Partnering *for* Sustainability

ALIGNING FORCES FOR QUALITY
NATIONAL MEETING
MAY 8–10, 2013 | CHICAGO, IL

Robert Wood Johnson Foundation

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Handouts

When we were planning this meeting, we wanted to be sure that you would go home inspired, your notebook full of ideas, your head brimming with possibilities.

How could we help you carry so many conversations and ideas back with you to your communities?

We thought this booklet might be a good start. Inside, you will find things to jumpstart your next steps on your journey toward sustainability - whether they are checklists, exercises, or refreshers of the ideas you heard in the breakout sessions, we hope they will spark your imagination or jog your memory.

Copies of all these materials, and links to their sources if they are outside of AF4Q, are available on the AF4Q website at www.forces4quality.org.

Thursday Morning

Thursday Morning

Robert Wood Johnson Foundation

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The State of Partnering with the States

What is the State of Play in Your State?

This tool can be used by regional collaboratives to facilitate a dialogue with stakeholders around how to leverage the current environment to work in closer alignment with the state.

Policy Levers Available to States	Key Questions to Consider	State of Play in your State?
As purchaser. . .	What is the status of Medicaid reform? How does Medicaid interface with the proposed insurance exchange? Can the State employee benefit plan be leveraged?	
As traditional regulator. . .	What is your state's regulatory role in: … health insurance exchange? …Insurance Commissioner? …transparency requirements? ...health information technology?	
As convener. . .	Does your state act as a convener for: …health reform task forces? …public-private partnerships? …other collaborations?	
As market setter or facilitator . . .	What steps is the state taking to encourage competition on price, quality, value? How does your state use statutory authority set market conditions? Is there relevant market share or antitrust issues to consider?	

Given the contextual factors in your state, what are your prospects for success?

What are your short-term and long-term next steps?

For example:
How is the organization engaging with the state in these different roles?
Who are the key contact points in state government?

Adapted from:
John M. Colmers, presentation at the Aligning Forces for Quality National Meeting, May 9, 2013

Stakeholder Relationships: Teachable Moments in Retention of Stakeholders

STAKEHOLDER RELATIONSHIPS: Teachable Moments in Retention of Stakeholders

We asked speakers at this session at the Aligning Forces for Quality May 2013 National Meeting to give us their thoughts on the top things that would drive stakeholders representatives away from the multi-stakeholder collaboratives that have been created within each Alliance. The panelists represented employers, consumers, health plans, and providers. Their thoughts, edited into a few top themes by our staff, follow.

Nine Things To Do To Ensure You Drive Your Stakeholders Away

- ✓ **Don't keep us informed and engaged**: It is easy to attract collaborators at the beginning of a project, but busy people will disengage if they don't have frequent updates about progress and activities. Meet face-to-face on occasion—webinars and phone calls are efficient, but cannot deepen relationships like in-person meetings. Don't underestimate the power of a personal phone call/outreach to discuss an issue—particularly if a stakeholder seems distant. And keep your stakeholders in the loop. Lack of communication is a major "don't."

- ✓ **Be unable to demonstrable success, or fudge the numbers**: If your goals are too large and long term, collaborators may not see visible progress in the short term. This could lead partners to question the value of the project and disengage before the long-term goals can be met. Don't ever publicly release incorrect data/reports. And work when possible to demonstrate success meaningfully – connect clinical data (graphs, percentiles, and goals/accomplishments) to lives impacted (how many episodes of pneumococcal sepsis/meningitis were prevented due to pneumococcal immunization improvement?)

- ✓ **Present data in a way that implies/communicates judgment.** Don't present data without context – look at comparisons over time, national/local benchmarks. Help providers see themselves in the context of others whom they know and respect, so they know that they are not alone. Don't forget to acknowledge that there can be many reasons for low scores, and remind your audiences that we need to understand the data to improve (was it ordered, was it obtained, was it obtained but did not flow in the EHR, is the provider open to new patients and therefore getting all of the new patients in the practice, etc.).

- ✓ **Step on our turf**: Don't replicate existing efforts underway by your partners. Instead, support and enhance those efforts with your unique contributions. Those contributions could include data, transparency expertise, or even 'donating' time from the external TA resources AF4Q provides to the Alliances. Use appreciative inquiry as a tool – for instance, ask high performing practices and providers how they are achieving their great results. Don't replicate – innovate.

- ✓ **Accept unequal effort among those at the table or take sides**: Treat your stakeholders with fairness. Collaborators want to feel that everyone is pulling their weight. Ensure accountability and equal access to available resources and ensure you have the resources available to support important stakeholder activities, especially consumer activities. And whatever you do, don't 'take sides' with one constituency (with the possible exception of patients).

- ✓ **Forget to connect your community reforms with your community.** Don't make the mistake of failing to connect with the community most impacted by the change you are pushing. Work to reach out broadly —success requires collaboration with diverse community stakeholders, especially on issues like health equity. When working with providers, connect practices' efforts to improving the health of the whole community—neighbors, co-workers, friends. Don't assume disinterest on the part of the practice/provider or other stakeholder—ask them what they think, what they are concerned about, what their barriers are, what their fears are. And keep patients at the center – remember to integrate consumer engagement in your quality improvement (QI) initiatives.

- ✓ **Talk over our heads:** Don't assume members or the public understand the issues or your strategies to address them. And don't assume they are all experts in the details of the health system. Your stakeholders – including some employers and consumers – are rarely all health care experts and should not be expected to know the jargon or weedy details of the health care system.

- ✓ **Be rude or devalue our contribution.** Don't underestimate the importance of relationships, trust and likeability. Follow up on your commitments. Don't publicly criticize your members – especially in the press. Express gratitude for very difficult work and investment of time. Think about your stakeholders and how to value them – for instance, don't forget to acknowledge/respect those aspects of delivering care to people that cannot be measured—like sitting with a patient who is crying because she just lost her husband (how do you measure that?). Treat all of your stakeholders as valued partners in the delivery of quality healthcare.

- ✓ **Take your eye off the prize.** It is crucial to avoid "mission creep" to keep us at the table. Maintain a focus on your mission and the importance of why you have gathered us all together.

With thanks to session speakers: Rhonda Moore Johnson, medical director of health equity and quality services, Highmark, Inc.; Karen E. Jones, medical director of quality and innovation, WellSpan Medical Group, WellSpan Health; Karen Linscott, chief operating officer, National Business Coalition on Health; Elizabeth Mitchell, president and CEO, Network for Regional Healthcare Improvement; and Johnny Simpson, chief executive officer, Simpson Consulting and Management, LLC.

What it Takes:
Characteristics of Sustainable Efforts

Ingredients for Organizational Sustainability

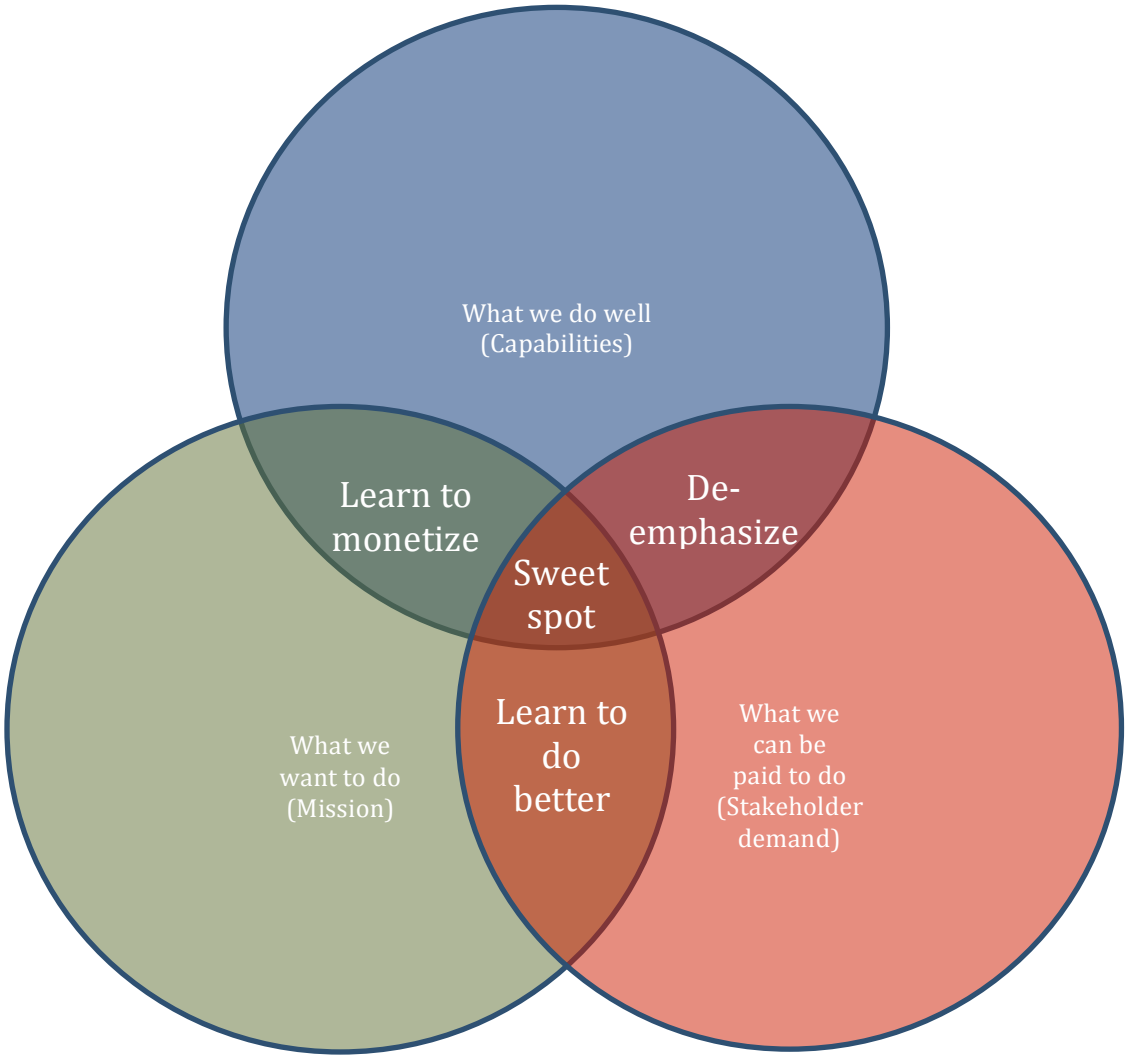
March 12, 2013

1. Understand the Alliance's market
    a. Health care market structure and dynamics
    b. Key stakeholders (including partners and customers) and their priorities and resources
    c. Competing and complementary organizations, including those able to assume responsibility for sustaining previous Alliance activities
2. Determine what the Alliance does especially well
    a. Areas of differentiation that meet market needs
    b. Areas that need to be bolstered
    c. Areas to withdraw from or transition to other organizations
3. Develop a clear point of view on what the Alliance wants to do
    a. Compelling vision to establish aspirational end state
    b. Clear mission to provide guidance on goals and activities
4. Articulate a value proposition by identifying a scope of activities (*see visual representation*)
    a. Identify "sweet spot" based on overlap of items 1, 2, and 3:
        i. What Alliance can be supported to do (demand from stakeholders, partners, customers)
        ii. What Alliance does well (capabilities)
        iii. What Alliance wants to do (its mission)
    b. Learn to monetize overlaps of capabilities and mission, e.g., by broadening stakeholder base
    c. Learn to improve capabilities on overlaps between stakeholder demands and mission, e.g., by hiring or partnering
    d. De-emphasize overlaps between capabilities and stakeholder demand, or use as a "cash cow" to fund mission-driven activities
5. Develop a return on investment (ROI) model to document the value proposition
    a. Make benefits, investments and timeframes explicit for stakeholders
6. Identify an appropriate funding model
    a. Evaluate dues, program funding, fee-for-service, royalties, grants, and donations
    b. Consider the mix of revenue types, fit with stakeholders' budgets, and lifecycle of revenue sources
7. Increase organizational effectiveness
    a. Become a high performance organization through improved planning, execution, adaptability, resilience, people development
    b. Measure success along key dimensions: people centeredness, clarity of vision, leadership, trust/transparency, sense of personal responsibility for the enterprise, culture of innovation
8. Match governance to the Alliance's desired future state
    a. Consider evolution from constituency board to one that focuses on the interests of the Alliance

b. Add councils, committees and task forces to match overall strategy

9. Evolve over time as the environment changes
    a. Develop appropriate mix of strategic commitment and flexibility
    b. Keep close tabs on the environment to recognize when a shift is needed
    c. Stay close to stakeholders

Framework for Value Proposition Development



Executive Summary

Robert Wood Johnson Foundation Local Funding Partnerships

Robert Wood Johnson Foundation Local Funding Partnerships is a national program that provides matching grants for innovative community-based projects aimed at improving the health and health care of underserved and vulnerable populations.

Since 1988, the program has awarded 369 grants in collaboration with 1,488 local funding partners for projects that implemented a range of health services and interventions. In 2009, the program added a special solicitation, *Peaceful Pathways: Reducing Exposure to Violence*, to attract smaller, under-resourced, diversity-focused funders and local programs

The Robert Wood Johnson Foundation (RWJF) Board of Trustees has authorized $146.2 million for *Local Funding Partnerships* from its inception through 2014, when it will end.

Read the full report.
Learn more about the program here.

CONTEXT

Since its launch as a national philanthropy in 1972, RWJF has promoted collaborations with local funders. Staff realized that these collaborations could yield a larger return on investment and identify local initiatives that could advance the Foundation's mission to improve health and health care for all Americans.

Starting with programs to stimulate support for new community health centers, over time the Foundation refined and expanded its efforts with local grantmakers to include issues such as assuring access to health care, improving care for people with chronic conditions, and reducing the harm caused by substance abuse.

In 2003, under the leadership of its new president, Risa Lavizzo-Mourey, MD, MBA, the Foundation restructured its *Local Funding Partnership* investments to target a set of priorities, including attention to issues relevant to vulnerable populations, such as child trauma, violence, and mental health.

THE PROGRAM

Local Funding Partnerships has taken a bottom-up approach—considering only innovative community projects that were nominated by a local grantmaker acting in concert with other local funders. Community funders were required to provide at least one dollar of support for every dollar of RWJF grant money.

