



THE  
COLORADO  
TRUST

ACHIEVING ACCESS TO HEALTH FOR ALL COLORADANS

November 2012

# EVALUATION

## Improving Access to Health Through Collaboration:

*Lessons Learned from  
The Colorado Trust's  
Partnerships for Health  
Initiative Evaluation*

BY DAVID BARTSCH, ANDREW KELLER, PHILLIP CHUNG AND CHRIS ARMIJO

## » KEY LESSONS LEARNED

*Evaluation findings and lessons learned by the wide array of public and community-based organizations that participated in The Colorado Trust's Partnerships for Health Initiative offer important lessons to help health care organizations better coordinate and align their services and systems and, in turn, to improve health outcomes. Key factors that were considered important to strengthening and sustaining local health collaboration were:*

**LEADERSHIP** – The participation of key community leaders was critical to providing collaboratives with insights and understandings unique to their community needs and potential solutions, and conferred a greater sense of credibility to each collaborative's efforts.

**BUY-IN** – Ownership of the process of the collaboration, as well as the outcomes of the collaborative's efforts, were essential to success. Such buy-in allowed partners in community collaboratives to form relationships and develop trust, resulting in their ability to focus on the work of the collaborative, and to look beyond the needs of their individual organizations.

**STAFFING** – In many cases, the collaboratives' efforts were significantly advanced by a formal project coordinator who could devote time to organize activities of the collaboration, and provided the supports necessary to maximize stakeholder participation.

**DATA** – The collection and use of data was crucial to many of the collaboratives in being able to accurately identify community needs, implement their respective projects and to make appropriate decisions.

**TECHNICAL ASSISTANCE** – External technical assistance was a critical supporting factor for all of collaboratives. In particular, meeting facilitation by a neutral party, especially at the outset, was cited as important.

### THE COLORADO TRUST

The Colorado Trust is a grantmaking foundation dedicated to achieving access to health for all Coloradans.

Phillip Chung and Chris Armijo are with The Colorado Trust

### TRIWEST GROUP

TriWest is a human services evaluation and management consulting company in Boulder, Colorado.

David Bartsch, PhD and Andrew Keller, PhD are with TriWest Group

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## » LETTER FROM THE COLORADO TRUST

Strengthening Colorado communities' ability to solve their own problems has been a cornerstone of The Colorado Trust's grantmaking since its first initiative – Colorado Healthy Communities – began in 1998. Continuing in that tradition, in 2005 the board of trustees authorized an assessment of community needs and possible solutions related to the Department of Health and Human Services (HHS) Healthy People 2010 goals. The findings from this assessment illuminated the frustration community members felt with the lack of coordination and infrastructure for strong public health services.

Following the needs assessment, further research conducted by Trust staff pointed to the need to develop local health partnerships as a means to better align, coordinate and publicize health care services. The Trust believed that such partnerships would build strong working relationships among various organizations and agencies, and would be able to address health needs in a more systematic and effective manner.

As a result of this research, in 2006 The Trust launched its six-year, \$8.6 million Partnerships for Health Initiative (PHI). The goal of this initiative was "to build, strengthen and sustain the infrastructure of Colorado communities to address ongoing public health issues." In addition to funding 13 communities and a technical assistance provider, The Trust funded TriWest Group to conduct an independent evaluation of the initiative. The primary purpose of the evaluation was to help The Trust and others better understand the collaboration process communities went through, and identify the factors that helped or hindered those collaborations. A secondary purpose was to link the collaboration process with the specific Healthy People 2010 outcomes each community partnership chose to address.

All 13 grantees made progress toward a stronger Colorado public health system. This report highlights the lessons learned from in-depth case studies conducted with four of the grantees – Chaffee People's Clinic, Ignacio Community Collaboration, Northwest Colorado Community Health Partnership and San Luis Valley Health Access Program. These four grantees were selected for the case studies because they chose the same Healthy People 2010 focus area – "Improved access to quality health services." The ability to look at four communities addressing the same issue was an opportunity to examine cross-grantee lessons.

Solving a problem as complex as the fragmentation of our public health system will take years and countless resources – both financial and human. Coming together across multiple agencies and organizations to create authentic collaborations is a critical component of this effort. The accomplishments these four communities achieved and the collaboratives they created will help to reduce fragmentation of services and improve access to health for the residents of these communities. We hope their lessons, shared in this report, will also help other communities to improve their abilities to work together to advance access to health.

Sincerely,



Nancy B. Csuti, DrPH  
Director of Research, Evaluation & Strategic Learning

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## » INTRODUCTION

The U.S. public health system has been described as “the broad range of organizations and partnerships needed to carry out essential public health services – including governmental agencies, non-governmental health organizations and other private and community-based organizations, such as businesses, schools, churches, nonprofits and foundations.”<sup>1</sup> Experts have underscored that community partnerships are an essential element of improving the ways in which health care services should be designed and implemented to meet community needs. As such, they envisioned a future whereby “As the scope of the public health enterprise increases, new partnerships must be forged to increase collaboration in communities . . . Practitioners will be called upon to engage with community partners through structured dialogue designed to reveal the fundamental values and needs of the community.”<sup>1</sup>

Yet, achieving the vision of partnership has not been easy. Too often, community organizations that operate in the same community are disconnected or misaligned. Consequently, congruency in community health planning and service delivery has, in many cases, been challenging to fully realize.

To address this challenge, the need to overcome fragmentation in the public health and broader health care systems has been a major emphasis of reform efforts over the past decade. In 2004<sup>2</sup> and 2006<sup>3</sup>, efforts to transform public health emphasized the importance of regional planning and broad partnerships to address a range of issues from preparedness to access to care, citing both opportunities and challenges related to the partnership process. More recent examinations of the evolving role of the public health system in the era of health reform have focused on its expanded role in addressing the challenges of chronic illness<sup>4</sup> and health disparities, particularly through the mobilization of community partnerships to address barriers to access to care.<sup>5</sup>

In the midst of this evolving national debate, greater attention was paid to creating tighter alignment within local communities in support of critical health care goals such as access to care. In response, The Colorado Trust commissioned a needs assessment in spring 2005 to identify Colorado-specific issues, as well as the best role for the foundation to take in helping communities collaborate and reduce fragmentation.

