MOVING BEYOND TRADITIONAL ALLIES: BUILDING AND SUSTAINING PARTNERSHIPS

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EXECUTIVE SUMMARY

The grantees funded under The California Endowment's (The Endowment) Clinic Consortia Policy and Advocacy Program (Program) successfully increased and enhanced partnerships beyond their traditional partners from 2001-2009. Consortia partnership development evolved from facilitating member clinic participation in consortia shared services and engaging in partnerships with other grantees to the creation of partnerships among consortia and non-health organizations that benefit grantees and their member clinics. Grantees were successful despite several challenges, including limited organizational capacity and differences in priorities among partners. The evaluation findings reveal that partnerships are especially important as grantees establish themselves as players in new local, state, and federal policy arenas. Alliances with other advocacy groups, government agencies, and the business community resulted in increased advocacy support at the local and state levels, increased access to resources, such as county contracts with clinics, and programmatic expansions. Continued integration of partnerships and increased sharing of resources is possible but not always feasible or necessary.

INTRODUCTION

Collaboration in the health care arena is increasingly the norm, with partnerships having the potential to generate resources that individual organizations cannot realize on their own. These partnerships come in different shapes and sizes, with many providing entrée into new policy arenas. However, the development and maintenance of organizational partnerships requires significant investment of time and effort. Funders have been willing to assist organizations in taking the first steps to creating partnerships, such as training and staffing. As part of its commitment to increasing access to high quality and affordable health care for underserved Californians, The California Endowment (The Endowment) provided multi-year funding for the Clinic Consortia Policy and Advocacy Program (Program). In early 2001, 15 California local and regional community clinic associations and four statewide clinic organizations ("consortia" or "grantees") were funded to strengthen the role and capacity of consortia in order to support the management, leadership development, policy, and systems integration needs of community clinics. Funding supported specific activities related to policy advocacy, partnership development, technical assistance, media advocacy, and shared services in order to increase the collective influence of clinics.

During the first round of funding (2001-2003), consortia partnership efforts focused on facilitating member clinic participation in consortia shared services, and engaging in advocacy partnerships with other consortia. During the second funding round (2004-2006), consortia focused on developing partnerships with local health organizations and leaders and establishing partnerships with non-health organizations with the goal of engaging the broader public in raising awareness of the uninsured. For example, many grantees pursued partnerships with their local Chambers of Commerce as well as academic institutions. In 2007, grantees were refunded for three years to undertake or continue a similar set of activities, with an emphasis on maintaining or expanding their partnerships with key non-health organizations.

This Issue Brief describes how clinic consortia developed and strengthened partnerships with: 1) their traditional allies in the community health center arena, including their member clinics and other consortia, and 2) various health and non-health organizations. The Brief also characterizes the usefulness of these partnerships to consortia, clinics, and their target populations, ultimately resulting in benefits to member clinics and underserved populations.

METHODOLOGY

UCSF engaged in multiple evaluation activities to assess grantee capacity to develop and leverage its partnerships with clinics, consortia, and health and non-health organizations:

- From 2003 to 2009, UCSF interviewed grantees about the status of their partnerships as part of an annual grantee interview;
- From 2004 to 2006, UCSF administered an annual grantee worksheet to document change in number, type, and perceived effectiveness of partnerships with non-health organizations;
- In 2007, UCSF interviewed grantees and representatives from 35 health and non-health organizations with which grantees had partnered during 2004-06. UCSF focused on partner awareness of clinic policy issues and perceived effectiveness of joint partnership activities;
- From 2007-2009, UCSF administered a 10 point scale to assess changes in organizational integration of three non-health partnerships per grantee; and
- From 2007-2009, UCSF asked grantees to indicate with which organizations they had partnered on three specific policy issues.

Lastly, UCSF compared the role of partnerships among 16 grantee case studies that focused on policy and program initiatives funded under the grant.