The core component of *Local Funding Partnerships* is an annual awards program. From 1988 through 2011, RWJF awarded about 10 to 12 grants annually. The grants ranged from $200,000 to $500,000 and ran for three or four years.

In addition, in 2009, *Local Funding Partnerships* launched a special solicitation—*Peaceful Pathways: Reducing Exposure to Violence*—targeting communities of color and people isolated because of their gender, sexual orientation, race, tribe, ethnic group, or remote location.

National program staff provides assistance to grant recipients via annual meetings, special issue meetings, webinars, and by connecting them with other RWJF programs.

OVERALL PROGRAM RESULTS

From 1988 through September 2011, when grantmaking ended, RWJF awarded 369 program grants in collaboration with 1,488 community foundations, corporate grantmakers, and other local funding partners.

- More than $129 million supported projects in 49 states; Washington, D.C.; and Puerto Rico—$127 million through the annual awards program and $2.76 million through *Peaceful Pathways*.
- Most projects sustained themselves over time. Two evaluations found that four out of five funded projects lasted at least one year after their RWJF grant ended.
- Several projects received further grant support from RWJF or became prototypes for national programs. Several others have been replicated nationally or statewide through other funding sources.

AFTERWARD

The final grants made under *Local Funding Partnerships* were in 2011. National program staff is continuing to support projects that are still active. Staff is also working to develop and disseminate case studies and lessons learned over the 25 years of the program.

Program Management

National Program Office: Health Research and Educational Trust of New Jersey

Program Director: Pauline M. Seitz

Robert Wood Johnson Foundation

Published: December 20, 2012
Program Results
Grant ID: 51437, 53607

Promoting Community Health Workers to Reduce Health Disparities in Minnesota

Coalition creates a statewide standardized competency-based community health worker training program in higher education

SUMMARY

From 2004 to 2009, the Healthcare Education Industry Partnership (a program of Minnesota State Colleges and University's System) worked with a coalition of educational institutions, health care systems, government agencies, foundations, businesses, and nonprofits to promote the role of community health workers in Minnesota. The partnership, called the Minnesota Community Health Worker Alliance, created a statewide standardized training and assisted in developing a sustainable funding stream to support community health worker services in Minnesota.

Community health workers assist diverse and underserved residents of all ages in gaining access to coverage, screenings, care, and related social services; in navigating the complicated health care system; and in expanding their health knowledge and self-care skills through health education and coaching. Because community health workers usually share ethnicity, language, socioeconomic status, and life experiences with the people they serve, they are also effective at teaching cultural competency to health care providers and improving the reach, quality, and outcomes of the services provided by teams in clinical, public health, and community settings.

Key Results

The project team reported these findings through reports to RWJF and in interviews for this report:

- The Minnesota Community Health Worker Alliance created a standardized credit-based curriculum for training community health workers composed of 14 credits and seven courses that blend classroom and field-based learning. It also incorporates a two-credit community internship. More than 300 students completed the curriculum and obtained certification.
- Created a "Scope of Practice" for community health workers in Minnesota.

- The project team provided published research on community health worker (CHW) return on investment and cost-effectiveness research to state legislators that helped inform an analysis that state Medicaid coverage of CHW services would be budget-neutral. The Minnesota Legislature passed MN256B.0625, Subd.49, which states that CHW certificate holders in Minnesota can enroll as Medicaid providers under Minnesota Health Care Programs.

Funding

The Robert Wood Johnson Foundation (RWJF) supported this project with two grants[1] from July 2004 to June 2009 totaling $447,861 as part of the *Robert Wood Johnson Foundation Local Funding Partnerships* program. For more information, go to the program website. Also see Program Results on the program.

CONTEXT

In a 2003 report,[2] the Institute of Medicine called for expanding the use of community health workers among underserved communities and racial and ethnic minorities. Studies have shown that such workers improve the quality of care and reduce health disparities. Such health workers are particularly effective at:

- Facilitating the participation of underserved residents in the health system and coordinating their care
- Educating patients about specific diseases and medical conditions, and ensuring that they attend their appointments and adhere to medication regimens
- Serving as liaisons between patients and providers, educating the latter about the needs and culture of a community

A 2002 statewide survey of health and human service organizations by the Blue Cross and Blue Shield Foundation of Minnesota revealed growing demand for these workers. Yet training of community health workers was inconsistent, and employers often found it difficult to recruit and retain them, relying mostly on grants to support their work.

RWJF's Interest in This Area

RWJF has supported a number of projects with a focus on community health workers over the years. Examples include:

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[1] ID#s 51437 and 53607

[2] Smedley BD, Stith AY and Nelson AR. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington: National Academies Press, 2002. Available online.

- **Training Opportunities and Credentialing for Community Health Workers.** The Community Health Worker Initiative of Boston was implemented by Action for Boston Community Development (ABCD). ABCD staff and collaborative members worked with employers to develop career opportunities; with educational institutions to develop advanced degree and certification programs; and with the Boston Public Health Commission to develop an advanced certification program. A new industry-recognized credential was developed and two community colleges started certificate and degree programs for community health workers. The initiative served some 219 participants, of whom 93 received credentials. Of those already working as community health workers, close to 20 percent received wage gains. Several employers offered new benefits to community health workers such as career ladders. See Program Results for more information.

- **Raising the Flag for Community Health Workers**. From 2006 to 2009, staff members at the Georgetown University Law Center, Washington, worked to raise the profile and influence of community health workers in the health care system and among policy-makers. They created much of the infrastructure for a new, national organization designed to represent community health workers. Staff members and community health workers put together key building blocks for the newly established American Association of Community Health Workers. As of October 2009, the organization had not been incorporated. They also provided technical assistance to state community health worker associations. See Program Results for more information.

- **Locally Recruited Lay Advisers Contribute to Community Health.** In 1998, Freedom from Hunger, a California-based organization that addresses issues of hunger and poor nutrition, began the replication and institutionalization of a program to train lay health advisers in several Southern states. The effort began 10 years earlier with training lay health advisers in three rural Mississippi communities in an effort to increase access to health care services there, an effort known as the Community Health Advisor Network (CHAN). The CHAN program office contracted with state agencies or schools of public health to implement CHAN projects, developed training materials, and provided technical assistance to state and local projects, including six conferences, developed a monitoring system, and conducted evaluations. See Program Results for more information.

- **Native Sisters Help Native American Women Overcome Obstacles to Breast Cancer Screening.** In 1995–96, Linda Burhansstipanov, MSPH, DrPH, at AMC Cancer Research Center in Denver implemented and evaluated the effectiveness of Native American Women's Wellness through Awareness (NAWWA). NAWWA is a culturally competent recruitment model aimed at increasing the number of underserved urban American Indian women participating in an early detection breast cancer screening program. The target population, Native American women 40 years of age and older, lived in the Denver metropolitan area or in the greater Los Angeles/Orange County area. An evaluation of the program found:

— "High-level" recruitment strategies involving steps and elements specific to Native Americans were much more effective than the typical "culturally sensitive" strategies used by most government programs.

— Among the high-level strategies tested, the Native Sisters Program, a "navigator program," was the most effective. Unlike other programs that provide a health care navigator only once breast cancer is discovered, this project used the Native Sisters throughout the recruitment and screening process. See Program Results for more information.

- **Jobs to Careers: Promoting Work-Based Learning for Quality Care.** This $15.8 million national program explored new ways to help frontline health care workers (including community health workers) gain the skills and credentials they need to advance their careers. It resulted in wage increases and a greater sense of confidence for participants, and had benefits for employers and educational institutions.

THE PROJECT

From 2004 to 2009 the Healthcare Education Industry Partnership (a program of Minnesota State Colleges and University's System) worked with a coalition of educational institutions, health care systems, government agencies, foundations, businesses, and nonprofits to promote the role of community health workers in Minnesota. The partnership, called the Minnesota Community Health Worker Alliance, created a statewide standardized competency-based training and assisted in developing a sustainable funding stream to support community health workers in Minnesota.

The initiative aimed to advance the role of these front-line workers in reducing health disparities, especially among underserved populations and Minnesota's growing racial and ethnic communities including Native Americans, Southeast Asians, East Africans, African Americans, and Latinos. The effort also aimed to offer pathways to employment in these communities and diversify the health care workforce.

To advance the initiative, the Minnesota Community Health Worker Alliance created two committees composed of representatives from the partner organizations:

- An Advisory Committee to help develop a curriculum for community health worker training
- A Policy Council to advance the role of community health workers and develop a sustainable way to fund their work

See the Appendix for coalition partners.

Other Funding

The project received additional funding from these sources:

- Delta Dental Foundation of Minnesota
- Minneapolis Foundation
- Minnesota Department of Health
- Otto Bremer Foundation
- Randy Shaver Foundation
- Susan G. Komen Foundation
- American Cancer Society
- Blue Cross and Blue Shield of Minnesota Foundation, which provided seed money and also nominated the project for *RWJF Local Funding Partnerships* support

RESULTS

The project team reported these findings through reports to RWJF and in interviews for this report:

- **Project staff created a state standardized credit-based curriculum for training community health workers composed of seven courses that blend classroom and field-based learning, and that build on their cultural skills.** Four two-year community and technical colleges and the East Metro Opportunities Industrialization Center in St. Paul offered the program. A private four-year college built it as an accredited pathway into a bachelor's of science program in public health.

  Students who complete the training program earn a certificate as community health workers, and can use their credits as an educational pathway to further studies in health care and social services. The statute included a one-year grandfathering option that allowed CHWs with a minimum of five years of supervised experience to receive a certificate of completion by passing an assessment exam administered by the Minnesota Community Health Worker Alliance.

  The Minnesota Community Health Worker Alliance has sold more than 50 copies of the curriculum nationally, and used the revenue to support scholarships for students enrolled in the program and to help support its ongoing community health workers field-building work to address health disparities and foster healthier communities. See the Bibliography for details on the curriculum.

- **More than 300 students completed the curriculum during the project and earned certificates.** Of those, an estimated 77 percent pursued further training in health care

or social services. More than 60 already employed community health workers passed the grandfathering process and also received certificates.

- **The project team compiled and provided community health worker return on investment (ROI) and cost-effectiveness studies to state legislators.** These informed a government fiscal analysis that found that state Medicaid coverage of community health worker services would be budget-neutral. The legislature then authorized the state Medicaid program to cover specific services provided by community health worker certificate holders who are supervised by physicians, nurse practitioners, dentists, and public health nurses working in a unit of government, and mental health providers.

  As of 2009, more than 80 community health workers had enrolled as Medicaid providers or applied to become one, and seven agencies were tapping Medicaid funds to pay for their community health worker health education services.

- **Project staff promoted the curriculum and the role of community health workers among businesses and health care organizations across Minnesota and the nation**. Staff:

  — Held forums for health care providers and payers in Minnesota on training and employing community health workers and applying for Medicaid reimbursement. Alliance member Blue Cross and Blue Shield of Minnesota Foundation created a video[3] to support this work.

  — Presented the business plan on the financing and cost-effectiveness of community health workers at state and national conferences and organizations, including the American Public Health Association, the National Rural Health Association, Community Campus Partnerships for Health, Minnesota Rural Health, and Minnesota tribal health agencies.

- **Project staff laid the groundwork for creating the Minnesota Community Health Worker Alliance composed of coalition partners, and created a website for the alliance**.

- **The project team contributed to national guidelines for educating community health workers, and to additional research on their training and work.**

  — The project team helped develop best-practice guidelines for training community health workers produced by the Community Health Worker National Education Collaborative—research that contributed to their curriculum design in Minnesota. (A report on the guidelines is available online.)

[3] The video, entitled "Critical Links: Community Health Workers," is available online.

— Blue Cross and Blue Shield of Minnesota Foundation commissioned research by the Center for the Health Professions at the University of California, San Francisco, resulting in two reports:

- For *Advancing Community Health Worker Practice and Utilization: The Focus on Financing,*[4] the researchers interviewed 25 people from 14 states and the District of Columbia who employ or train community health workers, to explore mechanisms for funding their work.
- In *Funding CHW Programs and Services in Minnesota: Looking to the Future,*[5] the authors analyzed Minnesota's program for training community health workers, and suggested how to more fully integrate them into the health care system.

LESSONS LEARNED

1. **When developing initiatives on community health workers, seek input from the workers themselves.** The project benefited when staff talked with community health workers about their educational and professional needs, and how to advance the field, according to Project Director Anne Willaert, MS. Those interactions also created ownership and buy-in for the initiative among the workers who became important partners at the table with the Minnesota Community Health Worker Alliance.
2. **When building programs to support community health workers, learn from other states.** The project team talked with colleagues in other states regarding real and potential pitfalls in promoting the profession. "It was helpful to learn where they went wrong, and what they did that was successful," Willaert noted.
3. **Synergies with national programs are valuable to state programs promoting community health workers.** Contributing to the best practice guidelines developed by the Community Health Worker National Education Collaborative helped the project team refine Minnesota's curriculum. (Project Director/Willaert)
4. **Successful CHW field-building to address health disparities requires strong, visionary, multi-sector leadership and the sustained efforts of broad-based partnerships.** Leaders need to bring focus, build consensus, integrate learnings, seize windows of opportunity, and engage an ever-widening circle of support. (Project Director/Willaert)
5. **Strategic communications are key.** While the CHW role has deep community roots and a long history in community-based settings, as an emerging health profession it is

[4] Dower C et al. *Advancing Community Health Worker Practice and Utilization: The Focus on Financing*. San Francisco: National Fund for Medical Education, 2006. Available online.

[5] Dower C et al. *Funding CHW Programs and Services in Minnesota: Looking to the Future*. San Francisco: National Fund for Medical Education, 2006. Available online.

still very new to many health providers, health plans, and policy-makers. The Minnesota Community Health Worker Alliance and its members have developed a set of useful communication tools. According to Joan Cleary, interim executive director of the alliance, the next stage of work needs to include a broad, sustained, multi-prong communications initiative to raise awareness of the community health worker role and its benefits, and to promote more widespread adoption of community health workers, especially under health care reform. In this way, the impact of the community health worker strategy on patients, communities, and the health system can be fully realized.