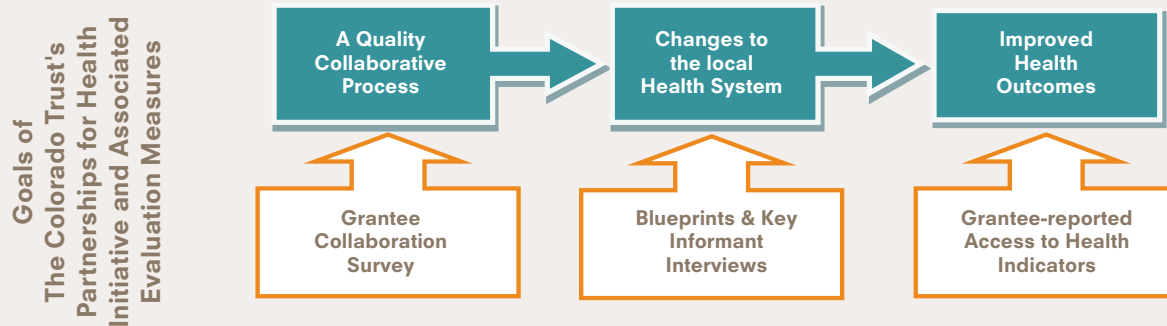
Key informant interviews and focus groups of state and local leaders were conducted within five regions throughout the state. Findings from the assessment pointed to two weaknesses in Colorado’s public health system:

1. A lack of coordinated services. In particular, a need to develop public and community-based partnerships to publicize services, collaborate with outside organizations and engage governmental and community leaders.
2. A need to improve public health leadership and communication between public and community-based organizations. Assessment results pointed to the need for these entities to augment the coordination and provision of health services and programs.

In response to the needs assessment findings, in 2006, The Colorado Trust launched the Partnerships for Health Initiative (PHI), a six-year, \$8.6 million initiative with 13 grantee organizations. The goal of PHI was:

- To increase the coordination of health services at the community level by providing planning and implementation grants to address local health issues.
- To develop, strengthen and sustain community partnerships through technical assistance and grantee networking programs.
- To improve communities’ health outcomes as related to the Healthy People (HP) 2010 focus areas.

Recognizing the complexity of fostering effective community collaborations, PHI had two phases. Phase I – Planning Phase – consisted of a 2-3 month planning process to help partnerships develop a coordinated plan to address a Healthy People 2010 focus area. Phase II – Implementation Phase – provided grantees with funds to implement their plan through their proposed or new collaborative partnerships.



Throughout the initiative, the 13 PHI grantees were provided a number of resources to support their success; The Trust selected The Center for Public-Private Sector Cooperation at the University of Colorado Denver (The Centers) to provide training and technical assistance. The technical assistance included meeting facilitation, assistance on best-practices in community-organizing and collaboration, and assistance with identifying and tracking Healthy People 2010 outcome indicators that grantees identified in the planning process. Additionally, The Trust coordinated technical assistance and opportunities to network among PHI grantees via trainings and all-grantee meetings.

An independent evaluation of PHI was conducted by TriWest Group, a human service evaluation and consulting company. This evaluation report describes the findings from the Partnerships for Health Initiative, including a set of lessons learned and recommendations designed to inform other funders who seek to foster local health partnerships to improve local health systems and health care access.

## » EVALUATION QUESTIONS AND METHODOLOGY

### Evaluation Questions

The Colorado Trust identified four evaluation questions for the evaluation to answer:

1. Do local community health partners increase coordinated health services and strengthen collaboration over time?
2. What factors lead to increased coordinated health services and strong partnerships in the various communities?
3. Is the ability to coordinate health services in response to public health issues sustained beyond the lifetime of The Trust's initiative?
4. Do the HP2010 health outcomes as selected and tracked by the grantees improve at the community level?

However, it became clear that answering these questions across 13 grantees, all doing considerably different work and addressing different HP2010 goals, was not possible. In December 2009, the evaluation plan changed to make use of a case study approach to answering questions 1, 2 and 4 using a systems framework for a sub-set of grantees who were all working toward the same HP2010 goal of increasing access to quality health services: The four case study grantees were: Chaffee People's Clinic, Northwest Colorado Visiting Nurses Association, San Luis Valley Health Access Program and Ignacio/Southern Ute Community Action Program, and the evaluation questions were rephrased as:

1. Does the work of local collaboratives contribute to improvements in their local health system?
2. Do the grantees' access-to-health outcomes improve as a result of these system changes?
3. What factors lead to or impede improvements to local health systems?
4. What recommendations can be made to The Trust and technical assistance providers about how to fund and manage systems-change strategies?

## Evaluation Methodology

Two rounds of data collection were conducted (2010 and 2011). Case study data were gathered primarily via key informant interviews with 5-10 stakeholders per grantee site; stakeholders included the project director and community partners with in-depth knowledge of the respective site's efforts to improve health care access. Case studies were supplemented by grantee-level data from: 1) an annual online collaboration survey designed to assess the level of collaboration among grantees community partners, including measures to assess the collaboration process and structure;<sup>6,7</sup> 2) Project blueprints, a visual depiction of a local system's structures and relationships; and 3) grantee progress reports to The Trust, which included self-reported tracking of indicators for grantees' Healthy People 2010 outcomes (for a full description of the data collection methods, please see Appendix A, available online at <http://tinyurl.com/cl4zvat>).

### Case Study Sites

While each of the case study sites focused broadly on increasing access to health care services, grantees adopted a different focus (for the complete grantee case study reports, please see Appendix B, available online at <http://tinyurl.com/cl4zvat>).

#### CHAFFEE PEOPLE'S CLINIC

In 2005, a group of community leaders in Chaffee County, in central Colorado, sought to improve access to health care services in their community. Through a needs assessment, including review of data from a 2003 county health assessment, information about emergency room visits to the local hospital, dialogue with community residents, and their own knowledge of the conditions in the community in regards to access to health care, their PHI project created the Chaffee People's Clinic (CPC), a community-based provider of primary care services for uninsured and underserved people living in Chaffee County. CPC offered day and evening clinic hours in space provided by the county's health department and staffed mostly by volunteers, including a volunteer medical director and medical providers. CPC's goal was to improve access to quality health services by increasing the number of individual receiving services at the clinic and reducing the number of people receiving care at the local hospital's emergency room.

