire facilitators to assist with network building and print bilingual brochures.

ABOUT THIS REPORT

This evaluation report focuses on the 32 grantees funded in the second NCH cohort, although the report also draws on findings and reflections from the entire NCH program. For more information about the first NCH cohort, the evaluation report, "Building Capacity to Promote Community Health," is available on the BTW *informing change* (BTW) Web site. For the evaluation of the second NCH cohort, BTW conducted the following data collection efforts from July 2010 to August 2012: 46 interviews and 10 focus groups that represented over 130 people (e.g., clinic grantee staff, partner representatives, individuals in the community, community health promoters); 6 site visits at project locations in Los Angeles, Coachella, Sacramento, Redding and Crescent City; surveys at the end of the grant among grantees and partners (88% and 61% response rate, respectively); brief topic-specific surveys throughout the program among sub-groups of grantees and partners; and a materials review of grant proposals, progress reports and final reports.[iv] The mixed-method evaluation is highly representative of the second cohort grantees and partners; however, limitations exist, namely: 1) the data are self-reported and reflect subjective perceptions of grantees and partners, and 2) given the varying structures, starting points, foci and levels of funding for projects, findings are not necessarily generalizable to other types of projects or initiatives.

In the following pages of this report, we describe the NCH grantee projects and partnerships, present key outcomes and factors for project successes, and offer an in-depth look at two NCH projects. In the final section we offer our considerations for funders or others who are interested in designing or supporting collaborative community health improvement initiatives.

THE NCH PROJECTS & PARTNERSHIPS

The NCH grantees and their partners launched their projects by identifying health issues in their communities, and then developing and strengthening partnerships with other organizations and individuals to collaboratively address these issues. Given that community health problems are often rooted in multifaceted, interrelated issues (e.g., access to services, local policies, community capacity), grantees took on multiple strategies to tackle these problems. Projects focus and types of partnerships varied widely across NCH projects (Exhibit 3 on the next page).

Exhibit 2

NCH Grantee Locations

Identifying Community Health Issues

CCI's grantmaking approach allowed grantees considerable latitude to develop projects that could address salient health needs unique to their communities, which are located across California (Exhibit 2). Grantees chose to address health problems ranging from high rates of chronic illnesses (e.g., diabetes, obesity, asthma), to the lack of affordable healthy food, to difficulties accessing services among specific populations (e.g., transgender patients, immigrants, farmworkers, youth). These complex, long-standing issues were ripe for NCH support because they were not easily solved by any one organization and required new and creative approaches.

Developing & Strengthening Partnerships

A central goal of the NCH program was to address community health issues collaboratively with community partners, building on existing partnerships where possible, and reaching out to new partners as needed. Clinic grantees developed and strengthened relationships with traditional types of partners, such as other health providers, as well as less traditional partners, such as youth development agencies, social service or advocacy organizations and city government agencies. On average, grantees collaborated with 3 partners on their NCH project, with a range from 1 to 37 partners per project.

Grantees and their partners built on one another's strengths to more effectively address the identified community health issues. While clinics already had long-standing roots in their communities and expertise about health conditions, partners provided connections, expertise and new perspectives that went beyond the clinics' scope. As one grantee noted, "[Our partner] brought an environmental perspective to the project.... They also have access to a statewide collaborative and brought local resources to the table." The NCH projects conceived out of these partnerships allowed clinics to stretch their boundaries, and at times, think more innovatively about how to address community health issues.

Exhibit 3

Two NCH Project Examples

Mission Neighborhood Health Center	Operation Samahan
The NCH project partners…	**The NCH project partners…**
• Community clinic • Immigrant family wellness and empowerment organization • Behavioral health and social service agency	• Community clinic • Academic institutions • Cultural associations • Social service agencies
Are working together to…	**Are working together to…**
• Address high rates of obesity	• Promote a dialogue about health disparities
Among…	**Among…**
• Latino children in San Francisco	• Asian-Pacific Islander groups in San Diego
By…	**By…**
• Identifying overweight or obese patients at the clinic • Making referrals to after-school wellness programs • Conducting assessments to identify unhealthy eating behaviors • Conducting nutritional assessments and counseling sessions • Recruiting and training community health promoters	• Conducting community-based participatory research (e.g., health surveys, focus groups) • Disseminating findings to the community (e.g., Web site, forums) • Creating health resources (e.g., cookbooks, training manuals, resource directory)

Designing & Implementing Strategies for a Healthy Community

Working together, grantees and their partners decided on strategies to address the health needs they identified. Although specific strategies differed based on the project foci, there were similar themes in the strategies employed by grantees (Exhibit 4). Many projects used both a "bottom-up" and "top-down" approach to get at the heart of community needs—including efforts to educate and empower community members to advocate for themselves and make healthy decisions, as well as efforts to improve community infrastructure, policies or systems that could influence healthy decisions among community members. For example, Clínicas de Salud del Pueblo's project, United for Health Action,[iv] worked to inform residents about the dangers of arsenic-contaminated water while also advocating for local policy and land use change. CCI encouraged projects to remain flexible and take advantage of new opportunities; therefore, during the projects' implementation, some grantees shifted their strategies to adapt to changing conditions.