FINDINGS

The evaluation findings indicate the Program has been successful at increasing and strengthening partnerships between member clinics and consortia, as well as with health and non-health organizations. Grantees expanded their purview and influenced the agendas of other organizations while strengthening existing partnerships. Partnership expansions likely were the result of increased grantee capacity, as the key factors necessary for launching partnerships include staffing, high member clinic interest, and funding opportunities. Creating and maintaining partnerships can be challenging, with no guarantee of long-term sustainability. The following is a description of the evaluation findings:

STRENGTHENED RELATIONSHIPS WITH TRADITIONAL ALLIES

A key objective of the Program was the establishment of effective *partnerships among clinics and between clinics and consortia*. All grantees engaged in diverse partnership activities to this end, including facilitating member clinic activities, convening peer groups, administering collaborative projects, providing centralized services, and sharing technical assistance materials. For example, consortia played a major role in funding and implementing disease collaboratives and quality improvement initiatives, which have strengthened clinic operations. Key barriers included member clinic factors such as size and diversity of membership, geography and large distances between clinics, and capacity issues such as limited staffing and time to support these activities. Factors that contributed to successful partnerships include clear roles, trusted staff, relationships that are collaborative in nature, and missions that support partnership activities.

> ***Member Clinic Perspective:*** California Family Health Council (CFHC) provides organizational strength and one voice for California clinics. As the only Title X agency north of Butte County, we depend on the advocacy work of CFHC. We can't afford to do the kind of advocacy work needed to maintain our funding. No other organization can represent the potpourri of providers representing family planning, women's health, and a range of geographic areas. That we can be represented by such an umbrella organization representing all the Title X clinics is incredibly important. -- *Women's Health Specialists of Northern California*

Grantees reported many benefits from *partnerships with other clinic consortia during Round 1 (2001-03)*, including grantee capacity development (such as trainings and sharing of best practices), strengthening of political allies, and coordination of grantee policy and advocacy activities. Key successes include improved collaboration among clinic consortia on policy strategies, such as the successful deletion of the FQHC reimbursement reduction from the 2004-05 State Budget, saving clinics $76 million.

Grantees were very successful at developing *partnerships with local health organizations and leaders* during Round 2 (2004-06). Partnerships with local government agencies tended to be ongoing and provided multiple opportunities for planning and negotiating the allocation of funds as well as providing clinic input on health system redesign. Reported grantee successes include new or maintained funding and improved access to care. For example, one grantee's partnerships efforts with the Alameda County Medical Center and the county health agency contributed to the allocation of $5 million per year of Measure A funds to clinics. Another grantee's participation on a One-e-App committee resulted in an eligibility and enrollment system that will be less burdensome for member clinics.

> ***Partner Perspective***: It makes sense to support the "natural alliance" between public entities, private non-profit clinics, and private for-profit inner city practices, and create a cohesive network of care for low-income families and the uninsured. These entities are mission-oriented and would end up being the providers of last resort anyway, so why not help them coordinate their efforts in order to optimize the use of limited dollars? CCALAC has also parlayed its significant role with CPCA (California Primary Care Association) to coordinate a statewide safety net strategy. This is reflected in federal policy changes and statewide policy changes that are favorable to the PPP community and supportive of LAC DHS efforts through the Waiver, health care reform, etc. - *Private Practice Physician*

Although grantees undertook many types of partnership activities, not surprisingly, advocacy was the key focus of these partnerships. Specific activities included joint advocacy, serving on committees or participating in planning efforts, providing presentations and technical assistance, and sharing resources. Consortia formed partnerships between consortia and decision-makers through their research and education on clinic policy issues, such as allocation of Tobacco Settlement funds, resulting in increased funding to clinics. Some partnerships are episodic and focus on a particular policy issue while others are ongoing and focus on a joint project or

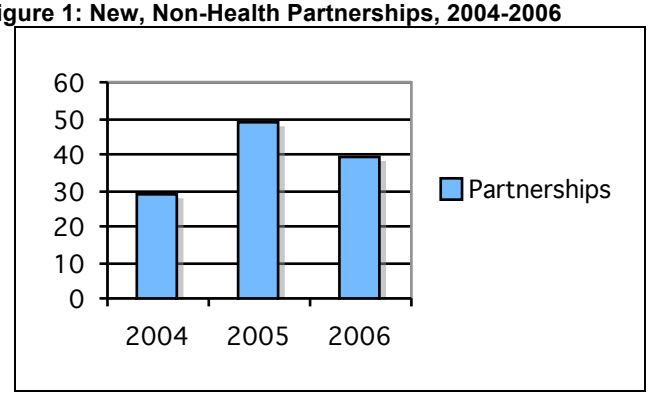
program. For example, some grantees are partnering with their local First 5 agency funded under Proposition 10 to plan and implement long-term programs, such as health insurance coverage and service expansions for children.

