



## INTRODUCTION

Early Childhood Councils (Councils) depend on the engagement of leaders, providers, and parents across child serving systems. To influence health outcomes, an Early Childhood Council needs to be effective at engaging their health partners. This brief explores how seven Early Childhood Councils in Colorado have engaged their health partners, from the perspective of the Councils, their active health partners, and potential health partners who they were unable to fully engage.

*Health partners are defined* as providers of mental health, social/ emotional health, physical and oral health services and/ or administrators who facilitate direct access to those services (such as staff at public health departments).

## CONTEXT

The Colorado Trust's Early Childhood Health Integration Grant area "assists Early Childhood Councils in building local systems infrastructures that better integrate health and health care as a means to improve health outcomes for children throughout the State" (The Colorado Trust). The development of Colorado's Councils was initiated through authorizing legislation in 1997 to "Improve and sustain the availability, accessibility, capacity and quality of early childhood services for children and families throughout the state"(CDE, 2011). In essence, state policymakers recognized the need to integrate multiple domains -Early Learning, Family Support and Parent Education, Social, Emotional and Mental Health, and Health- to meet the needs of young children and their families.

This vision of integrating multiple domains to ensure a seamless continuum of services for young children was captured in Colorado's Early Childhood Framework developed by staff from the Office of the Lt. Governor (CDE, unknown). Recognizing that the

### Summary of Recommendations

1. Clearly **identify the levels of partnership** needed on the Council and recruitment strategies specific to those levels.
2. Focus on **indirect recruitment strategies** that leverage community leaders and existing health partners.
3. Focus on the **direct and indirect benefits of partnership**, including building your evidence of those benefits.

health domain was an underdeveloped area for Councils, The Colorado Trust's Early Childhood Health Integration grant area was established in 2008 to support Councils in their efforts to engage health partners in enhancing systems of support for young children and their families.

To not only assess but to leverage learning, The Colorado Trust Health Integration evaluation is developing a series of briefs on Councils' health integration efforts. This second brief in the series examines the Council's outcomes from health partnerships, effective recruitment strategies, and benefits to health partners from their involvement.

## RESEARCH METHODS

A qualitative study was conducted to answer specific research questions related to identifying the features and impact of high quality health partnerships among Colorado's Early Childhood Councils and the facilitators and barriers to Councils developing and sustaining those partnerships. Recognizing that Councils operate in distinct communities, the brief examines variations in engagement strategies in the context of urban versus rural. The following research methods were used:

- Analysis of data from grantee progress reports related to health partnerships;

- Three focus groups with Council staff defining health partners, features of a quality health partnership and the desired impact of having health partners;
- One focus group with health partners to secure their perspective and input on motivators and barriers to their involvement;
- Review of relevant data points from the Colorado Department of Education’s Early Childhood Council Collaborative Process Survey, explored at the individual Council level; and
- Seventeen interviews, with questions driven by the results of the focus groups and a literature review on collaboration in a systems building context. The interviewees included seven Council staff members, seven actively engaged health partners, and three disengaged health partners. The seven Councils represented in this process were selected in partnership with The Colorado Trust and technical assistance consultants to the funding initiative.

Focus group and interview data was coded and used to generate themes. The interview data was analyzed within Councils first, generating themes for each of the Councils, and across Councils second, generating themes that are included in this report.

## FINDINGS

For numerous reasons—from the actual capacity of key health partners to collaborate (i.e., a single pediatrician who serves a three county rural area) to Council attempts to identify key providers in a large, overburdened and fragmented urban health care system—the ability for Health Integration grantees to effectively engage health partners continues to be an area of challenge. There is growing recognition among the Councils that their approach to incorporating the health domain into the other domains of the early childhood system is only achievable with focused strategies that engage the right health partners.

This brief’s first finding supports this assumption—specifically that not all health partners are equal, different health partners can be identified and recruited to achieve different outcomes for the Councils. A number of the brief’s other key findings

address the “now what?” by providing insight into how health partners can be more effectively recruited and their involvement sustained. The findings emphasize that relationships matter and that effective recruitment of a health partner often involves visibly demonstrating how their involvement in the Council will directly benefit them, their organization, and their clients. Several of the findings dig deeper into both the factors that bring a health provider to the table to strategies for sustaining their involvement.