Exhibit 4

Examples of NCH Project Strategies to Promote Community Health[v]

Empowering community members	93%	• Recruited individuals as community health promoters and leaders • Conducted leadership and skill-building trainings • Involved individuals in NCH projects as staff and volunteers • Conducted community-based participatory research
Connecting populations to services	93%	• Provided referrals to social services (e.g., legal assistance, parenting classes, food centers, women's shelters) or other health service providers (e.g., primary care, transgender health services, respite care) • Produced materials that promoted clinics' and partners' services (e.g., brochures, online resource directory)
Collecting or utilizing data	89%	• Conducted community needs assessments • Tracked project output or impact data (e.g., program retention rates, volunteer hours, body mass index measures) • Developed a joint data system for partners to input, share and utilize data
Providing health education or services	82%	• Provided medical services (e.g., screenings, behavioral health services, substance abuse treatment) • Conducted workshops and trainings (e.g., healthy cooking classes, nutrition workshops)
Mobilizing the community for action	70%	• Advocated for policy change by organizing community members (e.g., testified at city council meetings, visited the state capitol, met with local legislators) • Engaged in media advocacy (e.g., newspaper articles, radio public service announcements, television news stories) • Convened town hall or community meetings to discuss community health issues
Improving community infrastructure	54%	• Created and maintained community and school gardens or farmers markets • Transformed unused or unsafe areas into healthy places for recreation (e.g., children's playground, walking paths)

Project Outcomes & Key Factors for Success

As intended, the NCH projects helped build capacity among organizations, staff and community residents by increasing knowledge, improving skills and connecting resources. The projects also enhanced the capacity of the collective network as organizations and individuals increased their ability to function as a group with a common vision and shared goals. Finally, projects have started to make progress toward improvements in their communities (e.g., creating opportunities for healthy living, coordinating services, working toward policy change). Some projects have made more progress than others due to multiple factors (e.g., different starting points and levels of resources), but all NCH projects laid the groundwork for further improvements in community health. Grantees and partners identified some of the key success factors related to designing, implementing and maximizing the impact of collaborative community health projects.

PROJECT OUTCOMES

Grantee & Partner Organizations

Grantees and partners developed and strengthened relationships to promote community health (Exhibit 5). The NCH projects enabled many grantees to strengthen bonds and establish greater trust with existing partners. As one grantee noted, "We have much better relationships and collaborations [with our partner agencies] now. We trust each other so much more." For other grantees, the NCH project opened the door to working with new partners such as transportation justice groups, the police department and schools. Regular meetings, ongoing communication and more formalized structures of working together bolstered both new and formerly marginal relationships. Although grantees and partners admitted that collaborative work was difficult at times, overall, they felt supported by one another and better able to identify shared goals, develop trust, distribute responsibilities, draw on each other's expertise and call on each other for logistical support.

Clinics became more visible and credible as centers for community health. While many grantees reported that they were already on the way to becoming a center for community health prior to the NCH project, they said the project contributed to greater visibility and credibility among partner agencies and community members who may not be patients (Exhibit 5). Grantees noted that the project helped change perceptions about the clinics' role in the community and scope of services, as illustrated by one grantee who noted, "This [NCH project] was an opportunity for our clinic to go out into the community as an advocate for health, not just a treatment center if a community member gets sick."