Expanding Partnerships with Non-Health Organizations

Under the second funding cycle (2004-06), grantees prioritized *partnerships with non-health organizations*, including advocacy groups, academic institutions, non-health government agencies, business organizations, religious groups, media organizations, and labor groups. Many grantees (10) reported having "limited experience" in partnering with non-health organizations prior to Round 2. Some grantees (5) had "considerable experience", such as a long history of coalition building. The rest (3 grantees) reported having had "some experience."

Figure 1 highlights the number of partnerships established with various non-health stakeholders. Grantees engaged in grant-funded partnership activities with **117** non-health organizations since 2004. The number of partner organizations per grantee ranged from 2 to 11. The data suggests that partnerships require some advance time to launch and have the potential to "snowball" over time. The decline in partnership formation could speak to the lack of remaining organizations with which to partner or limited arenas that facilitate partnering. For example, workforce development, such as educating and training activities, is an area that lends itself to partnerships beyond the traditional allies.

Figure 1: New, Non-Health Partnerships, 2004-2006



Overall, grantees rated their partnership with non-health organizations **3.21** (where 4 = "very useful"). The most beneficial non-health partnerships tend to be with public institutions, such as social service agencies. Grantees were able to secure funding and increase clinic staffing as a result of these partnerships, such as support for a Certified Application Assistant trainer. Other types of partnerships show great promise, particularly with academic institutions where consortia can provide educational resources. Clinics also directly benefit from these partnerships, such as increased referrals to clinics, new funding, policy "wins", and strengthened ties between clinics and other organizations in the community.

The results of the interviews with 35 non-health partner organization with which grantees had partnered during Round 2 (2004-06) suggest high non-health partner familiarity with clinic policy issues, such as access to care for the uninsured, as well as the clinic consortia.

- Both grantees and partner organizations report a high regard for one another, with partner organizations rating their relationships with grantees as "highly beneficial (**3.5**, where 4 = "very beneficial").
- There is good alignment among the missions of individual partner organizations and grantees, and moderate partner familiarity of clinic policy issues (**3.0**); and
- Many partners (57 percent) reported being involved in joint projects on an ongoing basis, particularly joint advocacy activities such as targeting a policy or issue (69 percent). Many partners (46 percent) reported being involved with joint health programs.

At the onset of Round 3 (2007-09), grantees reported that they had initiated or maintained partnerships with 36 non-health organizations in their efforts to increase public awareness of clinic policy issues (such as the uninsured), as well as collaborate on advocacy initiatives of mutual interest. Different goals and varying levels of collaboration characterize these partnerships. The level of integration of these partnerships with non-health organizations was similarly rated over the three years or "somewhat integrated" (4.31 in 2007, 4.03 in 2008, and 4.12 in 2009). (Note: 1 = informal communications, 5 = collaboration on projects and policy issues, and 10 = tightly integrated, such as pooled funding and/or shared funding of positions). There were some differences in integration over time by partner organization type:

- Public agencies were rated more highly integrated during the three years and experienced an increase in integration over time, from 6.2 in 2007 to 7.7 in 2009;
- Coalitions were the next most integrated partnerships, declining in integration somewhat from 6.6 to 5.3;
- Chambers of Commerce partnerships increased in integration, from 2.9 to 4.1;
- Advocacy organization partnerships were a little less stable and declined from 3.6 to 2.2 in integration; and
- Partnerships with unions declined from 3.7 to 2.33 in integration.