## UNDERSTANDING WHY HEALTH PARTNERS ARE NEEDED BY COUNCILS

Participants in the health partner focus groups identified four potential types of outcomes from engaging health partners: improved access to families, improved communication with families, increased efficiency within the early childhood system, and improved decision-making on the Council itself. When interviewed in more depth on these questions, all of the Council staff saw the *greatest impact from their health partners as improving communication with families* through the health partners’ direct reach to many families.

*“It goes back to being the first line of contact with a lot of families. We depend on them (health partners) to understand the important messages and share with families we might not otherwise have contact with.” Council staff*

While all Councils spoke to the ability of their health partners to help them expand their reach to and communication with families, this increased access to families seemed to vary across rural and urban communities. Urban Councils shared examples highlighting how their health partners increased access to families via specific programs or campaigns, such as screenings or enrollment in insurance. Rural Councils, on the other hand, talked more generally about having a broader reach with families and children in their communities, but not specific to one program or service.

Council staff responses in both the focus groups and key informant interviews focused on the unique position of health providers to access families and the potential this creates for a need to engage the majority of health providers in a community. This

level of engagement ensures that communication to families is consistent, that providers share a common understanding of the multiple domains that contribute to a child's wellbeing, and that providers are informed of the resources available locally to serve young children and their families once specific needs have been identified.

However, Council staff shared that engaging all providers in a community, while achievable in more sparsely populated rural or mountain communities (in fact, several Early Childhood Health Integration grantees have successfully engaged all the dentists or primary physicians in their communities), may not be as easily achievable in a larger metropolitan area. In larger metropolitan areas there is often more competition (from professional obligations to client load) for a health provider's time and more potential venues through which health providers can volunteer their time and expertise.

This urban challenge is also true as relates to another outcome identified by some Council staff as achievable only through engaging many of their health partners: that health partners assist with efficiency in the system through decreasing duplication of screenings.

A second priority outcome that Council staff consistently identified as resulting from health partnerships related to overall systems building is: Health partners' *involvement can improve decision-making at the Council* by bringing their unique perspectives, influencing other providers, and helping to sustain health integration efforts.

*"We would lose an important part of the discussion and well-rounded viewpoints to make decisions that are made by the Council. A lot of non-health representatives don't have this perspective to get the best well rounded picture for kids." Council staff*

*"There is quite a bit of data, such as low birth weight. A lot of data collected drives decisions made by the Council. They [health partners] sit at the table on the executive team to help with the system. We have the system built a little, but they help with the refinement piece." Council staff*

Collaboration can occur at many levels within the early childhood system, from client to program to

policy to systems levels (Sowa, 2008). Where the focus on communicating with families highlights the need for collaboration at the client level, the focus on improving decision-making and systems building highlights another level entirely – collaboration at the overall policy and systems level. To transition from the big picture to the implementation of more targeted steps that help build components within the system, Early Childhood Councils need to be selective about the health partners they bring to the table. Having every partner at the table would actually create a barrier to developing momentum and traction versus when looking, for example, at ensuring families receive consistent communication a less in-depth but broader level of engagement of providers on outreach to families would make sense.

Although many Councils discussed how their health partners helped generate big-picture change, Urban Councils more commonly discussed this change in terms of systems change and overall health integration. Rural Councils were more likely to cite big-picture changes related to specific, individual program efforts such as screenings.

**Key Finding 1:** Not all health partners are equal – different health partners can be identified and recruited to achieve different outcomes for the Councils.

Engaging health partners needs to be a strategic and thoughtful process. Successful engagement of some providers can enhance outcomes at the family and program level, while successful engagement of others can enhance outcomes at a systems level. While both types are needed, they don't necessarily need to be the same people.

### RECRUITING HEALTH PARTNERS

The types of health partners that Councils attempt to recruit varied based on whether or not the Council was in a largely rural or urban community. In rural communities, Councils reported having the most success reaching out to and bringing on board health partners at the individual level—such as individual doctors, dentists or nurses. This speaks to the importance of building and leveraging relationships and personal connections in rural communities. In urban communities, instead of focusing on

individuals as potential health partners, Councils more commonly approached pediatric primary care offices, WIC offices, mental health organizations and public health departments. Partnering with existing organizations and offices helps Urban Councils leverage the most capacity and expands their networks significantly more so than a partnership with a single individual.