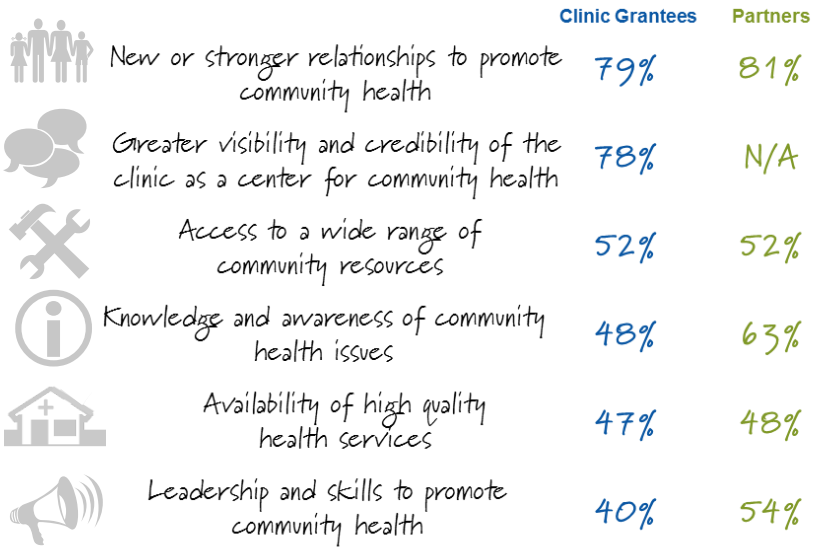
Staff involved in the projects gained knowledge about community health issues as well as skills and resources to better serve their communities (Exhibit 5). Through their work on NCH projects, staff became more knowledgeable about areas such as the health impacts of environmental exposure and capable in areas such as policy advocacy techniques; often they displayed leadership in relaying these learnings to community members. In addition, projects enhanced clinics' and partners' awareness about and access to a wider range of community

resources and connections. With greater familiarity came increased ability to draw on one another's expertise and tools to promote community health. As one grantee noted, "Our relationship with our partner and consultant gave us access to community resources that were originally not at our disposal." One grantee, La Clínica de la Raza, formed La Red Latina[v], a vast network of over 30 domestic violence organizations that came together to learn from each other, share resources and build skills to ultimately improve services available to Spanish-speakers in their communities.

Clinics and partners expanded the availability of services and programs in the community (Exhibit 5). The projects helped clinics and partners go beyond their usual service areas (e.g., focusing on a specific neighborhood, serving more rural areas) and engage in outreach efforts through a variety of means (e.g., involving community health promoters, working with partner to set up resources at their site). Accordingly, they took steps to strengthen their capacity to serve new groups of people. For example, after expanding services for community members in a new neighborhood, one project focused on increasing case managers' understanding of how to effectively work with undocumented immigrant clients.

Exhibit 5

Perceptions of "Significant" Capacity Improvements Among Organizations & Staff Involved in the NCH Projects[vi]



Community Members

Community members gained knowledge and awareness about specific health conditions and the broader determinants of health (Exhibit 6). Community members learned more about chronic health conditions, such as diabetes, and ways to prevent and manage these conditions, including eating healthy foods, being more physically active and regularly monitoring their health status (e.g., blood glucose levels). Also, community members learned to apply a broader lens to health issues, such as considering the effects of environmental factors on their health (e.g., arsenic in the water, pesticide use, unhealthy housing conditions). As a result of increased knowledge and awareness, some residents began making healthier decisions in their day-to-day lives, such as taking part in exercise classes, creating backyard gardens and accessing regular medical care.

Residents developed and utilized leadership skills in their communities (Exhibit 6). Primarily through NCH project trainings, many community members gained a sense of empowerment and skills (e.g., communication, presentation, data collection, advocacy) to promote health and become leaders in their community. Projects prepared community members to relay health information to their peers, voice their concerns and interests to government officials and communicate the needs facing their community to key stakeholders. For example, both San Ysidro Health Center and Planned Parenthood of the Pacific Southwest (see side bar) created programs that trained youth to provide health information to their friends and families. As one grantee noted, "Building leadership among community members is really important because this is their neighborhood. Things are going to happen over the [coming] years that can really change the landscape here, so it's important to engage and foster leadership."

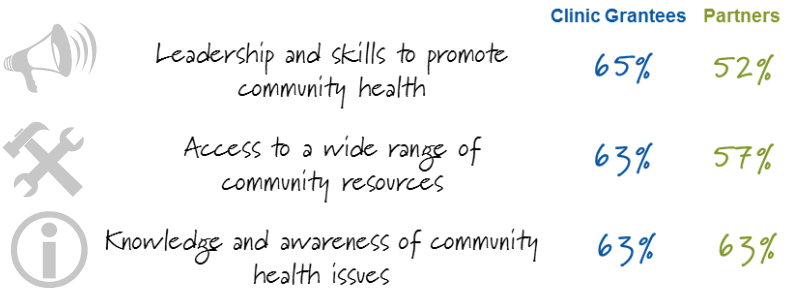
COMMUNITY LEADERSHIP

Click on the image below to watch a video about an NCH project that engaged youth community health promoters.

Community members gained access to a variety of community resources (Exhibit 6). Primarily through partner connections, community members obtained referrals to a larger array of medical and social services—such as public assistance benefits, medical homes and housing services—than they had previously known about or used prior to the NCH projects. For example, thanks to Hill Country Community Clinic's DEPTH project, youth in a remote region of Northern California gained access to recreational activities, adult mentors and job and college assistance that have helped them stay active, productive and healthy.