#### IGNACIO COMMUNITY COLLABORATION

The Ignacio Community Collaboration (ICC) project was organized in fall 2005 to increase access to mental health services in the Ignacio area, in southwestern Colorado. Ignacio is described as a "tri-ethnic" community, with a roughly equal ethnic split among American Indian, Hispanic and Caucasian residents. The new partnership involved a diverse array of partners, including local health agencies, the school district and mental health providers. The ICC's goal was to develop a sustainable system for delivering and coordinating initial emergency mental health interventions locally for children and adults. The collaborative's vision included the expansion of mental health services to early childhood populations and the development of training and education services for professionals and community members.

#### NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP

Led by the Northwest Colorado Visiting Nurse Association, a coalition of seven organizations all representatives of local and regional health and human service agencies, partnered to address the health care needs of the underinsured and uninsured of the four-county region that includes Jackson, Moffat, Rio Blanco and Routt Counties. Through PHI, the Northwest Colorado Community Health Partnership had four primary goals: 1) to develop a regional network of care, 2) to provide health-related consumer information, 3) to expand the use of technology to support accessible health care services and communication and 4) to sustain the regional network of care.

#### SAN LUIS VALLEY HEALTH ACCESS PROGRAM: CAREPOINT

CarePoint was a newly developed program through PHI designed to address the health care needs of the underinsured and uninsured in the six-county San Luis Valley in South Central Colorado; the counties are Alamosa, Costilla, Conejos, Mineral, Rio Grande and Saguache. The partnership was comprised of representatives from local and regional health and human service agencies, the County Commissioners, business leaders and the faith community. Based on enabling legislation that established pilot programs in rural counties to provide access to health care for individuals and families, CarePoint's goal was to enroll individuals employed by employers in the San Luis Valley so that they could receive services from local providers at a reduced cost.

## » SUMMARY OF FINDINGS

### EVALUATION QUESTION #1:

### Does the work of local collaboratives contribute to improvements in their local health system?

Overall, survey data indicates that each of the local collaboratives worked effectively and cohesively to implement their respective PHI projects. Partners reported that these positive indications of collaboration manifested specifically by:

1. Allowing partners to develop a sense of ownership of the project and be driven from within the community
2. Fostering a collective decisionmaking process that aligned with the context and true needs of the community
3. Providing partners with an ongoing focus on a defined problem in order to have a concrete community impact
4. Generating new understanding around the iterative and ongoing nature of local health systems change, particularly concerning the identification and prioritization of collaborative goals.

Likewise, it appears based on changes in project blueprints and key informant interviews, there were improvements regarding health care access systemically. Notably, there was a reduction or elimination of barriers to access and services, the establishment of structured program activities and linkages among service providers, and more organized processes for information sharing and care coordination among providers. Two grantee examples highlight these local health system changes:

1. Through the Chaffee People's Clinic project, the establishment of health clinics in Buena Vista and Salida enabled the reduction of barriers to health care services and improved referrals for services not provided directly by the clinics. These systems changes resulted in:
  - An emergent dental care voucher system accepted by all the dentists in the county, whereby a \$100 voucher was provided to clinic users for emergency dental care.
  - A voucher system with two local pharmacies provided patients with needed medications at a lower cost.
  - An agreement with an ophthalmology practice to see CPC patients with diabetes at a reduced cost.
  - Establishment of a patient assistance fund to aid patients in accessing specialty medical care beyond those services offered by the CPC.
2. Through the Northwest Colorado Community Health Partnership (NCCHP), the collaborative improved the integration and coordination of health care access and provision of health care services through:
  - Obtaining designations for Routt, Moffat and Jackson counties as Medically Underserved Populations (MUP).
  - Obtaining HPSA (Health Professional Shortage Area) designations for Moffat County for medical and dental providers.
  - Creating a common eligibility screening process that was used at three community health care agencies: the Northwest Colorado Dental Coalition, the Colorado West Regional Mental Health and Memorial Hospital. This common eligibility process facilitated access to care by utilizing a "no-wrong door" approach to health care access. Uninsured clients underwent eligibility screening at the Northwest Colorado Community Health Center (NCCHC), and their NCCHC sliding fee scale card was honored at participating agencies.
  - Coordinating delivery of care by integrating mental health and primary care services. A behavioral health therapist employed by Colorado West Regional Mental Health provided services at NCCHC. This therapist provided a key link between primary care and mental health services and promoted access to behavioral health services by providing onsite care and coordinating the delivery of care among providers.



- The Yampa Valley Medical Center in Steamboat, as part of NCCHP Medical Transportation Committee plan, provided funding in early 2011 to offer transportation services once a week to the clinic in Craig. The Community Health Center scheduled appointments for the weekly van service and provided transportation to and from the clinic for an average of six people per week.
- Early efforts to integrate NCCHP activities with health care reform, including the Health Care Policy and Financing Accountable Care Collaborative for Medicaid and health information exchange (HIE) efforts.

Certainly, much work needs to be done in order to sustain these changes. However, the progress made under the PHI strategy indicates that the grantee collaboratives made significant contributions to how their local health care systems operated.

## EVALUATION QUESTION #2:

**Do the grantees' access to health outcomes improve as a result of these system changes?**

While the evaluation indicates changes to grantees' local health systems, the purpose of the initiative was to increase Healthy People 2010 outcomes as a result of the systems changes. Grantees selected and/or modified specific metrics based on the Department of Health and Human Services (HHS) Healthy People 2010 Leading Health Indicators.<sup>8</sup> To this end, "access to health" was primarily defined and measured by an increase in the number of non-duplicated people served over the course of the PHI project.

### THE CHAFFEE PEOPLE'S CLINIC (CPC)

**SELECTED OUTCOMES:** *The number of people receiving services from the Clinic (with a goal to increase the number over time) and the number of people going to an emergency room for non-urgent care (with a goal to reduce this number as more people used the CPC as their ongoing source of care).*

Access to health care services as defined by those two indicators has improved in the community as indicated by the Chaffee People's Clinic project via their self-reported indicator results because of the establishment of the clinic. Progress reported by the project indicates a steady increase in the number of people who received health care services since the inception of the clinic in October 2006. By the end of May 2010, the clinic had provided services to over 1,400 new patients and had logged over 4,600 clinic visits, as shown on the project-provided table below.