AFTERWARD

As of September 2012, some 200 more state residents had earned certificates as community health workers, according to Cleary. The network of post-secondary schools that offer the certificate program is expanding with the addition of new Twin Cities metro and Greater Minnesota sites.

South Central College, Mankato, is piloting an online version of the curriculum in fall 2012 with 15 students across the state. This option is intended to grow the community health workers workforce in rural Minnesota to better meet community needs.

Based on feedback from employers and the availability of tested training materials, the alliance revised the curriculum in 2010, adding a three-credit course to build stronger health promotion/disease prevention competencies.

The Minnesota Community Health Work Alliance, now incorporated as a nonprofit and governed by a 16-member board composed of community health workers and stakeholder organization representatives, continues to support and build the field in order to address health disparities and empower communities for better health. For example, the alliance is working to include community health worker strategies in key state and federal health care reform efforts ranging from the implementation of health care homes to Minnesota's Health Insurance Exchange.

In 2012, the Agency for Healthcare Research and Quality (AHRQ) recognized the Minnesota Community Health Worker Alliance as an evidence-based innovation in its Innovations Exchange program. The AHRQ's profile of the alliance is available online.

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APPENDIX

Coalition Partners

(Current as of the end date of the program; provided by the program's management; not verified by RWJF.)

American Cancer Society

American Dental Association

Blue Cross and Blue Shield of Minnesota Foundation

Blue Earth County

Centro Campesino

Delta Dental of Minnesota

Fairview Health Services

Healthcare Education Industry Partnership

HealthPartners

Hennepin County

Intercultural Mutual Assistance Association

Mayo Health Systems

Medica

Minneapolis Foundation

Minnesota Board of Nursing

Minnesota Department of Health

Minnesota Department of Human Services

Minnesota Hospital Association

Minnesota International Health Volunteers (now Wellshare International)

Minnesota Nurses Association

Minnesota State Colleges and Universities

Multicultural Healthcare Alliance

Neighborhood Health Care Network

NorthPoint Health & Wellness Center, Inc.

Open Cities Healthcare Center

Open Door Health Center

Otto Bremer Foundation

Portico Healthnet

Ramsey County

Region Nine Development Commission

Southern Minnesota Area Health Education Center

Summit Academy Opportunities Industrialization Center

Susan G. Komen Foundation

Twin Cities Healthy Start Program

UCare

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(Current as of date of the report; as provided by the grantee organization; not verified by RWJF; items not available from RWJF.)

Books

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Communication or Promotion

www.mnchwalliance.org. Website of the Minnesota Community Health Worker Alliance. St. Paul, MN: Minnesota State Colleges and Universities System.

Cleary J, Eastling J and Itzkowitz V. Community Health Workers in Minnesota: Bridging Barriers, Expanding Access, Improving Health, Blue Cross and Blue Shield of Minnesota Foundation, 2010. Downloadable at *www.bcbsmnfoundation.org*.

Toolkits

Components of the curriculum:

- Communication Skills and Cultural Competence. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.
- The Community Health Worker Role: Advocacy and Outreach. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.
- Community Health Worker: Coordination, Documentation and Reporting. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.
- Community Health Worker's Role in Teaching and Capacity Building. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.
- The Community Health Worker: Legal and Ethical Responsibilities. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.
- Organization and Resources: Community and Personal Strategies. St. Paul, MN: Minnesota State Colleges and Universities System, 2005.

Blue Cross and Blue Shield of Minnesota
Foundation

Community health workers in Minnesota: Bridging barriers, expanding access, improving health

A decade of partnership, innovation and field-building to create healthy communities

2010

On the cover:

CHW Abdiqadir Harun of WellShare International regularly visits Somali cafes in Minneapolis as he engages with members of his community.

Inside front cover: *Clockwise from left*

Courtney Lawson and CHW Sophia Warsame of Intercultural Mutual Assistance Association (IMAA) in Rochester; CHW Sheena Loth of IMAA; CHW LaTrisha Vetaw of NorthPoint Health and Wellness, Minneapolis; CHW Maria Elena Escoto of Comunidades Latinas Unidas en Servicio, St. Paul, with clients on a home visit; CHW Abdiqadir Harun.

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Foreword

Our health company and Foundation recognize the critical role of community health workers in connecting Minnesota's diverse communities with the health care system. We're proud to have served as a catalyst for this important work.

— Patrick Geraghty, President and CEO, Blue Cross and Blue Shield of Minnesota

We are pleased to share this report on the development and growing recognition of community health workers as an emerging resource for Minnesota. This remarkable story of partnership, innovation and field-building provides a valuable model as our nation defines a solution to its health care challenges.

While Minnesota consistently ranks as one of the nation's healthiest states, not everyone who lives here shares in that good health. Immigrants, people of color and people living in poverty are particularly at risk. Many factors are responsible for health inequities, such as access to quality care, language barriers, cultural expectations about health and health care, housing and environmental conditions, and social connection.

Community health workers (CHWs) can be a critical part of the solution. They provide outreach, information, referral, advocacy and other support to promote health for underserved communities, and strengthen the cultural competence of health and service organizations. By fostering accessible, affordable and culturally appropriate care, CHWs — and the health and service organizations that employ them — are helping to address persistent health disparities for vulnerable populations and create healthier, more equitable communities.

Much has been accomplished in Minnesota over the last decade to train, support and provide sustainable funding for community health workers. A broad-based group of public and private agencies, and dedicated leaders — including CHWs themselves — is responsible for these accomplishments.

The Blue Cross and Blue Shield of Minnesota Foundation is proud to serve as a catalyst and funder for this work. Ten years ago our long-term commitment launched when we began to look for community-based approaches to close the gap on health inequities. We identified support for CHWs and the sustainable development of the field as one path to healthier communities. Since then we have invested in research, grantmaking and partnerships to build the field through our Critical Links initiative, with 41 grants totaling more than $3.3 million.

We welcome your comments and invite you to join us in helping to create healthier communities for all Minnesotans.

Blue Cross and Blue Shield of Minnesota Foundation

Patrick Geraghty
Board Chair

Marsha Shotley
President

Improving health Empowering communities

More than 121,000 CHWs worked in the United States in 2005, up over 40 percent from the start of the decade.[1]

Community health workers provide a community-centered approach to improving the health of underserved populations. As bicultural and often bilingual members of the communities they serve, community health workers improve access to care, promote healthy behaviors, facilitate effective management of chronic health conditions, increase the cultural competence of health care providers and organizations, bring greater diversity to the health care workforce, lower system costs and ultimately help to reduce health disparities for vulnerable populations. For centuries, communities the world over have relied on trusted and knowledgeable community members to promote health and healing. Building on this tradition, recent efforts in the United States have worked to formalize the role of community health workers by developing training, policy and funding. This report describes the community health worker story in Minnesota over the last decade.

Minnesota is home to the country's largest Somali and second-largest Hmong populations, and has significant numbers of immigrants from Central and South America. On these pages we recognize the important work CHWs are doing in these immigrant and refugee communities to help reduce disparities in Minnesota. We also want to acknowledge that CHWs serve as a critical link in many other communities as well, including Native American, African American, deaf and newcomers from many countries in Asia, Africa and Europe.

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Mejoramos la salud potenciamos a las comunidades

Los promotores de salud proporcionan un enfoque centrado en la comunidad para mejorar la salud de las poblaciones que carecen de servicios. Como miembros biculturales y, en ciertos casos, bilingües de la comunidad a la que sirven, los promotores de salud mejoran el acceso a la atención médica, promueven conductas saludables, facilitan el control efectivo de afecciones crónicas, incrementan la competencia cultural de los proveedores y de las organizaciones de atención médica, brindan una mayor diversidad a los trabajadores de atención médica, disminuyen los costos del sistema y, finalmente, ayudan a reducir las diferencias de salud en la población vulnerable. Por siglos, las comunidades de todo el mundo han dependido de los miembros sabios y confiables de la comunidad para promover la salud y la curación. A partir de esta tradición, los últimos esfuerzos en los Estados Unidos han colaborado para formalizar el rol de los promotores de salud al desarrollar capacitaciones, pólizas y financiación. Este informe describe la historia de los promotores de salud en Minnesota durante la última década.

Community health workers A critical link to health for Minnesota's communities

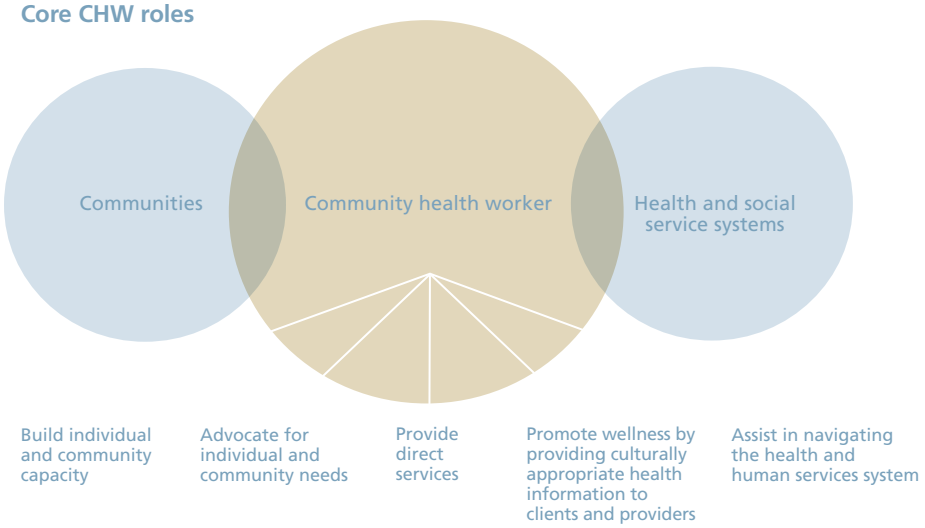
While Minnesota ranks as one of the healthiest states in the nation, people of color and those who are foreign-born typically experience poorer health than the native-born white population. The causes of these disparities are complex and intertwined. Research clearly implicates poverty as one contributing factor, but income alone does not explain why some groups are healthier than others.

Cultural attitudes, beliefs and practices explain some of the health disparities for individuals and communities, because culture can define how we perceive health and illness and how we view treatment and prevention options. Other factors include individual and collective historical experience with the health care system, fear and distrust of mainstream medical services and limited English proficiency.

A role for community health workers

To meet the needs of their culturally and linguistically diverse patients, health and human service organizations have begun to turn to community health workers (CHWs) as powerful allies. Also known as health educators, outreach workers and community health aides, CHWs help people with particular cultural needs navigate our complex health care system. At the same time, they help improve the cultural competence of the organizations that employ them.

Bridging the gap between communities and health/social service systems:
Core CHW roles



As trusted members of their clients' communities, community health workers can help to reduce the demand on overburdened providers by promoting healthy behaviors and guiding people to gain access to and use the health care system appropriately. For example, by facilitating clients' access to preventive services and to care in appropriate settings, CHWs can help them become aware of health conditions early, when treatment is most effective.

The diversity of roles and functions performed by community health workers is a strength that allows CHWs to meet community needs and build on community assets. Their work includes:

- Health education
- Information and referral to medical care and a range of social services
- Outreach
- Cultural consultation to clinical and administrative staff
- Social support, such as visiting homebound clients
- Informal counseling, goal setting, encouragement, motivation
- Advocacy
- Follow-up to ensure compliance with treatment recommendations

CHWs work in a variety of settings: health clinics, mental health centers, public health departments, mutual assistance associations and other community organizations and agencies that provide counseling, advocacy and health education. Community health workers can be especially effective in rural and other medically underserved settings, where health organizations are challenged by the cultural and linguistic needs of their patients and where physicians and other health care providers are in short supply. In Minnesota, CHWs are now also serving deaf, aged and disabled populations. Indeed, community health workers are a critical link to health for Minnesota's communities.

New immigrants and their U.S.-born descendents will account for 82 percent of the nation's population growth, while the resident population and its descendents will account for 18 percent.

— Pew Research Center

CHW LaTrisha Vetaw checks her client's blood pressure at NorthPoint Health & Wellness Center in North Minneapolis.

Partner spotlight:

NorthPoint Health & Wellness Center

"People feel comfortable talking to me, telling me what's going on," says LaTrisha Vetaw, a community health worker at NorthPoint Health & Wellness Center in North Minneapolis. "We can open a lot of eyes and show people what's available to them."

Vetaw provides education on the risks of smoking and secondhand smoke, encouraging parents not to smoke around their children. She delivers the message through community churches, public schools, businesses and other organizations. "I do this job because I want to help," she says. Vetaw also works with the Minnesota CHW Alliance.

One challenge Vetaw sees is a need to increase awareness of what community health workers do. "The biggest struggle is teaching others on the medical team what you do," she says, "so they understand your role and how it's made a difference."

CHW impact: effective management of chronic conditions

In a pilot study at two community clinics in Minneapolis and St. Paul, patients with diabetes who worked with CHWs significantly improved the management of their chronic condition.[2]

For many, diversity is this nation's demographic headline. It is projected that minorities … will make up the majority of the U.S. population in 2042.

— U.S. Census Bureau 2008

Collaboration The pathway to impact

Many organizations and individuals have contributed to the development of the community health worker field in Minnesota over the last decade. They include educators and academic institutions, the health care sector, health plans, public and private agencies, funders, policymakers, researchers and community health workers themselves. Their contributions have included the creation of partnerships and coalitions as well as individual efforts.

These partners recognize the importance of a number of key elements in the success of their work. They cite the need for strong leadership, a broad-based coalition of supporters, collaboration across sectors, a clear vision, an effective team to translate the vision into day-to-day realities and patience to stay the course.