Exhibit 6

Perceptions of "Significant" Capacity Improvements Among Community Members Involved in or Served by NCH Projects



Community Infrastructure & Systems

Grantees and partners created new opportunities for community members to engage in healthy activities and lifestyles (Exhibit 7). Some NCH projects transformed unused land into areas where residents could plant gardens, while others developed farmers markets or community "crop swaps" to increase access to nutritious foods. Open Door Community Health Center's Del Norte Community Wellness Center and Garden, for example, repurposed vacant land next to the clinic to develop a community garden, walking trail and children's playground.

Grantees and partners developed systems to increase the coordination of health care and other services (Exhibit 7). Some NCH projects focused on coordinating care by establishing referral mechanisms between agencies (e.g., hospitals, clinics, social service agencies) or providers (e.g., dietician, behavioral health specialist, primary care physician). As one partner noted about their newly-created referral system, "This collaborative effort was able to link medical services, physical activity, mental health, and education services together to provide a comprehensive approach to participant health." Other projects worked on different types of coordinated systems. For example, St. John's Well Child and Family Center's Slum Housing and Environmental Health project created a centralized data management system to collect data across agencies and use it to advocate against substandard housing conditions.

ACCESS TO HEALTHY FOOD

Click on the image below to watch a video about an NCH project that provided access to healthy food through community gardens and farmers markets.

Grantees and partners made progress related to health-promoting policies, but tangible changes were slow and difficult to come by. NCH projects worked with community members and government officials to advocate for policy changes across a number of different issues such as requiring a review of water quality in underserved communities, ensuring better housing conditions and selling healthier foods in local stores (Exhibit 7). One project successfully changed a city policy (e.g., removing exclusion criteria for transgender health services in a public medical insurance plan), and another project prompted the city attorney to prosecute negligent landlords. Despite these successes, most NCH projects will likely need more time and resources to pursue policy change in the future.

Exhibit 7

Perceptions of "Significant" Improvements of NCH Projects on Community Infrastructure & Systems

	Clinic Grantees	Partners
Opportunities to safely engage in healthy activities and lifestyles	70%	46%
Coordinated and responsive systems of health service delivery	47%	50%
Effective local, state or federal policies that promote community health	25%	44%

KEY FACTORS FOR PROJECT SUCCESS

Based on their NCH project experiences—both good and bad—grantees and partners identified key success factors related to designing, implementing and maximizing the impact of collaborative community health projects. They also identified key challenges that they faced while implementing their projects (see side bar). While many of these factors and challenges are not surprising, it is important that organizations interested in conducting similar projects take the time to consider these issues as they engage in collaborative work.

- **Identify committed partners.** Vet organizations carefully to ensure that they are strategically aligned with the goals of the project (e.g., similar missions and target constituencies) and have the capacity to engage in the work. Bring on new partners as needed to address gaps in knowledge, expertise or resources.
- **Assign a project coordinator.** Identify a point person who holds responsibility for keeping the overall project on track. If hiring staff from outside the organization, ensure a good fit with the project's mission, and choose staff with skills in relationship building, mobilizing and project management.
- **Set expectations for project engagement and leadership.** Agree upon roles and responsibilities at the beginning of the project, and revisit them periodically. Establish clear decision-making processes (e.g., consensus, voting, lead decision maker) to help the project move forward with minimal confusion. Capitalize on opportunities to enhance leadership among project staff and community members (e.g., representing the project in field-level meetings, conducting research).
- **Share funding.** Distribute funding among partners to facilitate accountability and ensure that partners have some "skin in the game." While one organization may serve as the fiscal agent for the collaborative, share a portion of the funds with partners based on their respective roles and responsibilities.
- **Set realistic objectives for change, and celebrate big and small successes.** At the start of the work, focus on effecting change in a defined geographic area or population; when successful and capacity allows, expand the project scope or set more ambitious goals. Remember that collaborative work requires considerable investment and that it takes time to make headway on complex health problems. Set interim goals and celebrate steady momentum and tangible progress to help maintain morale over time.
- **Communicate regularly.** Take the time to meet face-to-face at the beginning of the project, at a minimum, to help build relationships and trust. Thereafter, ensure regular communication mechanisms (e.g., monthly meetings at rotating partner organizations, bi-weekly conference calls) to plan, strategize and problem solve.
- **Reflect on the strength of the network.** Periodically meet with partners to assess where the network excels and where it needs to improve. Use tools such as the Network Health Scorecard which can provide practical guidance and aid planning and decision making.