Council staff reported a very diverse array of strategies for engaging new health partners, some of which required little effort while others were clearly major undertakings. Some of these strategies focused on the direct ask:

“I call it sales. I use my sales background. Know your customer before you approach them and talk about their needs first.” *Council staff*

“I do leverage them (key leaders). I hugely leverage them, when I am making my sales pitch, when I go to the school district. I right away say to them we are working on this grant. We are working with --- hospital, clinical directors at the health department. I name drop. It makes a huge difference in how much the key players are involved.” *Council staff*

Other strategies reported by Council staff focused on providing immediate benefit in hopes of longer term engagement:

“I invite some sort of expert come. That networking piece is so important.” *Council staff*

“One of the things we did to engage our providers... was we personally delivered a gift basket, which included educational materials about the program and Council and some goodies for the staff (chocolate, hand sanitizer, lotion, toothbrushes, sugar-free mints and fruit) to each health and dental office... We feel, based on the feedback we’ve received and the attendance at our January training, that these gift baskets were a huge success and asset to our Council. The baskets were a tool that got us into the office to speak one on one with many of the office team members, which has helped us build a relationship with them and got them engaged in our program.” *Council staff*

However, while Council staff reported a wide diversity of direct recruitment strategies, in contrast, all of the health partners interviewed reported that

they were engaged in the Councils through indirect means, ***largely based on their existing relationships or indirectly gained knowledge*** of the Council.

“It was probably four years ago when... I was looking for availability of resources that I got directly involved. The Council, Early intervention, Part C - all the agencies would go to those meetings quarterly and the Early Childhood Council would bring additional community partners to the table.” *Engaged health partner*

Other health partners named specific community leaders or leaders in their own organization whose encouragement to get involved drove their decision to participate. For some, it was their relationships with or ***respect for the leaders of the Council*** that motivated their involvement.

One Council has used an indirect, relationship-based method of recruitment very effectively by becoming active in the local Medical Society.

“The introduction specific to County providers would be through the Medical Society where we would have access to every health provider in --- County.” *Council staff*

This Council staff participated in a Medical Society subcommittee, providing ample opportunity to build relationships with primary physicians in the County and allowing the Council to make the case for integrated services while working with the physicians to help forward a specific shared screening goal.

Not only are relationships critical for recruiting health partners, the ***relationships health partners form while they are on the Council*** are also a key benefit health partners consistently reported from being involved with the Council.

“Sometimes the collaborative solutions are going to be retroactive. To know these people - practically it rocks and it works. Brainstorming with committee members, saying I have hit a wall for my client; do you have any other ideas?” *Engaged health partner*

“My engagement with the Council has helped build important relationships. If I have a question about Medicaid and C-CAP, I know who I can call. I don’t have to stay on hold for hours and it



makes my job immensely easier. Those personal relationships are so necessary. The hope is that we support each other in helping our community be in a better place; working together we can get a whole lot more done.” *Engaged health partner*

This benefit to the health partner was a common theme – not only for the opportunity to engage with other providers to learn about resources and develop important professional connections that result in better outcomes for clients, but also for the opportunity to network with a community’s “key players”, which would result in a direct benefit in other facets of a health partner’s work.

**Key Finding 2:** Relationships matter, perhaps more than any other recruitment strategy, including relationships with individuals who can access health partners and highlighting the relationships that health partners will gain through involvement.

Some Council staff reported health partner recruitment strategies that went beyond the direct approach or the relationship approach to instead building awareness throughout the community of the Council efforts, with the hope of becoming more visible to potential health partners:

“We have a monthly column in the newspaper; with a good percentage of the column on child health issues.” *Council staff*

“We have used partners that are sitting at the table. (Executive Director ---) has gone to some places to market what the --- is, health fairs and outreach fairs to other organizations.” *Council staff*

This approach of building the visibility of the Council may have direct payoff in recruiting partners, as some health partners either approached their Council to get involved after learning about it indirectly or are particularly motivated to participate due to the clout and visibility of the Council.

“They want to know what everyone else is doing, what new grants people have. They want to know new directors of agencies. Our HI committee is a good place to keep a beat on that.” *Council staff*

“Expanded professional networks, increased visibility in the community and expanded professional knowledge. It has increased referrals of new clients and almost a sense of respect in the community that our organization has developed – more of a reputation and credibility with families... and with physicians knowing where to go with referrals.” *Engaged health partner*

**Key Finding 3:** The visibility and reputation of the Council are important for recruiting health partners indirectly, allowing them to see the benefit in coming to the Council.