The impressive concrete outcomes that have been produced over the last decade include:

CHW impact: return on investment

CHW case management increased use of primary and specialty care for 590 under-served men, reducing use of urgent care as well as inpatient and outpatient behavioral health care. The return on investment was $2.28 for every program dollar.[3]

Training, curriculum, peer learning

- Development of professional standards for community health workers, defining their role in the health care delivery system
- Development of a standardized curriculum and an 11-credit CHW certificate program to educate community health workers in Minnesota. In Fall 2010 the curriculum will be expanded to 14 credits.
- Provision of CHW training to over 350 students who received certificates that make their services eligible for Medical Assistance payment
- Development of specialized training in oral and mental health for community health workers
- Provision of scholarships to support participation in CHW training
- Creation of the Minnesota CHW Peer Network to provide opportunities for peer learning and professional development

Workforce development and job creation

- Formation of the Minnesota CHW Alliance, formerly the Minnesota CHW Policy Council, a workforce development partnership
- Creation of new jobs for community health workers
- Growing understanding among health care providers that CHWs are important members of a multidisciplinary team and can enhance services for diverse clients

Research and legislation for sustainable financing

- Research on outcomes, cost effectiveness and sustainability
- Passage of Minnesota legislation authorizing Medical Assistance payment for community health workers

Awareness and public support

- Creation and use of tools and strategies to build awareness and support, including a public television program and DVD, communications, convenings and other activities
- A growing appreciation for the role community health workers play in increasing access to health care coverage, improving the quality and cost effectiveness of care, enhancing health and increasing the diversity of the health care workforce

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"One of the lessons I've learned is the importance of constancy of purpose. We need to hold the context of the vision and the elements and when the time is right, look for ways to champion these things. As conversations continue around clinic homes, CHWs have a role there. As we think about paying for care in different ways, that should include new care models, made up of inter-professional teams, of which CHWs are an integral part. This is an idea whose time has come."

— MaryAnn Stump, chief strategy and innovation officer, Blue Cross and Blue Shield of Minnesota

Inset: MnSCU Chancellor James McCormick and Anne Willaert

"Community health workers are a critical link between communities and health care providers. We are proud of the Healthcare Education-Industry Partnership for its engagement with community partners to make the training and education of community health workers possible. This program would not have succeeded without the commitment of many who cared enough to assist the Minnesota State Colleges and Universities system and our determination to improve access and opportunity in all areas of service."

— James H. McCormick, Chancellor, Minnesota State Colleges and Universities

Partner spotlight:
Minnesota State Colleges and Universities

Partners are critical to Minnesota's community health worker programs, according to Anne Willaert, former director of the Minnesota Community Health Worker Alliance. Under Willaert's leadership, a consortium of partners came together from many sectors: state agencies, associations, postsecondary education, nonprofit organizations and the health care industry, and from the community health workers themselves. Collectively, these stakeholders oversaw the development of a statewide standard curriculum for community health workers, defined a "scope of practice" for these workers, and identified standards and competencies related to protocols for reimbursing providers for community health worker services.

As a result of the Healthcare Education-Industry Partnership's work and compelling advocacy by community health workers, in 2007 the Minnesota Legislature approved an historic policy measure authorizing the direct hourly reimbursement of community health worker services under Medicaid.

"The alliance and its collaborative partnership between stakeholders and community health workers have made this program so successful," Willaert said. "Having community health workers as part of the health care team will provide better service, access and cost savings for all residents of Minnesota."

The Foundation's role Key steps in building a field

The Blue Cross Foundation has worked over the last decade to develop and expand the use of community health workers in Minnesota, create sustainable support and build the field. To advance this work, we have provided 41 grants totaling more than $3.3 million through our Critical Links CHW Program.

Grants have supported projects to improve health services and education, increase access to care, develop capacity and leadership, promote outreach and community engagement, provide advocacy — and more. Those served include Latino, Hmong, Lao, Cambodian, Somali, Sudanese, Bosnian and deaf communities in the Twin Cities and Greater Minnesota. One cluster of grants focused on mental health and social adjustment, while another targeted policy awareness and support. A complete list of grantee organizations is included on the inside back cover.

In addition to grantmaking, we have also conducted research to inform our plans, convened meetings to share learning and developed strategic communications to promote awareness. In all of this work we have relied on many inspiring individuals and organizations without whom the success to date would have been impossible. Their contributions are highlighted throughout this report.

2000 – 2001

- Early grantmaking focuses on the health and social services navigational role of CHWs in different settings, serving diverse populations.

2002

- The Blue Cross Foundation commissions statewide survey on use of community health workers and interpreters. Over 150 health and human service agencies in 44 Minnesota counties participate in a first-ever look at CHWs in the state. The survey underlines the growing demand for community health workers and the need for standardized training to increase the pool of qualified workers.
- Foundation holds forum for policymakers, educators and health care representatives to review survey results, hear from experts and discuss how to promote the use of CHWs and interpreters in Minnesota's health care system.

2003

- Foundation report directs attention to the contributions of community health workers and training challenges faced by their employers. *Critical Links: Study Findings and Forum Highlights on the Use of Community Health Workers and Interpreters in Minnesota.*
- Foundation invites representative from Minnesota State Colleges and Universities (MnSCU) to visit the Community Health Worker Certificate Program at San Francisco State University to consider possibilities for a Minnesota curriculum.
- Foundation commissions Wilder Research Center to conduct CHW focus groups to better understand their training and professional development needs. Participants are enthusiastic about a training program with academic credits that could be applied toward a degree. They also identify peer support as an unmet need.

2004

- Based on Wilder Research Center finding that CHWs consider peer learning and support important to their effectiveness and professional development, the Foundation provides funding to Minnesota International Health Volunteers (now WellShare International) to develop and incubate the Community Health Worker Peer Network. Foundation grants in 2005, 2006 and 2008 support the network's expansion and strategic planning.
- Two-year Foundation grant provides seed funds for the Healthcare Education-Industry Partnership (HEIP), a MnSCU program, to develop and implement a standardized training curriculum for CHWs through the state's community college system. Program credits can be applied to training programs for other health occupations, creating an educational pathway and career ladder for community health workers.

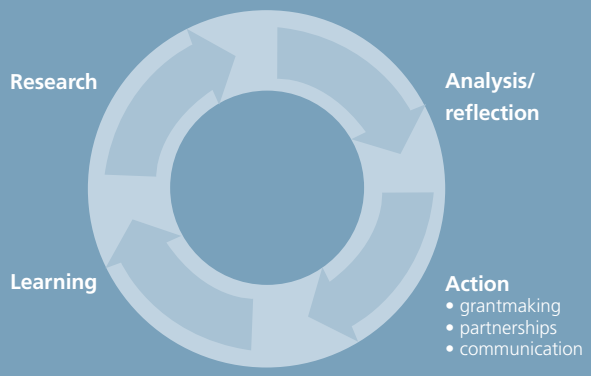
2005

- Foundation's successful nomination of HEIP to the Robert Wood Johnson Foundation Local Funding Partnership program leads to four years of support to advance the collaborative work of the Minnesota Community Health Worker Project and its statewide policy council.
- To explore options for sustainable financing for CHWs, the Foundation commissions the National Fund for Medical Education at the University of California-San Francisco Center for the Health Professions to identify promising CHW payment models.
- The Foundation launches *Healthy Together: Creating Community with New Americans*, incorporating Critical Links into this grant initiative with a focus on the CHW role in the mental health and social adjustment of immigrants and refugees.

"Our field-building approach reflects our partnership values and our focus as a learning organization, successively building on cycles of research, action and results. Our successes in Minnesota reflect the shared vision, leadership and commitment of so many individuals and organizations who have worked together over the past decade — to advance the CHW role with the goal of a healthier state."

— Marsha Shotley, President, Blue Cross and Blue Shield of Minnesota Foundation

Key steps: Building the CHW field in Minnesota



2006

- Foundation convenes representatives from community health worker organizations, government agencies and the health sector to discuss financing strategies to support CHWs. Blue Cross Center for Prevention works with NorthPoint Health & Wellness, Inc. to examine the impact that CHWs have on hypertension. Leads to three-year commitment to support CHWs to provide education and services related to tobacco use, secondhand smoke exposure, healthy eating and physical activity. Additionally, database is created to capture CHW activities and impact.

2007

- Twin Cities Public Television and the Foundation co-produce a 30-minute broadcast and a DVD on community health workers. More than 4,000 DVDs have been distributed and the ***tpt*** program has aired more than 40 times in Minnesota and beyond.
- The Community Health Worker Peer Network hosts its first statewide conference, attracting nearly 200 participants.
- The National Fund for Medical Education research and advocacy by the Minnesota CHW Project partners lead to Minnesota legislation (initially in 2007 and amended in 2008 and 2009) authorizing Medical Assistance payment for specific services provided by trained and supervised community health workers.

2008

- Foundation and ***tpt*** produce a second DVD on community health workers, a shortened version of the first program, in four languages including English, Somali, Spanish and Hmong. Requests come from across the United States.

2009

- With planning grants from the Foundation and other sources, the CHW Policy Council creates the Minnesota Community Health Worker Alliance to advance the role and its impact through education, policy and research, workforce development and a CHW association.

2010

- One-year Foundation grants to select Critical Links projects build organizational capacity and resilience during the Great Recession.
- Evaluation of current CHW grantmaking and assessment of future needs inform next steps for the Foundation's CHW field-building efforts.
- Exploration of CHW as a care model by Blue Cross and Blue Shield of Minnesota advances the Foundation's goals.
- Completion of expanded 14-credit CHW curriculum by HEIP.

Foundation as a catalyst

Goals, accomplishments and lessons

From the beginning, our goals have been to:

- Improve health care access, quality and cultural competence
- Increase the size and diversity of the health care workforce
- Reduce health disparities for racial, ethnic and immigrant groups
- Lower health care costs
- Provide an educational pathway and career ladder for CHWs

We are gratified and encouraged by the accomplishments of the last decade. Highlights, as noted elsewhere in this report, include:

- Support for a broad array of CHW models across the state that provide health education and services to underserved populations
- The development of a statewide standardized CHW training program in the Minnesota State College and University System as well as in the community
- The formation of a statewide CHW peer network for professional development and support
- Creation of a policy council to guide training and workforce development
- Landmark legislation that provides for Medicaid reimbursement of CHW services
- Exploration of ways to incorporate CHWs into clinic teams, health plan programs and new models
- A collaboration with public television on a 30-minute broadcast and national distribution of two DVDs on CHWs, one in English, Somali, Hmong and Spanish
- Growing awareness and support for the health benefits and cost savings of CHW programs

In the process of helping to develop the CHW field in Minnesota, we have learned many things, including:

- Foundations can serve as effective catalysts
- Research undergirds and points the way to effective action
- Complex issues require a formative, long-term approach
- Partnerships, shared leadership and strategic communications build support and impact

CHW Anita Buel and Interpreter Nathan Ellis in dialogue at Hennepin County Medical Center

Partner spotlight:
Deaf Community Health Worker Project

"Our goal is to empower deaf people to become active participants in their own health and wellness," says Anita Buel, director of the Deaf Community Health Worker Project. As deaf people, Buel and her colleague Mary Edwards know the communication barriers experienced by many deaf people who seek medical care. Now as trained community health workers, they provide support for deaf immigrants, senior citizens, cancer survivors and others who would otherwise lack linguistically and culturally appropriate care.

"For the first time, deaf people in Minnesota have someone who will help them get the answers they need," explains Nancy Meyers, program development specialist at the Deaf Community Health Worker Project. The Project's CHWs accompany patients to medical appointments and visit with them in their homes to provide health education, explain medical information and ensure adherence to recommended medical care. They also conduct health forums and support groups and offer cultural competency training for health professionals.

Through their work with the Deaf Community Health Worker Project, Buel and Edwards are helping to change health care for deaf people in Minnesota and to recruit other members of the deaf community to enter the field. At the same time, the example of their work has the potential to change practice and improve health and access to care for deaf people nationwide.

"Our community health workers keep our people going for the medical care needed."

— Tribal organization, Greater Minnesota

The Blue Cross Foundation's interest in helping to create standardized training for community health workers grew out of our statewide research in 2002. We learned that CHWs are highly valued for their role in addressing cultural and language barriers to health care. But we also learned that there was a shortage of qualified workers. Employers said that standardized training would mean a better-prepared workforce and an increased pool of qualified CHWs. Many CHWs saw training as an important means to validate their work and help them gain greater recognition and respect from health care professionals.

We knew that building a sustainable community health worker field would require multiple approaches and the involvement of both public and private partners. As a start, we worked with health care, higher education and CHW partners to develop a community health worker training program. This program not only fills a void in standardized training and ensures consistency in skills and competencies, but also leads to a career ladder enabling CHWs to enter other health-related positions. Ultimately, we intended to help produce a cadre of people with the skills to be effective CHWs, contribute to a more culturally diverse health care workforce that would better meet the needs of Minnesota's diverse population and address shortages in the health care professions.

Partnership and results

The Foundation approached the Healthcare Education-Industry Partnership (HEIP), a program of Minnesota State Colleges and Universities, with our research findings and grant support. HEIP attracted a broad funding base and a dedicated consortium of more than 20 other organizations to develop a curriculum from the ground up. The resulting statewide program, the first of its kind nationally, combines classroom learning, field work and internships in a standardized CHW curriculum.

The 11-credit program includes courses in advocacy and outreach; community and personal strategies; teaching and capacity building; legal and ethical responsibilities; coordination, documentation and reporting; and communication skills and cultural competence. The program is available at five educational sites: four MnSCU campuses including Inver Hills Community College, Minneapolis Community and Technical College, Rochester Community and Technical College, South Central

College (Mankato) and one community-based site at Summit Academy OIC (Minneapolis). By December 2009, over 350 students had received CHW certificates of completion, with another 68 experienced CHWs "grandfathered."

Program credits can be applied to MnSCU training programs for other health occupations, such as nursing, creating a career ladder for CHWs who want to move into other health-related fields. Community health workers who have been practicing at least five years were eligible to take an assessment in 2009 to measure their competencies. After passing the test, a worker received a CHW certificate of completion, required for application as an enrolled provider for Medical Assistance reimbursement for specific CHW services as a CHW in Minnesota. These features allow the training and certificate program to contribute to building and retaining a more diverse health workforce and address the overall shortage of health care workers in Minnesota. Next steps call for distance learning through I-TV as well as online training.

Peer support

In addition to formal training, the Foundation learned that community health workers identified ongoing professional development and peer support as important, unmet needs. Foundation grants enabled Minnesota International Health Volunteers, recently renamed WellShare International, to build the first statewide network for community health workers. The Minnesota Community Health Worker Peer Network provides CHWs with an opportunity to receive ongoing professional development, to support each other and to share resources and exchange information. The network also allows CHWs to serve as a collective voice to raise awareness about their profession and health issues in their communities.