### Cumulative Report Since Clinic Inception

	2006 Oct - Dec	2007 Jan - Dec	2008 Jan - Dec	2009 Jan - Dec	2010 Jan - May	Totals
Total New Patients	82	393	315	420	194	1,404
Total # Patient Visits	122	940	1,117	1,580	850	4,609

Also, consistent with its goal of increasing access to care in a clinic setting and reducing the incidence of people seeking care through a hospital emergency room, the CPC surveyed clinic patients in mid-2008 and determined that 14 percent of the patients receiving services through the clinic at that time had previously been relying on the hospital emergency department as their primary source of medical care prior to obtaining services from the CPC. In 2011, CPC reported that people were now routinely referred to the CPC from the hospital emergency department for management of chronic conditions, creating an opportunity for patients to establish an ongoing source of care and enhanced care continuity.

Overall, the number of new patients seen and the number of patient visits at the CPC have increased over time, despite operational challenges, such as the need to secure adequate space for the Salida clinic to conduct business, and a temporary drop in demand at the Buena Vista site that necessitated scaling back available clinic hours there until marketing and outreach efforts could take hold. Ultimately, these efforts resulted in an increase in demand, leading to the placement of an additional provider at that site.

**IGNACIO COMMUNITY COLLABORATION (ICC)**

**SELECTED OUTCOMES:** *Increase the number of adults age 18 and above who receive mental health service and increase the number of children and youth under the age of 18 who receive mental health services.*

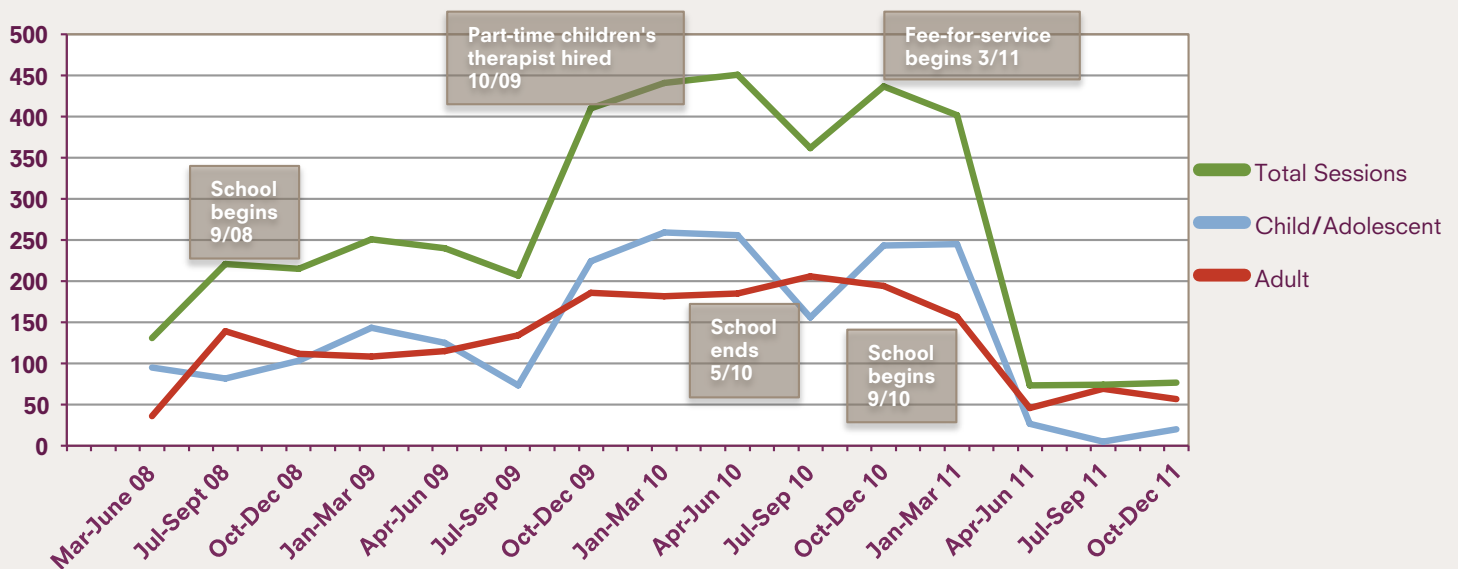
The ICC did not have information on community rates of persons with mental health issues who needed treatment, nor did it have community rates of individuals in treatment, so it chose to track the unduplicated number of persons receiving mental health services through the ICC project.

The ICC final progress report indicated that a total of 282 unduplicated persons received services; 143 adults and 139 youth. Key informants shared that the number of people seeking services has decreased due to the attempt to implement a fee-based service model. As presented in their final progress report... many here benefit from free services of many kinds because of their status as tribal members. "Others here find it difficult to pay for services even though we have developed a generous sliding fee scale and a low base rate. There is a need for a paradigm shift toward the value of services before many community members are willing to pay for mental health services." Based on key informant responses, the ICC continues to work to find a solution to sustaining the program.

The graph (Figure 1) shows the number of sessions provided over the course of the project. These data show that the number of sessions provided increased over the course of the project until March 2011. The addition of a part-time children's therapist in October 2009 contributed to this increase, along with the positive trend for sessions to adults. The graph displays the dramatic reduction in sessions after a fee-for-service system was implemented as an attempted sustainability effort in March 2011.

Throughout most of the project, access to mental health care services improved in the community, and this increase can be attributable to the increased availability of locally-based mental health services through the ICC. The numbers dropped in the last six months, demonstrating the difficulty in implementing a fee-based funding strategy.

**Figure 1**  
**ICC Mental Health Sessions by Quarter**

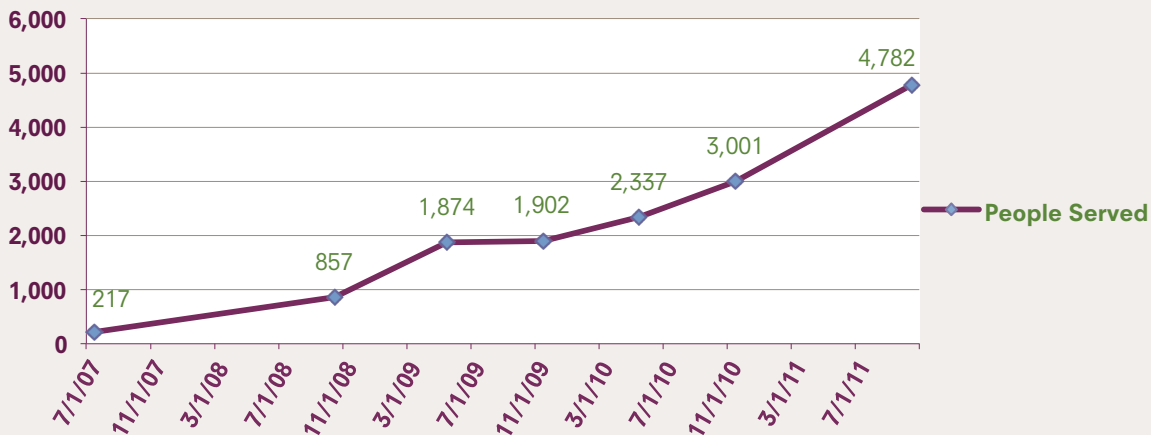


## NORTHWEST COLORADO COMMUNITY HEALTH PARTNERSHIP (NCCHP)

**SELECTED OUTCOME:** *Increase the number of unduplicated patients who have a specific source of ongoing care, specifically through the Northwest Colorado Community Health Center (NCCHC).*