Upon closer examination of individual partnerships, most of these partnerships (21 or 58 percent) were relatively stable during the three years and experienced limited change in integration. Eight partnerships (22 percent) increased in integration since 2007. Factors that contributed to increased integration included the desire to expand allies during the state budget crisis, expansions into new arenas, such as social justice issues, and partnering to secure additional resources. Seven partnerships (19 percent) with advocacy organizations, coalitions, and unions went down in integration. Grantees cited factors that undermine or forestall integration, such as a divergence in organizational and/or advocacy goals, staff turnover or organizational change, and a change in financial duties, such as fiscal agent.

Partner Perspective: As a member of Alameda County's Ongoing Planning Council, our agency has had the opportunity to review proposed strategies brought forth to the committee for review and ranking. Our relationship with AHC has only solidified since 2001 by working together for passage of the MHSA and integration of behavioral health care and primary care. The consortium and its individual member agencies have been on the front line at local level, State, and Federal policy forums to promote integration of behavioral health care and primary care services. – *Bonita House*

More broadly, grantees continued partnering with traditional allies during the course of the Program while expanding their partnerships. In comparing the policies targeted by grantees from 2007 to 2009, grantees partnered with their closest allies on all the policy issues, namely member clinics and other advocacy organizations (70 – 100 percent), such as the National Association of Community Health Centers. There were some differences in partnerships by policy. One-third of grantees that worked to *secure clinic funding under ARRA* and *to preserve clinic funding under the state budget* reported partnering with representatives from the business community. Partnerships for two carry-over policies remained unchanged.

Partner Perspective: We are working to design a comprehensive system of care in Orange County. COCCC has stepped up its role in looking at what the *entire* county needs – not just its member clinics. - *CalOptima*

DISCUSSION

The findings indicate that while there are significant barriers to pursuing partnerships, these partnerships may contribute to broader community support as well as increased access to resources benefiting consortia, clinics, and clinic target populations. Additionally, these partnerships can translate into advocacy networks and joint projects, with grantees being considered effective and useful collaborators on multiple fronts and with diverse organizations.

The challenges to creating partnerships with organizations are diverse, and require education and resources. Many grantees indicated that lack of a common vision or similar issues was a challenge to identifying mutual benefits. Similarly, making clinic policy issues relevant to non-health organizations that do not always understand them or see their relevance is a challenge. However, grantees are well equipped to engage in the information sharing that characterizes the early stages of a partnership.

Similarly, maintaining and integrating partnerships requires time and staffing. Challenges include the resources required to maintain the relationship, pre-existing barriers (such as institutional constraints), and divergence in priorities among the partner organizations. However, the potential for future partnership activities once a partnership has been established appears to be great, such as collaborating on a grant or mustering political support. For example, some grantees have moved beyond episodic media coverage and have partnered with the media to create documentaries about key health issues, on-going TV health education shows, and radio segments. Partnerships with public agencies are most likely to have sustained partnership activities, including mental health, emergency preparedness, workforce development, and children's insurance coverage.

One of the lessons learned from the evaluation is the importance of consortia in stabilizing partnerships with clinic members and among other consortia before branching out to other partners. There is increased likelihood of project success, such as shared IT, and having the benefit of member clinics and fellow consortia serve as extensions of the consortium, such as clinic staff and patients that engage in advocacy. Another lesson learned is that while engaging in new partnerships with non-health organizations can be challenging, the payoffs are great. Grantees benefit from increased visibility, increased access to resources, and an expanded consortia purview, such as expanding into a new service area or media venue. Last, partnerships achieve different levels of integration for different reasons. Some partnerships may peak at the stage of sharing information, such as partnering with the Chamber of Commerce. Additionally, changes in resources, including completion of a contract, may signal the end of an integrated partnership although these entities may partner later on.

CONCLUSIONS

From 2001 to 2009, consortia partnerships evolved from facilitating member clinic participation in consortia shared services and engaging in partnerships with other grantees, to the creation of partnerships with health and non-health organizations that had significant benefits for grantees and their member clinics. The close partnership among consortia and member clinics is vital for expanding a consortia's political voice, such as clinic communications with decision makers, as well as ensuring policy and program success. Additionally, partnerships with non-traditional partners provide new opportunities for growth although their development is heavily influenced by the policy context and ongoing usefulness to the partners. In short, partnerships are critical to policy and/or program success but they require significant effort and realistic expectations.

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