Participants come from Laotian, Somali, Latino, African-American and American Indian communities. All CHWs are welcome. Network activities include monthly meetings for training and networking, regional training opportunities for both CHWs and their employers in urban and rural areas, skill-building workshops, links to resources for CHWs and employers, a statewide conference, a quarterly newsletter and listserv. Future plans include expanded outreach, career development and leadership activities.

"We can reach communities in their own language and culture to connect them with medical services and to identify systemic barriers to health access."

— Gloria Contreras, Health Promoter Coordinator, Centro Campesino and graduate of the CHW training program

CHW Abdiqadir Harun and Wellshare International Executive Director Diana DuBois visit in a Somali mall in Minneapolis

Partner spotlight:
WellShare International

"We have seen the tremendous impact that CHWs can have within a community-based organization," says Diana DuBois, executive director of WellShare International, Minneapolis, formerly Minnesota International Health Volunteers.

Over the last 30 years, WellShare has trained over 4,000 CHWs in seven countries. In Minnesota, WellShare's extensive CHW-related work has included creating and sustaining the CHW Peer Network, the first statewide coalition of CHWs in Minnesota. "The network enables CHWs to share resources, develop leadership skills and advocate on their own behalf," DuBois explains. WellShare continues to facilitate network activities, communication and strategic planning. It also successfully organized the first-ever CHW conference in Minnesota, which included more than 200 CHWs, employers, nonprofits, foundations, health plans, clinics and government agencies.

WellShare employs eight full-time Somali CHWs who collect baseline data on Minnesota's Somali population, create culturally appropriate tools and conduct thousands of home visits. As a next-stage contribution to the CHW field, WellShare will publish articles on its extensive documentation of the impact of CHW activities. "It gives me great satisfaction to be able to raise the profile of CHWs and others who work on the front lines every day to assist Minnesotans in improving their health," DuBois says.

"Research studies show that community health workers improve health outcomes among minority and immigrant populations."

— Jose Gonzalez, Director, Office of Minority and Multicultural Health, Minnesota Department of Health

"We are fortunate in Minnesota to have had such strong legislative leadership. By championing the need for CHW reimbursement policies, legislative leaders helped to establish and sustain the important role of community health workers in promoting the health of underserved populations."

— Anne Willaert, project director, MnSCU

Sustainable funding is necessary to ensure that community health workers move from occupying a temporary position, often dependent on short-term grant support, to part of the mainstream system where they can contribute long term to the health of underserved populations.

The Blue Cross Foundation commissioned the National Fund for Medical Education at the University of California-San Francisco Center for the Health Professions to conduct the first national study of sustainable financing mechanisms for community health workers. The 2006 report, *Advancing Community Health Worker Practice and Utilization: The Focus on Financing,* noted that CHW programs with sustainable funding include these elements:

- A mandate or mission to provide services to an underserved population
- Identification of unmet health care needs that CHWs could help to meet
- Champions who believe in the value of CHWs and work to win support
- Solid outcomes data indicating positive impact on access, costs or health status
- Targeted training for CHWs

A report specific to Minnesota financing for CHWs was developed as a supplement to the national report.

State legislation

In 2007, the Minnesota State Legislature authorized reimbursement for CHW services. This important step forward resulted from the presence in Minnesota of many of the critical elements cited in the National Fund for Medical Education research and advocacy by partners in the Minnesota CHW Project. The Centers for Medicare and Medicaid Services approved amendments to the initial policy in 2008 and 2009 authorizing Medical Assistance payments for trained and supervised CHWs. To date, Minnesota is one of only two states to reimburse community health workers under the Medicaid program.

A study conducted by Anne Willaert of Minnesota State Colleges and Universities and others[4] examined the policy and systems change initiatives of a number of states working to integrate CHWs into service-delivery teams and use CHWs to help eliminate health disparities. Past approaches that focused on single measures have proven insufficient to achieve lasting change, according to the study. The authors believe the comprehensive approaches of Massachusetts and Minnesota can serve as models for other states seeking to eliminate health disparities.

The study recommends that comprehensive state legislation include financing mechanisms for sustainable employment, workforce development, occupational regulation and guidelines for publicly funded CHW research and evaluation. In addition, CHW legislation should:

- Include direct participation of CHWs in the development of any policy or regulation that affects CHW practice
- Minimize barriers (such as language or education level) that may restrict CHW employment or limit training opportunities for members of underserved communities
- Enhance accountability in the community and increase the credibility of services by encouraging providers to contract with community-based organizations to supply CHW services

Minnesota CHW legislation

Community health worker

(a) Medical assistance covers the care coordination and patient education services provided by a community health worker if the community health worker has:

(1) received a certificate from the Minnesota State Colleges and Universities System-approved community health worker curriculum; or
(2) at least five years of supervised experience with an enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or at least five years of supervised experience by a certified public health nurse operating under the direct authority of an enrolled unit of government.

Community health workers eligible for payment under clause (2) must complete the certification program by January 1, 2010, to continue to be eligible for payment.

(b) Community health workers must work under the supervision of a medical assistance-enrolled physician, registered nurse, advanced practice registered nurse, mental health professional as defined in section 245.462, subdivision 18, clauses (1) to (5), and section 245.4871, subdivision 27, clauses (1) to (5), or dentist, or work under the supervision of a certified public health nurse operating under the direct authority of an enrolled unit of government.

(c) Care coordination and patient education services covered under this subdivision include, but are not limited to, services relating to oral health and dental care.

— Minnesota Statutes 2008, section 256B.0625, subdivision 49

Courtney Lawson, Dr. Paul Targonski and CHWs Sophia Warsame and Sheena Loth share updates in the Mayo Clinic's Gonda Building

Partner spotlight:

Intercultural Mutual Assistance Association

"The ultimate impact of using community health workers will be improved health and reduced costs," says Courtney Lawson, program manager at Intercultural Mutual Assistance Association (IMAA) in Rochester. IMAA makes its CHWs available at no charge to any resident of Olmsted County. The agency also promotes the use of CHWs in southeast Minnesota and statewide through partnerships with health care providers. A project with the Mayo Clinic, for example, will provide a rigorous look at the health effects and program costs for patients working with CHWs in a primary care setting.

"The field has made enormous strides in a relatively short period of time," Lawson notes. Providing meaningful data for providers, businesses, payers and community members is critical to keep efforts moving forward. "The process of collecting these data starts with understanding the barriers to utilization and the needs of each stakeholder," Lawson explains. "The data must demonstrate both improved health outcomes and cost savings to illustrate the gap in services that CHWs fill. Our multi-year study in partnership with Mayo will be an important contribution to the literature."

CHW impact: better prevention

Studies of CHW programs have shown significant improvements in patients' use of prevention services, such as mammography and cervical cancer screenings among low-income and immigrant women, whose screening rates are typically lower.[5]

For those looking to enhance the credibility of the field and ensure that CHWs contribute to the health of Minnesota's communities to their fullest potential, some challenges lie ahead. These challenges include full integration of CHWs in the health care field, clarifying their roles, responsibilities and competencies, demonstrating the impact of investments in CHWs on patient outcomes, making the case for sustainable funding mechanisms, recruitment, training, ongoing professional development and retention. Based on the developments of the last decade and current trends, many are optimistic that these challenges will be met, creating a future for community health workers that includes:

- Integration of CHWs into the mainstream of health care delivery
- Perception of CHWs as valuable members of the health care team
- Development of sustainable funding, including funding from private as well as public payers
- Wage structures that attract and retain CHWs and reflect the value of their services
- Clear educational and career pathways for CHWs that lead to professional development and diversification of the health care workforce
- Documentation of impact in terms of health benefits and cost savings
- Broad recognition of CHWs as contributors to better health outcomes

CHW impact: improved quality of life

A CHW outreach program serving Medicaid patients with diabetes resulted in a 40 percent decline in emergency room visits, average savings of $2,245 per patient and improved quality of life.[6]

Recent promising developments include:

- A 2007 national conference, supported by Minnesota's Healthcare Education-Industry Partnership and a consortium of researchers, funders, and others, proposed a research agenda and other recommendations to strengthen the evidence base for the health and cost benefits of CHWs
- On the national level, a CHW membership organization known as the American Association for CHWs has been developed
- The United States Department of Labor created a classification code for CHWs in 2009. This will enable better collection of workforce data, including data on the number of existing CHWs.
- The National Center on Minority Health and Health Disparities, a division of the National Institutes of Health, targeted a portion of its American Recovery and Reinvestment Act funds to support research on community health worker training

- The Children's Health Insurance Program (CHIP), reauthorized in 2009, recognizes CHWs as providers of outreach, enrollment and education
- Federal funds support Centers for Medicare and Medicaid CHW demonstrations and pilots and now under the 2010 health care reform legislation, include grants by the Centers for Disease Control and Prevention to promote healthy behaviors among medically underserved populations through the use of CHWs

Minnesota CHW Alliance

The Minnesota CHW Project is in the process of creating a sustainable CHW Alliance to bring together CHWs, higher education, the health care industry, health care payers, foundations and public/private organizations committed to improving health care for all in Minnesota. The Alliance's mission is to reduce cultural and linguistic barriers to health care, improve quality and cost effectiveness of care and increase the number of health care workers who come from diverse backgrounds or underserved communities. The Alliance will concentrate its work in four areas: education, workforce, policy and research, and the CHW Association.

Next steps for the Blue Cross Foundation

The Blue Cross Foundation is encouraged by the success in building the community health worker field in Minnesota. But we know the work is not over. As health care reform efforts move forward, we will continue to collaborate with others to promote awareness, understanding and support of the CHW role and to document outcomes, costs and benefits. Future goals include increasing the number of curriculum sites, enhancing placement services and career counseling, and providing opportunities for distance learning. In particular, the Foundation will explore opportunities to better integrate CHWs into the health care system, sustain CHW models based in social service and community settings, and support next-stage policy work and innovative partnerships that advance the field.

One exciting recent step is our support for the further development of the Minnesota Community Health Worker Alliance, which will house and support training, policy, workforce development and related work to advance the field.

Moving forward

- Advance CHW knowledge, skills, career paths
- Recruit & retain CHWs, especially in underserved areas
- Integrate CHWs into new health care structures
- Ensure sustainable funding mechanisms
- Document impact & cost savings
- Raise awareness among employers and policymakers

Jose William Castellanos visits with Lauren Haun outside CLUES' Minneapolis office

Partner spotlight:
Comunidades Latinas Unidas En Servicio (CLUES)

"CHWs have changed social norms," says Jose William Castellanos, MD, director of the Comunidades Latinas Unidas En Servicio (CLUES) Family Centric Health Promotion Program. CLUES, which provides behavioral health and human services to Minnesota's Latino community, has trained over 100 community health workers on tobacco control, healthy nutrition, HIV/AIDS, CPR, cancer prevention and other health issues. Currently 25 CHWs support CLUES services.

Since 2004, CHWs at CLUES, with support from the Blue Cross and Blue Shield of Minnesota Center for Prevention, have performed more than 18,000 home visits, reached more than 135,000 individuals with information and education and referred more than 2,100 smokers willing to quit to tobacco cessation programs. Their work has been recognized with awards by the Minnesota Cancer Alliance, the National Association of Counties and the National Public Health Information Coalition.

Working with community members active in their own communities has been an important success factor, according to Castellanos. "These CHWs are seasoned professionals who make a difference in their communities," he notes.

CHW impact: increased health care coverage for children

A randomized controlled trial of a CHW intervention to increase health care coverage among Latino children in Boston found that children in the CHW intervention group were significantly more likely to be covered and to be covered continuously, compared to children in the control group.[7]

"Community health workers empower their communities to overcome illness and poverty and help them to achieve their American dream."

— Jose William Castellanos, MD, Comunidades Latinas Unidas En Servicio

What you can do Taking action on lessons learned

Business

- Authorize the addition of CHW services to the health benefits that you offer to your employees and work with your health plan(s) to secure these services in company locations where you employ a diverse workforce.
- Forge partnerships that include business, labor unions, local clinics, health plans and others to develop, implement and evaluate integrated CHW models for outreach, education and coordination in ways that lead to improved self-care and prevention, better understanding and appropriate use of care and benefits, cost-effective management of chronic disease, healthier working and living conditions for better health, productivity and value.
- Explore the addition of CHWs (as employees or contractors) to your occupational health team if your work-force is ethnically and/or racially diverse, including employees with limited or no English language skills.
- Support local community colleges or other appropriate educational sites that offer CHW training in order to build the local CHW workforce in areas in which your business employs an ethnically and racially diverse workforce. Help start a program if none exists. In Minnesota, contact the Minnesota CHW Alliance for information and assistance.

Community health workers

- Engage other CHWs and stakeholders in establishing and promoting CHW standards and competencies.
- Support and participate in CHW networks and associations such as the Minnesota CHW Peer Network and the Minnesota CHW Alliance for mutual support, professional development and advocacy.
- Educate others in your community about the role of CHWs, such as mutual assistance associations, clergy, neighborhood groups, high school students and guidance counselors, Head Start and Early Childhood Family Education, senior centers, social service agencies, community policing, local chambers of commerce, parks and recreation, town/city representatives, and the media.
- Advocate for competitive CHW compensation and benefits.
- Raise awareness of the CHW role as a career track and route into the health care professions within and beyond your own community.
- Mentor those new to the field and provide peer support along with self-care to contribute to a strong, resilient CHW workforce.
- Consider future opportunities to move into related health fields if interested. In Minnesota, apply the Minnesota State College and University credits from your CHW certificate program to training for other occupations to build an educational ladder.

Educational institutions and systems

- Raise awareness of the CHW role at the high school and post-secondary education level as a career track and path into the health professions. Encourage bicultural, bilingual individuals with interests in health and community advocacy to consider becoming CHWs. Outreach should include those just considering future careers as well as individuals with work experience.
- Consider starting a CHW training program at the community college level within diverse communities using a competency-based curriculum, articulated with other health career preparatory training. If none exists in your region, work in consultation with local clinics and hospitals, local public health and human services, health plans, community leaders, business and other stakeholders. In Minnesota, contact the Minnesota CHW Alliance for information and technical assistance.
- Conduct and publish rigorous evaluations at the university level, using participatory research models that demonstrate the impact of CHWs on patient and population health, cost savings, care delivery models, cultural competence, career opportunities and diversification of the health care workforce, and other key dimensions.
- Help establish and promote CHW standards and competencies along with other stakeholders.
- Support training, ongoing education and state and local networks and associations for CHWs for mutual support, professional development and advocacy.