By July 1, 2007 the NCCHC had provided health services to 217 individual clients (Figure 2). That number increased consistently to the point where over 4,700 unduplicated clients were served as of October 12, 2011, as shown in the figure below. The subgroup of people who received behavioral health care increased over that period from 60 in November 1, 2008 to over 1,300 by October 12, 2011.

Figure 2  
Cumulative Unduplicated People Served by NCCHC



Other access-to-health outcomes also have improved. Implementing the health center and serving new clients rippled throughout the community and brought about further positive change. In this case, as reported by key informants, serving people in the health center has resulted in a decreased use of emergency care for health care access and improved resource utilization through the eligibility process, and ultimately increased support from the Yampa Valley Medical Center through not only participation in the collaborative but also by financial support for transportation to the health clinic for people who have no transportation. Another example of improved resource utilization resulted from the development and implementation of a shared sliding fee eligibility process. That process has meant that each agency no longer has to assess eligibility when a person presents for services. Once eligibility is established the person simply presents an eligibility card.

## SAN LUIS VALLEY HEALTH ACCESS PROGRAM: CAREPOINT

**SELECTED OUTCOME:** *Increase the number of people with health coverage.*

CarePoint's initial work focused on connecting representatives from the local and regional health and human service agencies, the County Commissioners, business leaders and the faith community to form a partnership. The partnership's first project was to research various models of health access. The findings of this research pointed to the need to secure state legislation to enable their partnership to create a program to help employers in the San Luis Valley provide affordable health care coverage to their employees. Modeled in large part on the similar pilot Health Access Program in Pueblo, Colorado, CarePoint helped to develop such a policy solution – House Bill 09-1252 – which was passed by the Colorado Legislature in 2009.

CarePoint obtained nonprofit 501(c) (3) status for its pilot program and initiated a marketing and enrollment plan. Community meetings were held to gather input as to which services to include in the benefit package. As well, CarePoint worked with the San Luis Valley HMO to provide third party

administration services, determined reimbursement rates, and developed formal relationships with health care providers to provide services to enrolled employers and employees. CarePoint's services started May 1, 2010 with five participating employers and 55 employees enrolled. Those numbers grew to 27 employers and 97 employees by August 15, 2011. While key informants were very positive about the initial results, there was agreement that it was too early to have the numbers demonstrate impact.

Despite the differences in grantee communities, a set of cross-cutting factors emerged that served to facilitate or impede their progress in forming collaborations to improve the local health system.

### EVALUATION QUESTION #3:

### What factors lead to or impede improvements to local health systems?

#### Key Facilitating Factors

##### *Leadership: Technical expertise*

Key informants consistently expressed that community leaders not only brought guidance to project activities, but also knowledge of their segments of the health system and individual subject matter expertise in their respective fields. This technical expertise allowed the collaboration process and respective grantee projects to advance with greater effectiveness. In particular, their unique insights and understanding of the community's health care needs and challenges helped expedite the formulation of potential solutions.

*"A few key community leaders shape the way medicine is practiced and the kind of health care their community gets."*

– Atul Gawande  
Better Outcomes, Lower Costs: *How Community-Based Funders Can Transform U.S. Health Care. A Conversation with Atul Gawande*  
by Mark Kramer, FSG, Spring 2012

##### *Leadership: Influence and legitimacy*

Key informants reported that participation of community leaders conferred a stronger sense of credibility to the collaboration. For example, Chaffee People's Clinic (CPC) reported that the involvement of influential community leaders, such as physicians and local public health officials, appeared to serve as the catalyst to their system change efforts, which ultimately transcended many initial concerns. Their involvement lent further credibility to the CPC and helped it to be more widely perceived as a grassroots collaborative effort originating within the community. Moreover, the influence of key leaders also manifested in in-kind support from each of the respective leaders' organizations, such as in providing meeting space or planning time. In turn, the collaborative attained greater capacity to accomplish their PHI work plan.

##### *Community-focused collaboration*

Key informants reported that local health systems change was more likely if the collaboration was based on community-buy in and ownership. This community-based focus translated to stronger relationships between collaborative partners and a sense of mutual trust among partners. In addition, this focus provided a basis in which the collaborative implemented projects that met the true needs of the community. For example, with the Ignacio Community Collaboration (ICC), community ownership allowed them to sharpen their focus on the real needs of their tri-ethnic community, while also drawing on the local knowledge and expertise of its partners to develop a solution. Accordingly, while the ICC initially involved basing the mental health services 24 miles away in Durango, Colorado, this initial decision contributed to the profound sense that Ignacio's community members are often marginalized or neglected with regard to resources and service availability. As a result, health service decisions are often made in Durango without taking into consideration the needs of Ignacio. However, the subsequent decision to base and center services in Ignacio contributed to a feeling in the community that the effort was now "theirs" and that the community had the power to set its own course.

##### *Dedicated staffing for the collaboration*

A key factor in advancing grantees' efforts was the formal project coordinator who oversaw and organized many of the collaborative's activities. This person served as the pillar of the collaborative and provided the necessary organizational planning that allowed the projects to advance. In addition, as

key informants from NCCHP noted, the project coordinator’s skill at bringing participants together and coordinating and managing project activities enabled the project’s work to get done while maximizing the effects of the community leaders’ participation. Conversely, another grantee noted that while a central coordinating figure is important, the workload for project tasks among partners must be evenly distributed, otherwise project progress is jeopardized.