TOP FIVE NCH PROJECT CHALLENGES

1. **Staffing** (e.g., dealing with staff turnover, finding the right staff with skills for the job, dedicating staff time to the project)
2. **Circumstances of community members** (e.g., transportation issues, reluctance to report health issues, competing priorities, difficulty changing behaviors)
3. **Collaboration among project partners** (e.g., declining engagement over time, keeping partners accountable for work and timelines, scheduling meetings)
4. **Funding** (e.g., having sufficient funds to recruit experts, undergo a comprehensive evaluation or address larger community needs)
5. **Broader economic or political context** (e.g., economic recession and budget cuts, political climate related to immigration or other issues)

A Closer Look at Two NCH Projects

Below we look in more depth at two NCH projects—Venice Family Clinic's project focused on coordinating respite care services for homeless populations and Family HealthCare Network's experience providing on-site health education and other services to immigrant farmworkers at the local Mexican consulate.

A ONE-STOP SHOP FOR SERVICES & CARE

Imagine trying to keep an open wound clean while sleeping on a tarp, or recovering from foot surgery while figuring out how to find your next meal. Picture trying to keep medications organized and safe when moving from place to place, or not knowing where to receive care or ask questions about your health. While hard for many to imagine, this is the reality for a large number of homeless individuals served by Venice Family Clinic and Ocean Park Community Center (OPCC), a social services agency and homeless shelter, located in the western region of Los Angeles County.

Venice Family Clinic and OPCC staff dedicate themselves to "meeting homeless people where they are." For years, two clinic physicians, Dr. Coley King and Dr. Terri Brehove, have reached out to homeless individuals on the streets and at OPCC's shelters to provide basic health care. As they went about this work they realized that their patients, who suffer from a variety of health conditions (e.g., mental or physical illness, alcohol/drug dependency and/or disabilities), needed more regular health care. They also recognized that homeless individuals discharged from hospitals could not fully recover while sleeping on the streets; they needed a safe, consistent and clean place to recuperate.

KEY PLAYERS

Venice Family Clinic: A community clinic with seven sites.

Ocean Park Community Center (OPCC): A nonprofit organization that provides shelter and services for low-income and homeless youth, adults and families.

Saint John's Health Center: A private nonprofit hospital.

Santa Monica-UCLA Medical Center: A public teaching hospital.

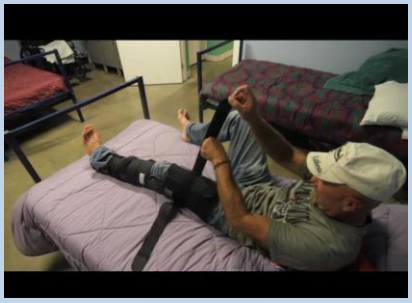
In 2007, OPCC renovated their Access Center, where homeless individuals receive access to services such as meals, groceries, laundry, showers and lockers. During the renovation, OPCC decided to add two medical exam rooms where Venice Family Clinic physicians, including Dr. King and Dr. Brehove, could offer on-site health care to individuals staying at the shelter. Furthering the capacity to provide care to homeless patients, Venice Family Clinic received a grant from the NCH program to create a more seamless system of care for homeless patients after being discharged from local hospitals. The resulting Respite Care Program, which is housed in OPCC's shelter, is a one-stop shop for medical, housing and supportive services for patients recuperating from surgeries or acute conditions. The program built on the existing relationships between the clinic, OPCC and nearby hospital, Saint John's Health Center,

organizations that serve homeless individuals and have a similar philosophy of creating a welcoming environment, building trusting relationships and allowing homeless individuals to take ownership of their treatment (see side bar on the previous page).

Currently, OPCC dedicates 12 of its 70 homeless shelter beds for program patients. While patients are in the program, they have a home-like environment—complete with a living area with couches, a television, board games, a fish tank and a small library—to recuperate from their acute conditions. During their three- to four-week stay in the program, patients also have access to case management and supportive services to help them pursue transitional or permanent housing, secure a source of income, and adopt a health home, ideally Venice Family Clinic. One staff member reflects on the process: "We get to know the patients really well so there is a 'warm' transition when the next person begins working with the patients in the program. There is a lot of work around relationship building and gaining their trust to make the transition between staff easier."

COORDINATING SERVICES ACROSS ORGANIZATIONS

Click on the image below to watch a video about the Respite Care Program.



Since 2008, the program has served nearly 300 homeless individuals with a range of health conditions, providing coordinated health services that have resulted in impressive outcomes (see right side bar). In particular, the program's cost savings for the hospital attracted another like-minded partner, Santa Monica-UCLA Medical Center, when Venice Family Clinic received a second NCH grant in 2010.