### INCENTIVES FOR HEALTH PARTNERS TO ENGAGE AND STAY ENGAGED

Participants in collaborative processes like the Early Childhood Councils come to the table in part due to consequential incentives and organizational/individual interdependencies (Emerson, et al., 2012; Ansell & Gash, 2008). Consequential incentives can be direct and tangible, benefiting the bottom line or goals of an individual or organization. They can also be indirect, causing positive change in a broader social issue that has an effect on the individual or organization participating. Interdependencies go beyond incentives and reflect those benefits that arise due to organizations undertaking together something that benefits them and could not be accomplished alone. Interviewees were asked about what they see as the benefits from involvement in the Councils, both the staff perspective on what the Councils have to offer and the health partner perspective on what they have gained.

While some overlap existed, many of the benefits highlighted by the partners were not identified by the Council staff as incentives and vice versa.

“Food - we feed them. That is a major draw especially for our Wellness Council.” *Council staff*

“People love coming to our meetings. We have a pediatrician. She has meetings with way bigger players. She loves coming to our meetings because the meetings are interactive and positive.” *Council staff*

While Council staff often reported such things as food, materials, gifts, regular meetings, stimulating

meetings, and positive meetings as incentives for health partners to engage and stay engaged, the health partners interviewed did not identify similar meeting processes or “goodies” as relevant to their decision to be involved with the Council. Instead, they highlighted direct benefits like being involved in a Council that functioned as an effective environment for collaboration.

“When you walk into the Council you walk in with the vision and the heart for the community, it is not just for the organization. It is not about what I can do for the health department, it is about how I can be a benefit for the community. Everybody at the table has the same mind set and it can help determine if we are helpful or need to get out of the way.” *Engaged health partner*

“I really personally and professionally like finding places that are intimate enough that I can make a difference – a situation with a smaller group where you are able to work on hands on kinds of things and the --- Council looked like the place to get that done.” *Engaged health partner*

The health partners interviewed only mentioned collaboration itself, but the health partners in the focus group elaborated, explaining that clear roles and expectations are important as well as demonstrating shared accountability. Clear roles, ground rules, actively seeking broad participation, transparency, and trusted leadership are all features of a collaborative environment that can influence its effectiveness in achieving goals (Ansell & Gash, 2008). This type of well-structured collaborative environment, while not necessarily an incentive that all health providers will recognize as valuable when being recruited, may help sustain health partnerships. A collaborative environment that creates synergy and can lead to “breakthroughs in thinking and action” as a result of engaging diverse participants’ skills and knowledge (Lasker & Weiss, 2003) may have great potential to sustain the participation of health partners.

The Councils are well versed in the importance of effective collaborative processes. All of the Councils have been engaged by their primary funder, Colorado Department of Human Services, through its evaluation arm at the Colorado Department of Education (CDE) in an intensive collaborative

process survey. Many of the Councils were found to be highly successful as collaboratives, suggesting they are already poised to sustain health partnerships through their current structure.

**Key Finding 4:** While “goodies,” food, and positive, engaging meetings may not be strong incentives for new partners to engage, effective collaborations are important for sustaining health partnerships.

When health partners were asked what they gained as a result of their Council involvement, *direct benefits to themselves, their organization, or their healthcare practice* were the most commonly cited.

“Being involved puts you out there so the families and other providers know who you are. I volunteer for the 9 News Health Fair. I am involved in Early Screenings. It is also about trying to have a presence in the county.”

“Partially to increase awareness of the WIC program amongst other people in early childhood in the community and to see if there was a way to work together to increase services for clients too.” *Engaged health partner*

“The ability to network with other early childhood professionals in the community so they are aware of our program and can refer.” *Engaged health partner*

While many health partners referenced similar personal and professional benefits, health partners in rural communities were more likely to frame these benefits in the context of network building (the importance of having a network and being part of a network, either for information sharing or referrals). While urban health partners highlighted similar types of professional benefits, they were less likely to explicitly reference “networks.” This is possibly driven by the fact that health partners in urban communities may be a part of a large practice or already connected in some other form of professional network and therefore not view the Council as one of their primary networks.