### ***Information-based decisionmaking***

Data served as a foundation to both identifying community need, conceptualizing the specific project and how the project would be implemented. For example, NCCHP reported that it was important to base decisions on needs assessments and other community and agency data. In particular, NCCHP stakeholders noted that bringing together assessment pieces, health disparities and organizational knowledge, input from focus groups and key informant interviews and discussions with consumers about their needs ensured a broader understanding of needs and facilitated discussion of how to better meet those needs.

### ***Technical assistance***

The technical assistance provided by The Centers was also seen as a key factor in supporting grantee efforts, in particular meeting facilitation in the planning phase of the project. For example, key informant respondents in the San Luis Valley cited the importance of neutral facilitation by The Centers in the development of the goals and mission statement and in making sure each participant was heard. At the same time, respondents noted there were specific areas of technical assistance, such as information technology and ongoing needs assessment, which could have been expanded.

These factors are certainly not novel to the effective practice of community collaboration. In fact, these factors underscore and complement other paradigms of effective collaboration. Two prominent parallels are evident through concepts advanced by FSG and The Bridgespan Group. FSG has outlined the notion of “collective impact” in which social change can be driven by broad cross-sector collaboration and coordination, rather than isolated interventions.<sup>9</sup> Similarly, The Bridgespan Group has forwarded the idea of “needle-moving community collaboratives,” an approach that engages multiple sectors in a community in order to achieve at least 10 percent progress in a specific community-metric.<sup>10</sup> Put side-by-side, there appears to be some similarity in the conditions that foster effective collaboration and ultimately yield results across the three paradigms.

Collective Impact (FSG)	Needle-Moving Community Collaboratives (The Bridgespan Group)	Partnerships for Health
<ul style="list-style-type: none"> <li>■ Common agenda: All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.</li> <li>■ Shared measurement: Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.</li> <li>■ Mutually reinforcing activities: Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.</li> <li>■ Continuous communication: Consistent and open communication is needed across the many players to build trust, assure mutual objectives and create common motivation.</li> <li>■ Backbone support: Creating and managing collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.</li> </ul>	<ul style="list-style-type: none"> <li>■ Shared vision and agenda, in which leaders from government, nonprofit, philanthropy and business develop measureable community-wide goals and a clear roadmap to achieving them.</li> <li>■ Effective leadership and governance, with highly respected leaders at the helm who are viewed as neutral, honest brokers, and who attract and retain a diverse group of large and small organizations to guide the collaborative forward.</li> <li>■ Alignment of resources toward what works, where nonprofits, government, philanthropy and business work together to target efforts and resources toward the most effective approaches and services.</li> <li>■ Dedicated staff capacity and appropriate structure to provide the facilitation, data analyses and administration needed for success.</li> <li>■ Sufficient funding to maintain staff and invest in the strategic priorities of the collaborative.</li> </ul>	<ul style="list-style-type: none"> <li>■ Community-focused collaboration: Stakeholders have shared ownership and buy-in, which can result in stronger organizational relationships.</li> <li>■ Leadership: A wide array of community leaders contribute their technical expertise, knowledge and influence to the collaboration.</li> <li>■ Information-based decisionmaking: A variety of data informs the process and outcomes of collaboration.</li> <li>■ Dedicated staffing: Formal staffing of the collaboration provides the necessary coordination, planning and skills to advance the collaborative’s efforts.</li> <li>■ Technical assistance: Providing ongoing support for the collaborative, which adapts to the needs of the collaborative.</li> </ul>

## Key Impeding Factors

### *History of collaboration: Moving from self-interest to the collective*

In some cases, grantees reported that previous collaboration efforts were useful starting points for the PHI project. Conversely, grantees also noted that some past efforts were characterized as siloed and fragmented. As a result, different sets of stakeholders tended to look after their own defined interests, rather than the collective interests. This historical context, at times, presented a challenge for grantees as they sought to foster new or renewed collaborations. Accordingly, some grantees reported that the process of building the collaboration was time-intensive and required explicit attention to past experiences.

### *Sustained partner participation*

Some grantees reported that it was difficult to either engage key partners in the collaboration and/or sustain their participation over time. Reasons for the lack of participation vary widely from concerns about potential competition as a health service provider to incompatible interests to, in one case, the challenge of dealing with city/county authorities and processes.

### *Resource limitations tied to the economic context*

Uniformly, grantees reported that the economic context (i.e., the national recession, decreasing availability of state and local funding, loss of local jobs) significantly contributed to the type and amount of local health systems change that was possible. The resource limitations manifested in multiple ways, including the capacity of grantees to secure additional funding to continue the collaborative and the capacity of partners to fully commit time and staff resources to the collaborative. One grantee, however, viewed the economic contextual challenges as an impetus to participate in the collaborative in order to utilize the available resources most effectively.

### *The rural area challenge*

Three of the four case study grantees specifically noted that implementing a collaborative project in a rural region presents unique challenges. Most notably, grantees reported that transportation was a significant barrier insofar as it affected clients' ability to access services and programs implemented by the collaborative. Another key challenge was the lack of available professional provider staff, particularly with respect to specialty care.

## EVALUATION QUESTION #4:

### What recommendations can be made to The Trust and technical assistance providers about how to fund and manage systems-change strategies?

Recommendations frequently stemmed from lessons learned by grantees. As a result, key lessons learned are presented below, followed by recommendations from grantees and the evaluators, which The Trust or other funders may consider in future funding of collaborative efforts.

## Key Lessons Learned

### 1. *Fostering a culture of genuine collaboration was fundamental to grantee successes.*

Key informants stressed that collaboration was only meaningful insofar as stakeholders were truly invested in the success of PHI. This investment required time and in-kind resources, as well as a genuine commitment. Accordingly, stakeholders emphasized that they could not have achieved their outcomes or the changes to the local health system as individual agencies. The process of collaboration allowed them to share perspectives on their part of the system of care and information about the needs being met and not being met. Planning and project activities stemmed from that collaborative process.

### 2. *Dedicating staff to the coordination and management of the collaboration was important to advancing the collaborative's work.*

Grantees reported that a key component to supporting a collaborative process was the explicit resource of a dedicated project director. Even with collaboration and planning, participants often don't have the time to guide the project's activities themselves, a role critically filled by the project director.