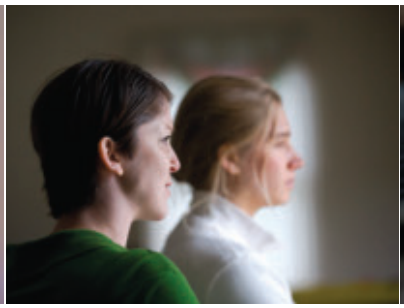
- Educate others associated with your educational institution on the role of CHWs including students, faculty, staff and alumni as well as health professionals, policymakers and business.
- Reach out to practicing CHWs through educational programs with CHW alumni as well as postsecondary educational institutions that offer training in other health roles to encourage them to consider pursuing additional training and education to enter other health professions.
- Expose students in the fields of medicine, nursing, dentistry, public health and allied health professions at academic health centers to practicing CHWs and interpreters as part of their residencies and fieldwork in order to prepare them for work as a team.

Funders

- Provide financial support to help health providers, and social service agencies and other nonprofits serving ethnically and racially diverse populations incorporate community health workers into their programs.
- Provide ongoing opportunities for training and professional development for practicing CHWs, including distance learning options.
- Support coordinated statewide systems of CHW training, including scholarships that reflect lessons from Minnesota and other states.
- Support a variety of models, as the field will benefit from innovation.
- Support the use of CHWs in rural and other underserved communities.
- Understand that funders involved in a variety of issues — early childhood, youth development, seniors, immigrants, environment, community development, healthy and/or supportive housing, workforce development, regional equity, poverty reduction, health and health care, etc. — can support the CHW field.
- Share what you have learned with others and communicate the value of CHWs through multiple vehicles. In particular, inform other funders, policymakers, health organizations and employers of the benefits and cost savings realized with CHWs and the need for funding strategies that keep the field viable.
- Raise awareness of the CHW role as a career track and pathway into the health care professions.
- Support ongoing rigorous research, demonstration and evaluation that identify success factors in clinics and outcomes in clinics and community-based settings to provide evidence of impact and cost reduction that will make the model sustainable.
- Support the development and work of the CHW peer networks and membership associations at the state and national level, building on lessons from Minnesota and other states.
- Focus on policy and systems change for broad impact.
- Stay focused on the long term and understand that change is incremental.

Health plans

- Help establish and promote CHW standards and competencies along with other stakeholders.
- Support training, ongoing education and state and local networks and associations for CHWs for mutual support, professional development and advocacy.
- Educate others in your industry and those it serves about the role of CHWs including health providers, employer groups, policymakers, members and agents.
- Identify and work with interested employer accounts that have a diverse workforce to pilot integrated CHW models and explore inclusion of CHWs as part of their benefit package.
- Educate provider networks about CHWs, encourage those that serve diverse communities to employ CHWs and, in Minnesota, provide information about guidelines for Medical Assistance enrollment and CHW payment under Minnesota Health Care Programs.
- Ensure that CHWs find a place within the medical/health care home model, home visiting programs and strategies that emerge from ongoing health care reform including global payment and performance-based systems.
- Consider the role of CHWs in contracted and carve-out programs, such as chronic disease management and maternal and child health.
- Serve as internship sites for CHW students, consider employing CHWs based on your health plan model and operations. Provide scholarships to interested employees to obtain training to move into CHW positions in your organization.



Health providers and other CHW employers

- Continue to learn about, support and use CHWs, structuring their role so that they are recognized and function as valued team members with voice, expertise and important community ties who help improve access, appropriate use of care, outcomes, cultural competence and community connections.
- Support the participation of your CHW employees in peer networks for ongoing professional development and mentoring such as the Minnesota Peer Network and in-state and national level CHW associations that help build the field such as the Minnesota CHW Alliance. Provide paid time to attend meetings. Subsidize dues or registration that may apply. Offer free meeting space.
- Educate others — including health professionals, policymakers, business — on the role of CHWs and the importance of a diverse health care workforce.
- Demonstrate competitive compensation and benefits for CHWs based on their performance and contributions as well as the need to attract and retain a skilled workforce.
- Ensure that CHWs find a place within the medical/health care home model and strategies that emerge from ongoing health care reform.
- Provide both formal and informal opportunities for CHWs to share their knowledge of their communities in ways that build provider and organizational cultural competence, stronger relationships and programs that more fully reflect the needs and assets of community members they are intended to serve.
- Learn how CHWs can help demonstrate community accountability and community benefit. Improve your system's performance by involving CHWs in efforts to reduce costly preventable, inpatient admissions and readmissions, and unnecessary emergency room use.
- Build CHWs into new and existing oral health models and healthy housing efforts.
- Integrate CHW tools and reporting into patient/client data systems and make changes to billing/financial systems needed for CHW payment, where applicable.
- Serve as internship sites for CHW students and provide scholarships to employees to obtain training to move into CHW roles.
- Encourage and if possible, subsidize, interested CHW employees to complete education and credentialing needed to move into related occupations in your organization to create a career ladder.

Media

- Learn about CHWs and broaden your coverage of health topics to include their contributions to improving health care access and outcomes for those experiencing cultural, language and other barriers to care, lowering costs, reducing health inequities, strengthening health care cultural competence and increasing the size and diversity of the health care workforce.
- Feature local CHWs, their roles, training, clients, communities and employers, from a variety of angles — emerging health career, bridge builder for health systems and cultural communities, new member of the health care team, community advocate.

Policymakers

- Learn about the community health benefits and cost savings produced by CHWs and recognize their value in the broad health field as well as in early childhood development, youth services, aging, refugee resettlement and immigrant integration, housing and the environment.
- Develop policies that will fully integrate CHWs into federal- and state-level health programs and ongoing health reform initiatives, with sustainable funding.
- Engage community health workers, health providers and other key stakeholders in establishing and promoting CHW standards and competencies.
- Expand and refine current legislation on the federal and state levels, as appropriate, to broaden the pool of trained CHWs and reduce barriers to the use of payment streams for CHWs by health providers such as federally qualified health centers and by community-based organizations.
- Approve funding for an integrated CHW research agenda that supports participatory research and rigorous evaluations that demonstrate the impact of CHWs on patient and population health, cost savings, care delivery models and approaches, cultural competence, career opportunities and health care workforce size and diversity.
- Encourage and if possible, subsidize, interested CHW employees to complete education and credentialing needed to move into related occupations in your organization to create a career ladder.
- Recognize the contribution of the CHW role to local economic development through the creation of jobs in underserved communities that value the life experience of local residents as a job qualification.

Partner spotlight:

Robert Wood Johnson Foundation

"As we look at our needs as a nation to be healthier and to reduce health care costs, the on-the-ground community connections of community health workers can make a difference," says Pauline Seitz, director of Local Funding Partnerships at the Robert Wood Johnson Foundation.

Local Funding Partnerships provided four years of support to advance the collaborative work of the Minnesota Community Health Worker Project and its statewide policy council. "The program has touched so many lives and made it possible for talented people in the community to enter the health professions and have a career ahead of them," Seitz says.

Noting the difficulty health care providers have in reimbursing for services that are not standardized, Seitz explains, "The Minnesota program put the policy piece in place to obtain funding and develop core competencies. We are extremely impressed with their ability to accomplish their goals."

Seitz also highlights the "exceptional example" of academic/community partnership provided by this project. "Often, programs that are academically centered are short-term enterprises," she says. "This is not short-term. This is really systems change."

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Our partners and grantees*

American Cancer Society – Midwest Division*

Blue Cross and Blue Shield of Minnesota

Bosnian Women's Network*

CAPI, Centre for Asians and Pacific Islanders*

CentraCare Health Foundation*

Centro Campesino*

Comunidades Latinas Unidas En Servicio (CLUES)*

Community-University Health Care Center (CUHCC)*

Confederation of Somali Community in Minnesota*

Family and Children's Service*

Health Advocates

Intercultural Mutual Assistance Association*

La Familia Guidance Center*

Lao Assistance Center of Minnesota*

Mayo Clinic*

The Minneapolis Foundation*

Minneapolis Medical Research Foundation*

Minnesota CHW Policy Council

Minnesota CHW Peer Network

Minnesota Council of Churches*

Minnesota Deaf CHW Project*

Minnesota Department of Health

Minnesota Department of Human Services

Minnesota International Health Volunteers* (now WellShare International)

Minnesota State College and University System/ Healthcare Education-Industry Partnership (HEIP)*

Multicultural Healthcare Alliance*

National Fund for Medical Education at the University of California San Francisco, Center for the Health Professions*

Neighborhood Healthcare Network*

Neighborhood House*

NorthPoint Health & Wellness Center

Open Cities Health Center*

Open Door Health Center*

Otto Bremer Foundation

Pillsbury United Communities*

Portico Healthnet*

Red Lake Comprehensive Health Services*

Robert Wood Johnson Foundation Local Funding Partnerships

St. David's Child Development and Family Services*

The St. Paul Covenant*

Sioux Valley Tracy Medical Center*

SNG Research

Somali Community Resettlement Services*

Touchstone Center for Collaborative Inquiry

Twin Cities Public Television

Vietnamese Social Services of Minnesota*

WellShare International (formerly Minnesota International Health Volunteers)*

Western Mental Health Center*

Wilder Research Center*

Women's Cancer Resource Center*

Women's Initiative for Self Empowerment (WISE)*

YWCA Mankato*

**Denotes grantee organization*

Blue Cross and Blue Shield of Minnesota
Foundation
An independent licensee of the Blue Cross and Blue Shield Association

The Blue Cross and Blue Shield of Minnesota Foundation is the state's largest grantmaking foundation to exclusively dedicate its assets to improving health in Minnesota, awarding more than $27 million since it was established in 1986. The Foundation's purpose is to look beyond health care today for ideas that create healthier communities tomorrow, through a focus on key social, economic and environmental factors that determine health, to improve community health long-term and close the health gap that affects many Minnesotans.

Fulfilling the vision of healthier communities for all Minnesotans will require the participation of many organizations and individuals. We are dedicated to working collaboratively with others in the community and to sharing the lessons we learn along the way.

Contact us at:
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LFP RUBRIC-STAGE I-BRIEF PROPOSAL Vulnerable Populations - How would this project improve health or health care for people made vulnerable by social factors?				
LIMITED - This project employs a proven intervention to provide access to health care services for people made vulnerable by well-known social factors.	**MODEST -** This intervention addresses the health needs of a newly recognized vulnerable population (i.e. a recent immigrant group), combines health services in a new way or adapts services to be more sensitive to the needs of vulnerable clients.	**COMPETITIVE -** This initiative offers an out-of-the-box solution to improve health or health care by causing significant change in one or more social factors such as education, housing or poverty.	**STRONG -** This program operates outside of traditional service systems, demonstrates a high level of client involvement, engages professionals beyond health care, and alters at least one social factor (such as transportation) to reduce barriers to care.	**EXCEPTIONAL -** This project was developed and implemented by health care and other sector professionals working together with clients, creates public/private partnerships, is a catalyst for systems change in more than one social factor.
Funder/Applicant Partnership - How have funders been involved in development of this idea?				
LIMITED - Nominating funder was recently contacted by the applicant agency to write letter of nomination; no prior funder involvement in this project.	**MODEST -** Nominating funder has expressed interest in committing new grant dollars to the project, has been consulted on the proposed program and assisted in preparation of the application.	**COMPETITIVE -** Nominating funder has been engaged with applicant agency in the planning and development of this project, has expressed interest in committing new grant dollars and is actively working with other funders to raise additional support for the program.	**STRONG -** Multiple funders have been engaged in the planning and development of the concept and have expressed interest in providing grant dollars and technical assistance if the proposal advances with RWJF.	**EXCEPTIONAL -** Multiple funders participated in the original collaborative that identified the need for this initiative as a high community priority. Grantmakers continued to participate in the development of the concept, investing resources and technical assistance to facilitate convening, planning and/or piloting the project. Funding partners are committed to supporting implementation of the program with dollars and technical assistance.
Community Collaboration - What are the origins of this coalition and how is the partnership evolving?				
LIMITED - Idea was developed and will be implemented by the applicant institution.	**MODEST -** Project created by applicant agency and endorsed by other groups.	**COMPETITIVE -** One organization created project and convened community groups as active partners.	**STRONG -** Problem identified by community agencies that typically do not work together and have now joined forces to address the issue with a new infrastructure and clearly defined decision-making process.	**EXCEPTIONAL -** Project actively engages a broad-based, non-traditional coalition of community groups whose new working relationship/partnership stimulates breakthrough thinking leading to systems change.
Innovation - How new/creative is this idea?				
LIMITED - This project would replicate a well-tested model that has already been described in the literature, been broadly disseminated and demonstrated in the U.S.	**MODEST -** This grant would bring a new pilot project to scale for the first time or fund an early replication of a successful intervention.	**COMPETITIVE -** This program will be the first adaptation of the model in a very different setting or with a different population (i.e. rural to urban, children to adults, chronic disease to acute condition).	**STRONG -** This intervention adds original program elements or methods that offer ambitious outcomes such as significant systems change.	**EXCEPTIONAL -** This initiative shows highly creative, fresh thinking about old problems to challenge the pervasive wisdom in the field, demonstrate a groundbreaking approach and unveil a potential new national model