The non-engaged health partners were asked to talk about the other types of community service activities they undertake and the benefits gained from those activities. Similar to health partners’

description of the benefits of involvement in the Council, the non-engaged partners reported that their variety of other types of community service resulted in **increased referrals, provided them with greater professional and personal visibility, and expanded their professional networks**. This common thread among engaged and disengaged health partners suggests that these types of direct benefit are of value to health partners in many types of community service and should not be underestimated as a strategy for recruiting and sustaining health partnerships.

**Key Finding 5:** Health partners can achieve direct personal and organizational benefit from Councils and Councils should not hesitate to market these benefits.

While health partners consistently reported direct benefits from Council involvement, some health partners also identified benefits that went beyond meeting their professional needs.

“I can’t imagine [not being involved in the Council]! We would go back to having tunnel vision for only internal programs and a lack of knowledge about what else is available in the community that is funded through different federal, state or private funding streams. If these are not at your agency you do not always know about them. The Council helps so programs are not siloed in the community.” *Engaged health partner*

“A lot of the collaborative team work... It would fade without that weekly time and it would be filled with something else. Some of the things I have mentioned would still exist. The satisfaction part however would be much less and links would be broken.” *Engaged health partner*

“It has been refreshing to not feel like I am the only person that is working towards these goals and to have the early childhood health integration team that shares the same mission.” *Engaged health partner*

“I was one of the few very lucky people to get involved early in trying to connect the two. It is all connected. Half the kids I was working with failed health screenings. I was frontline for looking at the connection between education and health challenges. You have a kid with a chronic ear infection and you need to look at how that

impacts their behavior and ability to learn.” *Engaged health partner*

These same health partners reported a strong personal passion for making a difference.

“Yes, for [my] County it is really about what benefits the children and what is happening -- preventative measures, interventions, follow-up and long-term. This is my passion. At a manager level, I felt that I needed to help with any measures or program support.” *Engaged health partner*

“I think my greatest contribution is that I care very deeply. I am very good about bringing resources back to our team. Things that might be helpful to our team in their efforts to help our clients.” *Engaged health partner*

The personal passion articulated by health partners was sometimes specific to making a difference for kids, while other times it was more broadly about integrating the health system with other systems, and yet other times, even as broad as simply making a difference in their community. Regardless of the motivator, this suggests that some health partners come to the table for **both the direct benefit and to make a difference in their community**.

**Key Finding 6:** Some health partners also care about making a difference beyond their own personal benefit and believe the Council can help make that difference.

When asked what they would lose if they ended their involvement with the Councils, many health partners could articulate concrete dependencies with the Councils.

“[The Council] provides referrals to my clinic and consults with me about families (and directly connects families to additional service providers) and helps me by cataloging the relevant resources we have available in the community so that we know the resources and can connect families to additional resources.” *Engaged health partner*

“Patients would lose the most. We would lose ability for broader outreach to families.” *Engaged health partner*

“We would not know how to best help clients and refer them.” *Engaged health partner*

For many health partners, their biggest losses if they ended their involvement were the referrals of new clients, access to information, and the network of other organizations participating in the work of the Council. All three of these needs articulated by health partners are based on the Council having effective networks of organizations engaged.

Council staff also identified ways that they were dependent on their health partners.

“If we lost our health partners we would lose our lens, our eyes into what is going on in the community to increase accessibility, quality and availability of health care for children and families. We would not know. We would not be informed to help children and families with health care.” *Council staff*

“We would be in the dark. We would not do what we are doing. We can’t build the system unless we have the systems involved. We could not integrate health without health partners.” *Council staff*

Council staff discussed their need for health partners in order to move the system integration work forward, bringing diverse perspectives into their dialogues, identifying gaps, and filling those gaps by providing critical community services. Council staff also recognized that health providers filled a critical role of helping them to access families, through their direct contact with many families in the community. Similar to the health partners needs from Councils, the Council needs from health partners will benefit from a broader engagement of health partners, as that will expand their access to families and the diversity of information brought to the decision-making table.

**Key Finding 7:** Health partners and Councils can achieve inter-organizational dependencies, which is a powerful strategy for sustaining involvement.

## SHARED DEFINITIONS OF THE PROBLEM AND SOLUTIONS

For a collaborative effort to be effective at causing systemic changes, rather than merely programmatic

changes, the partners in the effort need to have shared beliefs about the problem that needs to be solved and the potential solutions (Nowell, 2009). It does not mean all the solutions have to be known – in fact, uncertainty about how to best solve a problem can serve as “an impetus for collaboration” (Emerson, et al., 2012), but without agreement on the problem and basic assumptions about solutions, the collaboration would struggle to succeed.