Beyond the numbers, the program provides personalized care that makes a world of difference to its patients. One patient summed up the impact of the continuum of care she received: "I couldn't have made it on my own out there on the streets. I was broken—financially, emotionally and mentally. My life was spinning out of control. I was able to rest in the Respite Program; Venice Family Clinic's doctors didn't give up on me."

Program staff attribute success to the "champions" at each agency as well as the strength of their partnerships. The staff from each partner agency meet once a month to review progress, share data and make decisions about the health care and services delivered to their patients. Partners remain flexible and are willing to adjust their practices based on data and the needs of their patients and partners. For example, OPCC adjusted the number and gender distribution of program beds (initially 5 for men and 5 for women, now 10 for men and 2 for women) based on the level of need and utilization. For their part, the hospital partners adjusted their policies to provide patients with three days' worth of medication upon discharge to ensure that they have necessary medications upon entering the program.

KEY PROGRAM ACCOMPLISHMENTS SINCE 2008*

287 homeless individuals were served.

41% of patients entered transitional or permanent housing following respite care.**

For each of 10 program patients discharged by St. John's Health Center, the hospital saved approximately $3,000 in outpatient services and $34,000 in inpatient services.***

* Data were reported in June 2012.

** 2011–2012 patients only.

*** Reported by St. John's Health Center on pre-post data of 10 patients who received the majority of their treatment through the Program. This does not include any data from Santa Monica-UCLA Medical Center.

Going forward, Venice Family Clinic and its partners are seeking funding that will enable them to continue and expand the program. Future plans include increasing the number of hours the on-site clinic is available to patients, and hiring a full-time registered nurse to provide medical care to patients. Reflecting on the program, Dr. Terri Brehove describes its importance, "An open wound can heal when patients have a place to stay and get better. The Respite Care Program makes it easier to deliver medical care to homeless individuals who need it."

BRINGING HEALTH RESOURCES TO THE COMMUNITY

Upon entering the waiting room at the Mexican Consulate in Fresno, California, one may overhear questions that seem unusual for a government office, such as, "When was the last time you saw a doctor?" or "Would you like to know your blood pressure?" These conversations have become more common since the local community clinic, Family HealthCare Network (FHCN), created a partnership with the Consulate to establish an on-site Health Resource Center.

FHCN strives to provide quality health care to all who need it within the Central Valley; however, the rural landscape and apprehension of many Mexican immigrants to access care through an unfamiliar medical system creates considerable challenges. Immigrants in the area often lack a medical home and need assistance navigating the complicated health care system. To address these challenges, FHCN partnered with the Consulate and the Central Valley Health Network, a consortium of community clinics in the region, to adopt the nationwide *Ventanilla de Salud* Program in 2008 with NCH support. The Program works with local organizations to create health referral and education programs at Mexican consulates across the United States. Since the Mexican Consulate in Fresno draws Mexican immigrants from throughout the Central Valley, overlapping with much of FHCN's service area, establishing an on-site resource center was an ideal way to address the health care needs of many hard-to-reach community members.

As individuals and families sit in the Consulate's waiting room, they can attend health education sessions about topics ranging from diabetes to pesticide safety to cervical cancer. Touch-screen kiosks allow them to search for health information, and monthly health and resource fairs offer additional ways to access information. Furthermore, FHCN staff provide assistance with complex health insurance forms and refer individuals to FHCN or other nearby clinics, all while they wait in line for their Consulate appointment. Norma Verduzco, Chief Operations Officer for FHCN notes, "The program is helping individuals access the care they need for themselves and their families and establish a health home in their community."

After two years of running the Health Resource Center, FHCN staff realized that they needed to expand their efforts to reach individuals living in unincorporated and very remote areas of the Central Valley. With a second NCH grant in 2010, FHCN developed a partnership with Proteus, a community services provider, to create a mobile Health Resource Center in a 36-foot vehicle equipped with computer workstations, Internet access and office supplies. Through this project expansion, FHCN staff recruited and trained four community health promoters who work out of the mobile unit. As the mobile unit travels throughout the Central Valley, the health promoters provide basic health screenings, education and referrals, as well as help community members understand their health status and take action. Rosie Herevia, the Program's Community Health Representative, describes one of the benefits of health promoters' services: "Often community members don't know what their blood pressure numbers mean.... Teaching them the meaning of these numbers is important so they can understand if their blood pressure is getting better or worse in the future."

KEY PROGRAM ACCOMPLISHMENTS SINCE 2008*

59,769 clients received health education and information.

3,104 clients were referred to a medical home.

4,721 clients received preventive health screenings (e.g., blood pressure, hemoglobin, glucose screenings).

* Data collected by FHCN from 2008–2011.