LFP RUBRIC-STAGE II-FULL PROPOSAL Evaluation: How will the impact of the intervention be assessed/quantified?				
Limited-No baseline data; vague or absent quantifiable outcomes and no evaluation model or plan in proposal.	**Modest**-Some baseline data available but most extrapolated from state, national data; quantifiable outcomes not fully developed;evaluation minimally discussed in proposal.	**Competitive-**Baseline data specific to region targeted for program; quantifiable measures explained with some datail;model for evaluation described;evaluation conducted internally.	**Strong-**Detailed baseline data specific to region targeted for program;quantifiable measures, process and outcome evaluation elements described; evaluation conducted primarily internally, may have some external consultation/advice.	**Exceptional**-Baseline data specific to region targeted for program; quantifiable measures, process and outcome elements described in detail; evaluation conducted internally as well as externally; may have opportunity to measure impact using controls or proxies.
Sustainability: What measures, opportunities are identified to promote continuation of this work after the RWJF grant? How does this program fit the mission of the larger agency?				
Limited-Single matching funder identified; program has minimal likelihood of attracting funding streams; project is a stretch for the mission of the parent agency.	**Modest**-Several funders identified for year 1 matching funds; long term funding commitments are uncertain;questionable likelihood of attracting funding streams; mission is broadly aligned with mission of the parent agency.	**Competitive**-Multiple funders providing match in year one and some expression of commitment for funding support in subsequent years;possibility of attracting funding streams;new project is a natural outgrowth of current services.	**Strong**-Diversity of funders at the table including some who have never supported the organization or health issues;part of year 2 match secured; likely avenues to pursue funding streams through public, private sources; project well aligned with mission of the parent agency.	**Exceptional**-Full match in place at the start of the grant; diversity of funders engaged including some who have never supported the organization or health issues;project has potential to influence policy to support funding streams and replication to other communities; project is essential to mission of the parent agency.
LFP RUBRIC STAGE III-SITE VISIT Organizational Capacity: Does the agency have the infrastructure, management and Board to support the new initiative?				
LIMITED - Small or start-up organization; initiative would mark the inception of a new organization; Board is small, purely advisory or non-existent; financial instability.	**MODEST -** Agency is young, original Board in place; limited internal management structure. OR Project resides in a large organization such as a hospital or university and has limited independence.	**COMPETITIVE -** Stable, established agency; diversified sources of income/funding; Board is established; Executive Director is supportive of the new initiative.	**STRONG -** Locally well-known agency; stable income/funding; Board is strong, engaged; Executive Director promotes new initiative.	**EXCEPTIONAL -** Prominent organization; stable income/funding; Board and full management team in place; Executive Director active on policy level.
Leadership: Is there a recognized "parent" for the program? Does the project have strong leadership?				
LIMITED - Project developed by committee, grant writer coordinating; no agency person appearing to own project OR competition for ownership of project.	**MODEST -** Project developed collaboratively with plan to hire director once funded OR project director in place but appears inexperienced; competing agendas among collaborative partners.	**COMPETITIVE -** Project developed by collaboration with project director identified; individual appears qualified.	**STRONG -** Project collaboration in place for several years; project director emerged during this process and appears to have leadership potential; dedicated staff in place.	**EXCEPTIONAL -** Long standing collaboration with strong leader and staff with strong credentials; potential succession to leadership roles in evidence.
Fiscal Controls and Budget: Can the program manage the money?				
LIMITED - Agency has never had an audit or filed a federal form 990; not yet established as a 501©3; budget reflects unrealistic salaries and other expenses; overall financial status appears problematic.	**MODEST -** Agency has had an unfavorable audit or management letter indicating need for stronger internal controls; federal form 990 incomplete; budget is reasonable for program but may be the largest agency has managed.	**COMPETITIVE -** Agency has routine audits and completes federal form 990; budget is reasonable and proportionate with other projects within the organization.	**STRONG -** Agency has routine satisfactory audits and completes federal form 990; Guidestar reviews organization; Board has strong role in financial management.	**EXCEPTIONAL -** Agency has impressive internal controls; long standing history of strong fiscal management; Guidestar reviews.

Thursday Afternoon

Thursday Afternoon

Robert Wood Johnson Foundation

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

The Road to Financial Stability: Partnering with Grantmakers

Partnering with Grantmakers: A Brief Guide

In the May 2013 Aligning Forces for Quality National Meeting session *The Road to Financial Stability: Partnering with Grantmakers*, decision makers from foundations already funding work in the healthcare world discussed their thinking around awarding grants. Understanding what foundations consider when awarding grants can go a long way in helping an alliance craft the right proposal or pitch. Here are some additional resources to inform your efforts to partner with grantmakers.

Catalog of Federal Domestic Assistance
The online Catalog of Federal Domestic Assistance (CFDA) is a database containing information on all financial and non-financial federal assistance programs.

Website: www.gsa.gov/cfda

The Chronicle of Philanthropy
The Chronicle of Philanthropy is the newspaper of the nonprofit world. It is the #1 news source for charity leaders, fund raisers, grantmakers and others involved in philanthropy.

Website: http://philanthropy.com

Corporation for Public Broadcasting
The Corporation for Public Broadcasting has developed an easy guide enumerating the basic elements of grant writing.

Website: http://www.cpb.org/grants/grantwriting.html

Council on Foundations
The Council on Foundations is a member organization supporting grantmakers in foundation management. While its purpose is not to provide services to those seeking grants, this is a good resource for learning more about philanthropy from the perspective of grantmakers. Members are foundations, corporations or philanthropic entities that primarily provide charitable support to two or more organizations or individuals on an annual basis.

Website: http://www.cof.org/

The Foundation Center
The Foundation Center is a leading source of information about philanthropy. The Center maintains a comprehensive database with information on grantmakers and grants. Close to 550 foundations support its work to connect people seeking positive change to the resources necessary for success.

Website: http://foundationcenter.org/

Foundation Tutorial: http://foundationcenter.org/getstarted/tutorials/ft_tutorial/index.html

Proposal Writing Short Course:
http://foundationcenter.org/getstarted/tutorials/shortcourse/index.html

Catalog of Nonprofit Literature (database of philanthropy literature, updated daily):
http://cnl.foundationcenter.org/

Foundation Directory Online Professional Database
The Foundation Directory Online Professional Database is available through the Central Library. It provides detailed information on over 90,000 foundations and 900,000 recent grants. Information includes application information, limitations, and funding interests of foundations.

Website: http://www.ilibrary.org/cgi-bin/ilib_authorize.pl?mode=single&dbident=73

Free Management Library
The Free Management Library is an online library of comprehensive resources informing self-management and leadership as well as management and leadership of other individuals, groups and organizations.

Website: http://www.managementhelp.org

Grantmakers In Health
Grantmakers In Health is a nonprofit, educational organization serving trustees and staff of foundations and corporate giving programs. Its mission is to help grantmakers improve the nation's health by strengthening grantmakers' knowledge, skills, effectiveness to fostering communication and collaboration among grantmakers and with others.

Website: http://www.gih.org/

GrantsNet
GrantsNet is a tool managed by the Department of Health and Human Services Office of Grants Management. It is designed to facilitate the exchange of information about federal grant programs.

Website: http://www.hhs.gov/grantsnet

GuideStar
GuideStar manages a database of IRS-recognized nonprofit organizations and includes information about nonprofits' missions, programs, leaders, goals, accomplishments and needs.

Website: http://www.guidestar.org

Nonprofit Solutions Center
The Nonprofit Solutions Center maintains a free online database of pre-screened consultants and contractors who work with nonprofit organizations. Information about consultants includes their skills, backgrounds and competencies.

Website: http://www.nonprofitsolutions.iupui.edu

The Toolbox Guide to Development Funds
The Toolbox Guide to Development Funds is a database of local, state and federal funding available for community and economic development. It is maintained by the Center for Economic and Community Development.

Website: http://www.bsu.edu/cecd/toolbox

SUSTAINING IMPROVED OUTCOMES:

A Toolkit

by Scott Thomas, PhD
and Deborah Zahn, MPH

The development of this toolkit was funded by the Asian Pacific Islander American Health Forum, the Community Health Foundation of Western and Central New York, and the New York State Health Foundation.

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SUSTAINING IMPROVED OUTCOMES: A Toolkit

by Scott Thomas, PhD and Deborah Zahn, MPH

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SUSTAINING IMPROVED OUTCOMES: A Toolkit

by Scott Thomas, PhD and Deborah Zahn, MPH

INTRODUCTION

As quality improvement continues to be a major focus in the areas of public health, healthcare, social service, education, and related fields, there is growing interest in developing strategies to ensure that such improvement is sustained in the long term. Although there is general agreement that it is ineffective from either an implementation or a funding perspective to make improvements that do not last, there is a need for clear definitions and models to guide sustainability. In this toolkit, we focus on sustaining improved outcomes and provide a framework for assessing and planning for sustainability.

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DEFINITION OF
SUSTAINING IMPROVED OUTCOMES

This toolkit addresses how to sustain improved outcomes that have been achieved during project implementation. The definition of sustainability of improved outcomes that guides this toolkit is "when new ways of working and improved outcomes become the norm."[1] This definition has three important parts.

NEW WAYS OF WORKING

The first part of the definition is "new ways of working." This means that, due to an intervention of some sort, a targeted group of individuals has begun to work in new ways. These interventions can include trainings, systems changes, or policy development. For example, a health clinic that transfers the duty of providing foot exams for patients with diabetes from doctors to nurses has developed a new way of working for the clinicians. A local coalition getting store clerks to more consistently check the age of people buying tobacco products has developed new ways of working for the clerks.

IMPROVED OUTCOMES

The second part of the definition is "improved outcomes." This means that a measurable improvement has occurred as a result of the new ways of working. In the first example described above, this would mean that a significantly higher percentage of patients with diabetes are receiving foot exams because of the new way of working. In the second example, this would mean that fewer minors are illegally purchasing tobacco products from store clerks.

BECOMES THE NORM

The third part of the definition is "becomes the norm." This means that the improvements are permanent instead of temporary and do not need ongoing support to make them continue. Stated another way, the new way of working becomes the regular way of working. In the first example above, this would mean that the increased percent of foot exams are continuing a year later and that both doctors and nurses have accepted their change in duties. In the tobacco example, this would mean that tobacco sales to minors remained lower two years after making the changes, and the store retailers still accepted that this was now the regular way of operating.

NOTE: Other terms are sometimes used when addressing sustainability, including maintenance, institutionalization, continuation, internalization, and durability. However, most reports and journal articles now use the term sustainability, and we will be using it throughout this guide.

DIFFERENT DEFINITIONS OF SUSTAINABILITY

There are many ways to define and address sustainability. This toolkit focuses on the sustainability of improved outcomes. Two additional definitions of sustainability also are often used: the sustainability of a specific program or service and the sustainability of an organization. The term sustainability is frequently used without a clear explanation of which type of sustainability is being discussed. Our experience is that both funders and grantees will generally default to defining sustainability as securing ongoing funding for programs and services.

The primary difference among the types of sustainability is that some level of ongoing funding is required for sustaining organizations and programs but not for the sustaining improved outcomes. Although we do not discuss the sustainability of organizations and programs/services in this toolkit, we believe that many of the principles and factors outlined here can be applied to all types of sustainability. However, fulfilling the need for ongoing funding likely will require additional strategies not discussed in this toolkit.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.

WHY FOCUS ON SUSTAINING IMPROVED OUTCOMES

SUSTAINABILITY DOES NOT HAPPEN AUTOMATICALLY

It is important to address sustainability because improved outcomes achieved during the implementation phase of a project do not *automatically* result in lasting improvements. For example, a social service agency might increase the number of referrals to a parenting program as a result of their activities during a grant project, but, once the grant has ended, that number drops back down to its earlier level. This occurs far too often Indeed, a frequently referenced study of organizational improvements found a 70% failure rate in sustaining long-term changes. Formally focusing on sustainability throughout the planning and implementation of an improvement project can increase the sustainability of those improvements.

FUTURE FUNDING SHOULD NOT BE THE SOLE OR PRIMARY FOCUS

Because there may be elements of projects that require ongoing funding, funding is included as one of the 12 factors in the sustainability framework described below. However, it should not be the sole or primary focus of sustaining improved outcomes. Our experience has been that when individuals or organizations do not *formally* focus on sustainability, they frequently default to seeking continued funding. However, if new ways of working have truly become the norm, sustainability can often be achieved without the need for ongoing funding.

WHO CAN BENEFIT FROM USING THIS TOOLKIT

We designed this toolkit to be used by a number of different audiences.

GRANTEES

This toolkit can be used by organizations that receive grant funding or contracts to make external changes and improvements. This includes community-based organizations, state and county departments of public health, social service agencies, voluntary organizations, and similar agencies. These organizations will be referred to as grantees throughout this toolkit.

ORGANIZATIONS

This toolkit can be used by organizations that are making improvements within their organization. This includes the same organizations noted above as well as schools, health and healthcare facilities, and other agencies.

FUNDERS

This toolkit also can be used by funders. This includes government, foundation, and corporate funders. While all of the information in this toolkit is useful for funders in supporting sustainability among their grantees, the second part of this toolkit specifically addresses sustainability from a funder's perspective.

HOW TO USE THIS TOOLKIT

PLANNING FOR SUSTAINABILITY

The objective of this toolkit is to help individuals and organizations formally plan for sustaining improved outcomes. We present 12 factors and a set of tools that can contribute to the sustainability of improved outcomes. These factors can be used by grantees or by funders who want to assist their grantees in sustaining improved outcomes.

USING THE TOOLKIT

There are many ways that you can use this toolkit. We encourage you to use it in whatever way helps your project or your grantees' projects sustain improved outcomes. That said, our experience has shown that addressing sustainability *in some formal manner* is the most important step.

One way to use the toolkit is to read through it and become acquainted with the definitions and concepts. This can help you start to think about how you can formally address sustainability. It can help you develop a common understanding of how and what is trying to be sustained. Our experience has been that even this level of engagement can significantly improve sustainability planning. You also can read more about sustainability by reading the articles listed in the Resource section. These can provide you with additional models that can help you develop a working understanding of sustainability.

In addition, you can print out the list of definitions of the 12 sustainability factors and use it to guide you in a focused discussion with others about your sustainability for a project or your grantees' projects. Or you can just use the Sustainability Worksheet to provide you and others with a further level of detail for your sustainability planning. Finally, you can go through or support a more detailed, step-by-step process by using the Sustainability Assessment Tool and Sustainability Planning Tool together. These worksheets and assessment and planning tools are located in the appendices.

FRAMEWORK FOR SUSTAINING IMPROVED OUTCOMES

12 SUSTAINABILITY FACTORS

PERCEIVED VALUE

MONITORING AND FEEDBACK

LEADERSHIP

STAFF

SHARED MODELS

ORGANIZATIONAL INFRASTRUCTURE

ORGANIZATIONAL FIT

COMMUNITY FIT

PARTNERS

SPREAD

FUNDING

GOVERNMENT POLICIES

THE FRAMEWORK

This toolkit uses a 12-factor framework to address sustainability. These factors are listed on the left.