The Councils have developed definitions of health integration and what successful health integration and systems building will look like in their community. Both Council staff and health partner focus group participants emphasized the importance of the Councils and their health partners having shared goals, vision, and expectations. However, among the health partners interviewed, half were largely unable to articulate the goals of the Council at a systems building level, instead being aware of a specific program or activity. This same group, when asked what health integration should look like in practical terms, provided responses there were partially aligned or not aligned at all with the Council’s definition of health integration and systems building.

For example, in one community, the Council defines health integration as a combination of connecting providers, engaging the education and healthcare systems, and seamless communication, all leading to comprehensive access to services for families of young children. In contrast, the health partner defined the integration of systems as:

“...empowerment of parents and families and communities to understand what normal child development is and what abnormal development is. The health care profession plays an integral role in that because families need to be better equipped with information. It is important to reach out to the families early and frequently.” *Engaged health partner*

This same health partner, when asked what her Council’s goals were, described specific screening programs, but had no familiarity with the broader systems building goals. While neither the Council or health partner’s definition of systems integration is wrong, they do not demonstrate alignment around shared goals and vision.



**Key Finding 8:** Some health partners have goals and beliefs about integrating health and early childhood systems that conflict with their Council's goals.

This is not to suggest that all health partners lack this alignment with their Councils. One Council's health partner very clearly understood and agreed with the goals of the Council as relates to health integration and three other health partners had goals there were aligned, if not entirely overlapping, with their Councils, though their direct knowledge of the Councils goals was weak. For example, in three cases, the health partner used similar language as the Council goal, though they did not report being familiar with it, with ideas that were largely overlapping, but also added a personal focus, such as a strong interest in Medical Home as the future of primary care.

Notably, the health partners who were more aware of and in agreement with the goals of their Councils differed in their motivation for being involved with the Council than the four health partners who were the least aware of and in alignment with the Councils goals. Health partners *whose goals were not in alignment largely reported incentives to participate that had direct benefit to them* and their organization. Health partners whose goals aligned reported incentives to participate that directly benefited them and their organization, but also less tangible benefits related to the overall improvement of the system and access for families.

**Key Finding 9:** Health partners who do not share the goals of the Council are coming to the table for personal benefit reasons, while health partners who do share the goals value both personal benefit and making a difference.

## RECOMMENDATIONS

Colorado Early Childhood Councils were developed through legislation to be a mechanism for integrating services and supports to meet the needs of the whole child. The Councils have experienced many successes in strengthening other key early childhood system domains, such as early education

and often family support and parent education. Integrating health partners in their efforts has been a more recent area of focus for many Councils. While this area presents ongoing challenges for the Councils, they have also been successful at engaging many health partners.

While they are successfully engaging health partners, Councils also continue to face barriers and disconnects in their understanding of what brings health partners to the table. This brief provides an opportunity to learn from the experiences of both the Council staff and their health partners, providing Councils with new ideas for how to engage and sustain engagement of their health partners. Ultimately, the brief strives to capture what strategies may be most effective in moving Early Childhood Councils' efforts at engaging health partners from concept to implementation.

### Recommendation 1:

Clearly identify the levels of partnership needed on the Council and recruitment strategies specific to those levels.

The findings indicate the Councils have at least two distinct types of outcomes they want to achieve through health partnership and they do not have to be achieved through the same health partners:

- **Network Partners.** Councils see value in engaging health partners in order to expand their ability to communicate with families. This suggests a broad network of health partners who see direct benefit from participating with the Council, who are willing to implement activities of the Council and who will share information directly with families.
- **Collaborative Partners.** Councils want to bring the perspectives and knowledge of health partners into their decision-making. This suggests a targeted group of highly engaged health partners, willing to invest time and energy into systems building for reasons that go beyond direct benefits.