### 3. *Involve the right community players.*

Collaboration, particularly one focused on effecting how a local health system operates, cannot simply comprise an array of community partners who are able to participate in the collaborative effort. Identifying the key institutions and community leaders who have the will to enact changes is fundamental. Often, this identification process takes place informally based on past participation; however it is equally important to actively seek out the ‘unusual’ voices who may offer significant contributions. Certainly, each community’s context dictates who the ‘right’ players are, however key groups include local public health officials, hospital and community health clinics. Other groups to consider include social service agencies, schools, business groups and elected officials. Irrespective of who participates, the identification and recruitment process must be strategic and focused. Key informants frequently mentioned that the barriers to program success were often a result of non-participation or support on the part of key segments of the community, including hospitals, physicians and other service providers.

### 4. *The outcomes of collaboration must be clear, tangible and realizable from the outset.*

Certainly, though the act of collaborating was important, it was nonetheless insufficient in the absence of a clear and tangible set of outcomes that stakeholders agreed upon and ultimately organized their efforts around. Each case study grantee determined and iteratively revisited their desired outcomes. As a result, each of the four sites demonstrated that their programs resulted in improved access to health care. Although changes were grantee-specific and looked different across grantees, comparisons of pre-program and developed blueprints very clearly demonstrates this outcome. The numbers of people served increased, locally defined innovative methods for improving access were implemented and people and agencies in the community witnessed the successes and supported the programs.

### 5. *Collaborations can produce a leveraging effect.*

As a result of working together as collaboratives, grantees were able to leverage PHI as a basis for involving other funders and policy makers for ongoing technical assistance and support. Other funders and policy makers that became involved included the Colorado Health Foundation, the Colorado Department of Health Care Policy and Finance and even the legislature in the case of the San Luis Valley in order to implement the CarePoint program. This leveraging effect was seen in three of the four case study grantees.

### 6. *External influences, particularly those related to health care reform, affect programs and can result in new opportunities.*

The economic downturn resulted in decreased resources for all agencies and likely served to increase the number of underserved people. However, collaboration is a means that can result in more effective use of resources, as has been reported by key informants. Health care reform seeks to improve access to health care, but must continue to rely on existing programs for eligibility and services support. As the Affordable Care Act is implemented, both Chaffee People’s Clinic and CarePoint believe the need for their programs could be substantially reduced or possibly eliminated. However, given cutbacks in state support for Medicaid, it seems likely in the short-term that health care reform will not fully solve health coverage issues for all people. Instead, respondents reported they believe it is more likely there will remain a role for them to provide health care for the people who are not yet covered as a result of federal health care reform requirements. They also expressed that they value participating in health care reform efforts to help people gain access to coverage. For example, they have been assisting the people they serve who are eligible to enroll in Medicaid and/or Medicare. They found they can educate people about needs and services, and work with social service agencies in the eligibility process to improve health care access; this also will likely continue in a post-reform system.

## Recommendations for Funders

The following recommendations seek to provide feedback to The Trust and other funders involved in local health systems change and the broader role of collaboratives in health care reform. In addition, the individual case study reports provide additional, project-specific data.

A key aspect of these recommendations is the crucial role the funder can play in the collaborative process – most notably, holding the “big picture,” vision and direction of the strategy. While PHI grantees achieved

several key health and systems-building goals at the local level, foundation staff are uniquely positioned to make adaptations to the strategy, provide insight on the changing political landscape and its potential impacts on local systems-level work and assess how external factors positively and negatively affect the collaborative's progress. The recommendations below outline specific areas for foundation staff to consider and practices that can support collaborative efforts beyond financial resources.

1. ***Funders must establish a realistic and achievable time horizon to achieve goals.***

The fact that change often takes longer than expected was frequently mentioned and was a common experience by the grantees. Initial and ongoing planning efforts take time but bring participants to a shared vision of the desired changes. Once a plan is in place, agency approvals and agreements are necessary to work through, including, for example, federal approval for a Federally Qualified Health Center. There can be barriers to progress that may not initially be overcome, such as the need for legislation by CarePoint, before their health access program could be implemented. By the same token, another barrier experienced was non-participation by important stakeholders. Key informants stressed that patience was necessary to long-term success, by demonstrating positive effects over time and through information sharing and awareness of the program in the community. Funders should expect that to realize sustained local health systems change likely requires a long-term time horizon. PHI was a six-year initiative that, while achieving several important milestones, still remains a starting point for sustained changes to the local health system.

2. ***Funders should assess opportunities for ongoing involvement and decisionmaking.***

Grantees commented that there are ongoing opportunities at various points in the projects for a funder to influence systems-level change that could have potentially been as important as the initial decision to fund a project. This was particularly the case in a time of heightened broader systems change such as that surrounding state health reform efforts since 2007 and national efforts more recently. As a result, grantees recommended that the role of the funder include more ongoing involvement in order to help grantees adjust and respond to evolving system influences and opportunities over time. This could include greater involvement of any future funder of an initiative such as PHI in periodic planning efforts in order to develop consensus with the grantee and possibly across grantees for potential new directions.

3. ***Funders should consider the strategic influences and opportunities of the broader environment.***

Because factors beyond the reach and control of the project can and will ultimately influence the success of major systems change efforts, the opportunities posed and the limitations imposed by extraneous factors should be more clearly documented and taken into consideration on an ongoing basis. During the planning phase, the funder should take into account the extent to which the system is ready not only to begin the proposed change effort, but also to deal with external factors and their consequences, such as the economy and health care reform. More formal readiness assessments would help with initial funding and program planning and later technical assistance decisions. It is important to keep in mind that systems change can and will be influenced by both the local context and the broader environment, in both a potentially negative manner (in the example of the economic environment) and in a potentially positive manner (in the example of health care reform). For example, when the program began, the substantial progress toward health reform at the state and national levels achieved over the past few years had not yet begun. Funders for initiatives such as PHI should explicitly discuss influences and opportunities with local health care system leaders and explore whether their role as a transitional funder within the systems change process should evolve or remain stable in light of potential opportunities.

4. ***Funders should assess ongoing technical assistance (TA) needs and assist grantees in meeting those needs throughout the course of the initiative.***

As noted above, grantees generally found TA to be helpful. Funders should regularly assess grantee TA needs through discussion with the grantees and identify mechanisms to make TA available as needed. In PHI, TA was provided early on to support collaboration and was found to be helpful. In particular, independent meeting facilitation was seen as valuable insofar as it provided neutral support and a guidance function in meetings and planning efforts, particularly early on. Grantees also appreciated TA regarding specific areas of technical knowledge and skills assistance to meet emerging needs. For example, key informant responses and progress reports documented that, in some specific skill areas such as health information exchange and community needs assessment,



the local leaders participating in the project and their agencies were not able to provide the range of necessary knowledge and skills for project success.