The *Ventanilla de Salud* Program meets immigrants where they are, whether at the Consulate or near their homes, to provide needed services. Marisol de la Vega Cardoso, Director of Business Development, describes FHCN's ongoing commitment to this work: "We will continue to strengthen our partnerships with community-based agencies and health centers to offer resources that support the health and well-being of individuals and families served by *Ventanilla de Salud*."

Looking Forward

Since its inception, the NCH program has enabled clinics to go beyond their four walls, strengthen community relationships and build the capacity of local organizations and residents to make positive changes for the health of their communities. Overall, CCI's efforts have been successful in positioning clinics to become centers for community health. One grantee aptly described: "Our partners used to see us as the clinic that provided medical and some ancillary services. Now, they see us in a new light as a community agency committed to improving the health of the neighborhood through collaboration."

As the NCH program concluded in June 2012, grantees and their partners reflected on how they are better prepared to undertake similar or complementary projects. Almost three-quarters of grantees reported that they are continuing their NCH project; the remaining grantees have plans to build on the project. While the continuation or expansion of NCH projects is encouraging, the broader success of the NCH program lies in the improvements in collective capacity in communities throughout California.

CONSIDERATIONS

Based on the NCH evaluation findings and BTW's experience with similar types of initiatives, we offer considerations for funders and others who may be interested in supporting collaborative efforts to improve community health.

Clearly articulate the program's intentions and parameters, but strike a balance between structure and flexibility. Invest up-front time to articulate the program's overall goals and desired outcomes. Provide a clear framework, such as a theory of change, logic model or outcomes framework about how the program expects to achieve change at multiple levels (e.g., policy change, community infrastructure, individual behaviors). While a heavily prescribed program may be easier to manage, support and evaluate, allowances for variability and customization are essential for on-the-ground collaboratives to meet the needs of their communities. As the program and individual projects evolve, revisit and clarify the framework so that organizations remain clear about how their work aligns with and furthers the program's and their own vision for community change.

Structure the program in distinct phases. Customize funding according to projects' planning, implementation and expansion phases. An initial planning phase can provide organizations the time and space to gather information (e.g., conduct a community needs assessment), identify key strategies, strengthen the network of partners and create evaluation plans. Allowing for planning time, whether in a structured phase or not, is especially vital when organizations pursue projects outside of their normal scope of work and/or engage with non-traditional partners. A subsequent implementation phase can build on the planning phase and strengthen a network's capacity to respond to the community's needs by implementing a variety of strategies to improve community health. An expansion phase can allow organizations with successful projects the time and resources to

demonstrate the effectiveness of programs, identify new funding sources and expand to new communities or sites. Structuring a program in phases can also help increase accountability by requiring grantees to complete certain milestones before receiving additional funding to move on to the next phase.

Allow partnerships to develop organically. You can't force a marriage—that is, don't push specific agencies to partner with each other or prescribe how to structure partnerships. The strongest partnerships tend to emerge when organizations build on previous working relationships and decide together on the type and level of engagement that they want to have in the collaborative effort. For example, while CCI encouraged first cohort grantees to form new partnerships, in the second cohort they shifted their emphasis to asking grantees to focus more on already existing partnerships.

Build a robust support plan and adapt as needed over time. Although specific needs for assistance vary, it is difficult to underestimate the value of technical assistance and small grants to resource-strapped nonprofits. In general, it is helpful to offer a range of technical assistance opportunities (e.g., in-person versus online opportunities, group versus one-on-one settings, topic-focused versus general support) that will resonate with organizations that have different needs and preferences. To help shape and refresh a support plan, ask for regular feedback from organizational staff and community leaders to ensure that the assistance is timely and relevant. Common areas for capacity building assistance—for the NCH grantees and others—often focus on:

- **Strengthening and growing networks:** Networks are constantly changing, growing and evolving; therefore, it is important to understand the network's stage in the life cycle of development to tailor supports (e.g., funding, trainings, tools). For example, when a network forms, organizations may need help to determine a vision and identify areas of alignment, whereas a more evolved network may need support for specific operations and activities (e.g., facilitating meetings, accessing community data).
- **Collecting and utilizing data:** Given that nonprofits and community members have a wide range of data utilization skills, it may be most practical to ask organizations to collect a baseline level of simple data that can be aggregated across projects, with individual assistance that allows organizations to collect more in-depth data. Help organizations use data to support project improvements, leverage additional resources and inform others about the community's needs and project impacts.
- **Mobilizing the community and advocating for change:** Offer focused trainings and resources about how to successfully mobilize community members and advocate for change. Consider focusing on how to craft effective messages, reach out to the media, create project materials (e.g., videos, reports, brochures), and educate key stakeholders about needed changes.