While some health partners might be in both groups, not all health partners need to be in both groups for the Councils to accomplish the outcomes they

articulated as important from health partnerships. For this reason, recruitment strategies could focus on each of the two tiers:

- **Recruiting Network Partners:** These providers may be the individuals who are primarily interested in direct benefits to their practice or who have limited availability. Some health providers who were interviewed were primarily interested in direct benefit to them and their organization, did not demonstrate a familiarity with the goals of the Councils, and yet remained involved as health partners due to the benefits they were receiving. This may mean that recruitment strategies for this group do not need to focus on the big picture goals of the Council, but instead could focus on the immediate asks and benefits of involvement.
- **Recruiting Collaborative Partners:** Some providers interviewed articulated benefits from Council involvement that went beyond personal interest and focused on broad community benefit. Many of these providers were either familiar with their Councils goals or had personal goals for involvement that aligned with Council goals. This suggests that recruiting these health partners may benefit from clearly articulating system building goals and learning from the health partners about their goals for making a difference in health integration.

### **Recommendation 2:**

Focus on indirect recruitment strategies that leverage community leaders and existing health partners.

Health partners consistently reported that they were recruited through indirect means, often based on relationships with leadership level stakeholders on the Council or others in their professional networks. Some health partners also approached the Council themselves, based on their knowledge of the Council and its positive reputation. In contrast, Council staff reported a wide variety of direct recruitment strategies, bringing information about the Council directly to providers to encourage them to join. Based on the findings, strategies Councils may want to consider as alternatives to direct outreach from Council staff include:

- Leveraging the existing relationships and reputation of Council leaders to outreach into the community and build interest among health partners to participate;
- Build relationships with key individuals (e.g., agency directors) and groups (e.g., the medical society) in the community who have access to health providers, with an ask for them to help identify and connect the Council with health providers in their network; and
- Building the visibility and clout of the Council among professionals in the community, including articulating the Council members' access to decision-makers and leaders, opportunities to make influential decisions, respect in the community for their involvement, and other direct benefits of being involved with such a high visibility effort.

### **Recommendation 3:**

Focus on the direct and indirect benefits of partnership, including building your evidence of those benefits.

Health partners consistently reported that participation with their Council has had direct benefit to them and their practice/programs. These benefits include such things as an increased professional network, increased referrals into their organization, increased knowledge about resources for their clients, and increased personal and professional visibility and reputation. Some health partners also reported that participation allowed them to benefit in less tangible ways, such as making a difference in their community, addressing health integration challenges that are important to them, and acting on their passion for helping children and families. To assist in recruiting new health partners as well as helping current health partners articulate the benefits they are gaining, Councils may want to:

- Create mechanisms to explicitly encourage and track referrals to and from health partners and then report overall findings to current and potential health partners;
- Create mechanisms for building greater visibility of health partners in the community and track

these opportunities in order to report back to current and potential health partners;

- Create mechanisms for health partners to report back to each other or the committee they are attending on the benefits of the network of relationships formed through their work with the Council, and capture those anecdotal examples to share with potential health partners;
- Measure systems building outcomes and report them back to health partners, sharing information about how they are making a difference in their community; and
- Learn from health partners what they want to know in order to better understand the impact of their involvement with the Council and find ways to measure and report back.

## CONCLUSION

The scope and variety of strategies utilized by the twenty-five Health Integration grantees provides not only rich information, but tangible, replicable tactics for effectively engaging health partners. Councils operate within the constraints of available capacity and resources, which emphasizes the need for refining and narrowing engagement strategies to those that are the most likely to succeed.

These three recommendations are generated directly from the experiences of Councils and their health partners, focusing on what is most likely to be successful. They reflect the successes that Councils have experienced and the unique perspectives of their health partners. Successful recruitment of health partners creates tremendous opportunities for benefit, both to Councils and the partners. As one primary care physician shared, until he was actively engaged in his Council, he didn't realize the naturally symbiotic relationship between his

practice and the Council and can now articulate how that relationship results in direct, immediate benefits for his clients.

The findings and recommendations of the brief are encapsulated in an *accompanying toolkit* to ensure that this brief is a living document and that the Councils are equipped with a user friendly tool to apply these recommendations to their own efforts to engage health partners in strengthening systems of support for young children.

## REFERENCES

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Want practical tips to take action on the information in this brief? Tips and tools for engaging health partners can be found at [www.sparkpolicy.com/ECC](http://www.sparkpolicy.com/ECC)

The toolkit and brief are part of the evaluation of the Early Childhood Health Integration Initiative of The Colorado Trust. Visit [www.coloradotruster.org/grants/show-grant?id=33](http://www.coloradotruster.org/grants/show-grant?id=33) for more information.