5. ***At the outset of the strategy, funders should clearly identify and communicate to grantees the expectations around sustainability, and subsequently provide the necessary technical assistance and support.***

Grantee project leaders specifically observed that more structured TA in the area of sustainability would have been helpful from the beginning of the project. While The Trust was very clear in communicating its priority regarding sustainability from the beginning, it took grantees varying lengths of time before they addressed the issue in earnest. Funders should focus not just on encouraging sustainability, but also on requiring such planning early on and using the evaluation and broader oversight to monitor progress. For example, given the success of the Northwest Colorado Community Health Partnership in prioritizing a set of sustainable efforts early in their planning process, grantees might be asked to develop a sustainability hypothesis describing their initial theory about how to achieve sustainability as part of the grant application or initial planning. Moreover, funders could develop their own hypothesis and process for grantee sustainability as part of their strategy. Funders could then use this process to identify and implement specific, tailored sustainability technical assistance. To this end, funders should be explicit about what they envision being sustained. For PHI, the foundation wanted both the specific project that resulted from the collaboration and the collaboration itself to be sustained. In other cases, sustainability may focus on a specific, measurable outcome, such as a population health indicator.

6. ***Funders should keep in mind that health care reform is a fluid and locally varied process.***

This recommendation could be considered an extension of the previous recommendation, but add a specific emphasis on local efforts and resources. While much recent attention has been on federal and state health reform efforts, it remains the case that local circumstances matter tremendously. Local health care providers, local health facilities, local county and Tribal governments need to understand how local residents provide, receive and pay for health care services. As state and federal plans continue to evolve, communities cannot base their planning solely on these necessarily fluid potential resources. Given this, funder support of regional collaborative planning entities such as those involved in the CarePoint project, Chaffee County and Northwest Colorado, is essential so that local communities can (1) weave state and national health reform efforts with local needs and resources and (2) continue local planning to build on emerging opportunities and respond to continued policy and funding changes.

## Evaluation recommendations

The following evaluation recommendations all stem from lessons learned at various points in PHI. Some of the lessons were acted upon and resulted in changes to the evaluation, particularly in Phase II. These changes included the addition of key informant surveys and case studies.

1. ***Health indicator efforts should be the joint responsibility of grantees and the evaluator.***

The evaluator should be directly engaged with grantees with respect to evaluation planning and indicator development. Through Phase I, the evaluator was a consultant in the process of grantee indicator specification and definition. The technical assistance provider worked directly with the sites, had primary responsibility with The Trust for emphasizing the importance of the indicators and had final approval of proposed indicators. The evaluators' primary interaction with grantees was to provide technical assistance, when requested; ongoing engagement with grantees would have been helpful, especially given that evaluators have experience with implementation of indicators and data collection. Although the evaluator had responsibility for summarizing progress in indicator implementation, information to that effect came second hand through review of grantee progress reports and not through hands on monitoring and ongoing review of progress with grantees.

Performance improvement is a critical component of systems change and best practice promotion initiatives. Efforts to promote a wide range of best practices have begun to be subjected to systematic study in the past decade, and Fixsen and his colleagues summarized the lessons learned through that research in their seminal 2005 work.<sup>11</sup> Their detailed review describes a multi-year, six stage process involving (1) exploration and adoption, (2) program installation, (3) initial implementation, (4) full operation, (5) innovation and (6) sustainability. Evaluation and performance

improvement data are key to development across each step and require the evaluator to be an active part of the change management process. This engagement allows the evaluator to design evaluation questions with greater sensitivity and awareness of key issues, the context of change, and emerging issues as change progresses. As well, increased engagement also allows project management to draw on the evaluator as an ad hoc resource to inform project decisions through real time participation and sharing of evaluation information as it emerges, to inform practice change.

2. ***Given the possibility for grantee project variation, consider two tiers of data collection: multisite and project-level.***

As a multisite initiative, the requirement by The Trust for the sites to develop HP2010 related indicators was an effort to connect the initiative to the broader base of indicator data available through HP2010 reporting. The sites were able to specify HP2010 indicators that depended on the focus of their program, but frequently experienced difficulty collecting data on those indicators. In hindsight, it might have been more conducive to designate, at the onset, one or more indicators common to all sites that could have provided results at the multisite initiative level, and then to develop additional indicators for each program at the local level. For example, the four case study sites that adopted HP2010 health care access indicators eventually reported on people served, an indicator that was common to them but not to all other program sites. The Trust could have identified an indicator of interest such as access and then let the evaluator work with sites to develop specific metrics to measure the indicator, defining both common requirements and tailored approaches as needed by grantees. Such a framework could have also better supported tailored, local level program-specific indicators. The evaluator could have developed these through specific interaction with each grantee, informed by both up front planning time and their ongoing involvement with each site.

3. ***Employ qualitative data collection to tease out the nuance and context for collaboration efforts.***

Key informant surveys provided rich contextual information about each grantee site. These qualitative data add critical insight and detail not available through other methods (such as surveys). For PHI, case studies developed from those surveys, in association with collaboration surveys, project blueprints and other evaluation data, provided a very helpful mechanism through which to bring all project components together to paint a picture of each project, and to enable a forum for discussions of program progress, barriers and successes. The case studies were also particularly helpful overviews of each program and enabled discussions with The Trust that resulted in recommendations to The Trust for an in depth clarification and understanding of lessons learned.

## » CONCLUSION

Complex health care problems can rarely be ameliorated by a solitary entity. Indeed, too numerous are the pitfalls of fragmentation and a misalignment of resources and services, which can ultimately leave consumers struggling to have their health care needs met. As such, local collaboration has long been seen as a vehicle to create tighter alignment among key health care stakeholders. Through the Partnerships for Health Initiative, The Colorado Trust sought to capitalize on this ambitious vision and invest long-term in understanding if and how strategic local health partnerships could effect changes to the local health system and increased access to care. The findings from the evaluation demonstrate that intentional local health partnerships can be a powerful tool to realize measurable gains; however key conditions must be met in order to translate potential into success. Chief among these conditions: community and project-level leadership, information-based decisionmaking, community-centric collaboration and the provision of timely and strategic technical assistance.

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