Create space for learning while respecting the diversity of projects. Learning opportunities can take various shapes and forms; there is no one-size-fits-all approach to embed learning into the fabric of a program. It can be particularly challenging to create an appropriate collection of learning opportunities when organizations or networks address a wide range of issues with varying strategies and intentions. Look for commonalities across the projects and identify sub-groups that can focus on specific topics and strategize about how to promote change. For example, CCI brought select groups of grantees together throughout the NCH program based on similar strategies (e.g., establishing community gardens, engaging community health promoters, empowering youth). They also held a series of trainings for more advanced learning (e.g., multi-session trainings on media advocacy).

Assist in connecting the dots between partners and ensuring forward movement. Support one or more individuals—a foundation staff person or local community member, for instance—to take on the role of a "network officer" or "network weaver" to help strengthen connections among current members, identify and reach out to potential partners and pursue additional resources. Someone who is aware of key stakeholders and resources within and across communities, and has strong facilitation and coordination skills, can help the network move forward strategically.

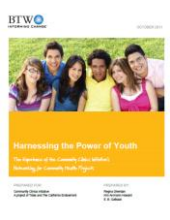
CONCLUSION

At the conclusion of the NCH program, the networks of clinics, partners and community members working on community health issues are stronger and better connected, functioning as greater forces than when each entity works on its own. Ultimately, this collective capacity positions clinics and their partners for ongoing collaboration to address their communities' unique and shifting needs as well as the opportunities and challenges in the changing health care landscape.

LEARN MORE ABOUT THE NCH PROGRAM

A series of four briefs explores in more depth the strategies used by grantees in the Networking for Community Health Program (NCH) and the complementary Community Health Organizing Project. Each brief focuses on how community clinics and their partners have come together to address persistent health issues in their communities.

Getting to the Roots of Healthy Living: Prevention efforts that hone in on the causes of poor health, such as environmental and behavioral factors are becoming more critical to make meaningful improvements in health. This brief examines the activities NCH projects undertook to improve community environments and behaviors to promote healthy living among residents.



Harnessing the Power of Youth: A healthy community needs youth who will grow into healthy, caring and productive adults. This brief describes how NCH projects involved youth in their community health promotion efforts, built their skills and empowered them to navigate their paths towards adulthood.

The Bridging Role of Community Health Promoters: Community health workers, public health aides, *promotores* and peer educators are all terms used to describe the role of community health promoters. This brief examines how NCH projects engaged community health promoters to apply their knowledge of their communities and their personal connections with residents to promote the public's health.

The Power of Partnerships for Policy & Advocacy: The Community Health Organizing Project was designed to complement the NCH Program by focusing on community clinic associations in California. This brief describes how these associations worked with clinics to engage more diverse clinic and patient voices into health policy discussions throughout the state.

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FOR MORE INFORMATION

At BTW *informing change* (BTW) we are driven by our purpose of informing change in the nonprofit and philanthropic sectors. We partner with our clients to improve their effectiveness and build a culture of learning and continuous improvement. To find out more about the Center for Care Innovations, please contact Jane Stafford at jane@careinnovations.org. To find out more about BTW information-based services or this report, please contact Kim Ammann Howard at kahoward@btw.informingchange.com or visit www.btw.informingchange.com.

Endnotes

[i] In the second cohort, CCI distributed $5,441,000 in core grants to 32 clinics. More than half of the grantees (19 clinics) were continuing on from the first NCH cohort and had already established their projects, while 13 were new to the program. Although the NCH program technically ended in June 2012, 9 grantees received no-cost extensions to complete their grant projects by the end of 2013.

[ii] Throughout this report we use the term “grantee” to refer to the clinics that received core grants through the NCH program and “partners” to refer to the organizations that the clinics partnered with to implement their projects. The term “NCH project” is used to refer both to the grant project and partnership overall.

[iii] One-on-one assistance and trainings were provided by BTW *informing change*, Berkeley Media Studies Group, Prevention Institute, and Youth Development Network, among others.

[iv] Grantees were asked to select up to three partners that they worked with most closely to respond to the end-of-grant survey. All but one of the grantee respondents had at least one partner submit a survey.

[v] The percentages in the chart represent the proportion of grantees (n=28) who reported using each strategy at some point during their NCH project.

[vi] In Exhibits 5–7, the number of grantee and partner responses fluctuates for each variable given that respondents were allowed to opt out of a question if it was not a goal of their particular NCH project. Exhibit 5 has a range of 19–28 grantee respondents and 27–37 partner respondents. Exhibit 6 has a range of 20–24 grantee respondents and 29–30 partner respondents; these data were not reported by community members themselves. Exhibit 7 has a range of 16–20 grantee respondents and 18–28 partner respondents.

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