THE SOURCE OF THE FACTORS

These factors were developed from a number of sources. The primary source was a qualitative study conducted by the Primary Care Development Corporation and funded by the Commonwealth Fund[1]. Both authors of this toolkit worked with a research team on the study. That study examined factors that contribute to sustaining and spreading quality improvements in healthcare settings. Those factors were then compared with published studies and available reports on sustainability. (*See Resource section.*) One of the main publications used—and the source of our definition—was the *Sustainability: Model and Guide*[2], produced by the National Health Services' Institute for Innovation and Improvement in the United Kingdom.

The framework also has been influenced by more than 20 workshops that the authors have conducted on sustainability over the past three years. The feedback from workshop participants has been instrumental in helping us refine, narrow, and clarify the 12 factors we now use.

LIMITATIONS OF THE FRAMEWORK

To date, there is limited research that examines both the factors responsible for sustaining improved outcomes and the contribution of each factor relative to others. There are exceptions to this, such as the National Health Service guide and the work of Mancini and Marek[3]. Because of this, we cannot yet say which factor is more important than another factor and in what situations and if a particular combination of factors is especially effective in producing sustainable outcomes.

However, the factors used in this framework have appeared with enough frequency in other studies to make them an excellent starting point for addressing sustainability. Additionally, workshop participants with experience in implementing improvement projects consistently indicate that these factors are useful in helping them sustain improved outcomes.

---

1 K Hinchey Judge, D Zahn, N Lustbader, S Thomas, D Ramjohn, and M Chin. (2008) Factors Contributing to Sustaining and Spreading Learning Collaborative Improvements: Results of a Qualitative Research Study. Primary Care Development Corporation.
2 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.
3 Mancini, J. & Marek, L. (2004). Sustaining community-based programs for families: conceptualization and measurement. Family Relations, 53, 339-347.

GRANTEES AND ORGANIZATIONS
HOW TO WORK WITH THE 12 FACTORS

2 IMPORTANT QUESTIONS

How important is this factor to your particular improvement project?

To what degree do we believe that you will be able to influence this factor?

It is a menu of options, not a to-do list

We have provided a list of 12 factors that you can use to develop a sustainability plan. It is important to keep in mind that the 12 factors are meant to serve as a *menu of options*, not a *to-do* list. You do not need to plan and conduct activities for all 12 factors. Rather, choose the factors to work on based on their importance to your particular improvement project and on your ability to influence them.

Two important questions when choosing factors

As noted above, there are two questions that you need to answer when choosing which factors to select. These questions will be addressed in more detail in the worksheet and tools. However, it is helpful to keep these questions in mind from the start when considering any particular factor.

How important is this factor to your particular improvement project?

When asking how important the different factors are to your improvement project, remember that some factors will not be relevant. You may be working on a community project in which the factor *Organizational Infrastructure* does not apply. Or you may be working on organizational improvements in which *Partners* does not apply. Each improvement project will have a different set of factors that is important to its success in being sustained.

To what degree do we believe that you will be able to influence this factor?

Ask yourself to what degree you will be able to influence the factor that you believe is important to affect. You will likely be able to influence some factors more than others. An example of this might be the factor *Government Policy*. Changing a government policy might be very important to sustaining the improvements you have made but would take more resources than your organization has. Another example might be *Leadership*. You might believe that leadership support within your organization would be very helpful to sustainability but realize that you have little access to leadership and, therefore, cannot influence them.

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GRANTEES AND ORGANIZATIONS
HOW TO WORK WITH THE 12 FACTORS
– continued

Use three or four factors

Our experience has been that when first developing a sustainability plan it might be best to select only three or four factors to work with. This will allow you to develop a more in depth plan on each one, monitor how the sustainability activities are going, and make adjustments along the way. You can decide to start with just these three or four factors and move on to other factors at a later time. How many factors you initially select will depend on your particular project, your available resources, and the degree to which you believe you can impact the chosen factors.

Multiple subcategories

You can assess and plan for sustainability factors both generally and specifically. For example, you could generally assess how strong you think *Leadership* is overall in regards to sustaining the improved outcome. Or you could focus more specifically and assess subcategories of *Leadership*, such as executives, managers, or champions. As another example, you could plan general activities for *Monitoring and Feedback* to sustain the improved outcome. Or you could focus more specifically and plan *Monitoring and Feedback* activities directed at a community, clients, staff, or your funders. You can see examples of different subcategories for each factor in the *Sustainability Factors: Subcategories* sheet in Appendix C.

Factors strengthen factors

You often can strengthen factors by using other factors. As examples, you can frequently increase *Perceived Value* by providing ongoing feedback about the positive outcomes your project has achieved (i.e., *Monitoring and Feedback*). You can increase the continuous support of *Staff* by putting *Organizational Infrastructures* in place that are easy for them to use, such as a one-step referral system. Therefore, when thinking about how to strengthen a sustainability factor, consider how the other factors can work together.

How the factors work

The following 12 sustainability factors each have a definition, a suggestion on how to use the factor to influence the sustainability of improved outcomes, and an example of how that suggestion might be implemented.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **PERCEIVED VALUE**

DEFINITION: Acknowledged value by those affected by the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Conduct specific activities to increase your target stakeholders' perception of the value of your work and its outcomes.

EXAMPLES: Give regular feedback on your improved outcomes to key stakeholders; present data at meetings with leadership.

FACTOR: **MONITORING AND FEEDBACK**

DEFINITION: Information on improved outcomes is collected and communicated to target audiences.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Track and communicate your improved outcomes to your target audiences on a regular basis and in easy-to-understand formats.

EXAMPLES: Host quarterly information-gathering calls to monitor project outcomes; display charts and graphs of improved outcomes in locations within an organization where target audiences will see them.

FACTOR: **LEADERSHIP**

DEFINITION: The degree to which leaders, including decision-makers and champions, are *actively* engaged in the implementation stage and beyond

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that leadership is involved in program development and activities

EXAMPLES: Have leaders present updates on improved outcomes at regular management meetings; invite leaders to participate in planning meetings.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **STAFF**

DEFINITION: Staff have the skills, confidence, and interest in continuing the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Provide staff trainings, technical assistance, and feedback on the success of the program.

EXAMPLES: Train staff on a new referral system and provide updates on its impact on patients; staff experience a new curriculum as more effective in achieving better outcomes.

FACTOR: **SHARED MODELS**

DEFINITION: Continued use of a shared model among those involved in the new ways of working.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Use a commonly accepted model to plan, implement, and evaluate program progress.

EXAMPLES: Use the Chronic Care Model at planning meetings to determine gaps in implementation; use the 40 Developmental Assets model to coordinate staff activities.

FACTOR: **ORGANIZATIONAL INFRASTRUCTURE**

DEFINITION: Degree to which organizational operations support the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Embed changes to the organization that are difficult to get rid of.

EXAMPLES: Revise job descriptions to include new job roles; allocate resources to new ways of working.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **ORGANIZATIONAL FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the organization's overall goal and operations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that staff and administrators view the new ways of working as a important part of the organization's identity and operations.

EXAMPLES: Incorporate the new ways of working into the organization's strategic plan; train staff on the purpose and importance of new ways of working.

FACTOR: **COMMUNITY FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the communities' interests, needs, and abilities.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that community members and/or organizations view the new ways of working as helpful and important to their communities.

EXAMPLES: Provide health screenings at locations accessible to community members and available at convenient times.

FACTOR: **PARTNERS**

DEFINITION: Involvement of partners who actively support new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that partners have an active role in both decision-making and the provision of resources.

EXAMPLES: Develop agreements with partners to continue to contribute staff or resources after the implementation phase.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: SPREAD

DEFINITION: Expansion of new ways of working and improved outcomes to additional locations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that multiple locations incorporate the new ways of working.

EXAMPLES: Expand a new protocol for conducting foot exams for patients with diabetes from one community health center site to other sites.

FACTOR: FUNDING

DEFINITION: Funding beyond original project period.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Obtain additional funding to assist with the continued implementation of new ways of working.

EXAMPLES: Obtain second-year grant funding for school-based asthma education because it was effective and well received in the first year of implementation.

FACTOR: GOVERNMENT POLICIES

DEFINITION: Degree to which new ways of working and improved outcomes are supported by government policies.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Policies are enacted that make it easier to conduct new ways of working.

EXAMPLES: Secure reimbursement for providers to conduct smoking cessation with specific populations.

EXAMPLES

DESIGN

IMPLEMENTATION

EVALUATION

PUTTING IT ALL TOGETHER

SUSTAINABILITY AND PROJECT DESIGN, IMPLEMENTATION, AND EVALUATION

Improved outcomes are most likely to be maintained when sustainability is addressed during all phases of an improvement project. The following scenarios provide examples of how sustainability can be built into a project's design, implementation, and evaluation. The examples are composites informed by examples from the authors' work.

As has been noted throughout the toolkit, even focusing on just a few sustainability factors can have a positive impact. And you can address more factors as the project progresses.

DESIGN EXAMPLE

A public health organization designed an intervention to improve the monitoring and removal of lead-based paint in a low-income community. It received a small grant from the city government to design and implement the intervention over two years. As it was designing the project, it chose to focus on three primary sustainability factors: *Partners, Organizational Fit, and Staff.*

Partners:

Because the organization did not anticipate that the government would renew the funds at the end of the project, it chose to work with a partner organization that could conduct the monitoring and coordinating of the removal of lead-based paint in their clients' homes. The partner organization was actively involved in all aspects of the planning and design process. This involvement helped make sure that the partner organization felt that the project was its project too

Organizational Fit:

This new function of monitoring and removing lead-based paint fit well with what the partner organization already did in their clients' homes. It already had an ongoing contract with the government to provide a range of in-home health services, including helping its clients improve their living situations. It also recently identified addressing environmental hazards as a new priority area during an internal strategic planning process.

Staff:

The public health organization designed a training program that showed how important lead-based paint is to the health of the partner organization's clients. It also emphasized the skills the home care workers needed to monitor and coordinate the removal of lead-based paint.

SUSTAINABILITY AND PROJECT DESIGN, IMPLEMENTATION, AND EVALUATION

IMPLEMENTATION EXAMPLE

A community health center was implementing a project to improve the health outcomes for their patients with diabetes. During implementation, they chose to focus on three primary sustainability factors: *Leadership, Spread, and Organizational Infrastructure*.

Leadership:

The Chief Executive Officer (CEO) was the main champion of the project. She did a number of things to ensure that her staff knew how important this project was to her and that she expected to see the health center's outcomes improve in a sustainable way. She kicked off the project during a meeting with all of her executive managers. At the meeting, she talked about how important this project was to her and the health center, giving a personal example of how diabetes impacted her family. She gave a presentation that showed data on how the health center's diabetes numbers compared with national standards and led a discussion on what the health center needed to do to improve and sustain those improvements over time. Throughout the implementation period, she routinely asked her managers to report on progress and spoke at several staff meetings about the project. She also worked with her managers to solve problems that the project encountered and ensured that the staff working on the project had the resources they needed to embed the new ways of working into regular operations.

Perceived Value:

The project staff worked to increase the perceived value of the improved outcomes among their leadership, staff, patients, and community partners. They regularly gave their leadership data on the diabetes improvements as well as personal stories about patients whose health outcomes had improved. They posted graphs showing the improvement in diabetes outcomes and patient thank-you letters throughout the health centers. They also worked with the marketing department to include articles in staff and member newsletters and on their public website. The CEO regularly provided updates on the project's outcomes at Board meetings.

Organizational Infrastructure:

The project staff incorporated the new ways of working into many aspects of the entire organization. They developed new protocols for how patients with diabetes were identified, monitored, and treated. They made changes to their electronic medical record system so that doctors and other health care staff were automatically alerted when their patients with diabetes needed a test or follow-up care. The project staff worked with the human resources department to incorporate the new roles that staff had to play into job descriptions and performance reviews. The CEO and the health center Board included a focus on diabetes in their strategic planning process.

SUSTAINABILITY AND PROJECT DESIGN, IMPLEMENTATION, AND EVALUATION

EVALUATION EXAMPLE

An organization was working on a project to reduce childhood obesity among students in a public school district. As they were designing and implementing the evaluation of the project, they chose to focus on three primary sustainability factors: *Monitoring and Feedback, Perceived Value, and Government Policies*.

Monitoring and Feedback:

The project evaluation was designed to capture information on outcomes at the end of the project and provide project staff with information and feedback throughout the implementation process that helped them assess and address sustainability. In addition to measures related to weight, the evaluators selected measures to monitor changes in the school environment that could help sustain reductions in childhood obesity over time. This included reduced availability of sugar-sweetened beverages, increased availability of fresh fruit and vegetables, and increased opportunities for physical activity. The project staff created easy-to-understand posters that showed how the school environments were improving and provided the data to each school's administration and district leadership. The data showed the district's outcomes and compared outcomes across schools. The staff also sent parents material with information on how to support improvements at their child's school.

Spread:

The project staff first implemented the project in one school. After achieving initial success at the first location, they implemented the project in the other schools in the district. This helped make the new ways of working become the norm throughout the entire school district. In response to new issues that arose as they implemented the project at the other schools, they made a few changes to their sustainability plan, such as bringing the Parent-Teacher Associations onboard as key stakeholders.

Government Policies:

The project staff identified policies that would help sustain the improved outcomes. Because several advocacy organizations were already working on the issue, the project staff decided to contribute to increasing government funding for physical activity in schools. The staff provided data from their project and personal stories to support the advocacy activities.

ANSWERING THE SUSTAINABILITY QUESTION IN GRANT PROPOSALS

Many funders are beginning to expect grantees to address sustainability of improved outcomes in a more formal and strategic manner.

In most grant applications, there is usually a question about how your planned improvements will be sustained after grant funding had ended. Many applicants answer this question by describing plans to obtain future funding. This answer is sometimes satisfactory to funders because they are also thinking of sustainability in terms of funding. However, many funders are beginning to expect grantees to address sustainability of outcomes and in a more formal and strategic manner. One way grantees can do this is to describe their sustainability plans using some of the factors that are outlined in this toolkit. Grant reviewers will then see that they are thinking through sustainability with the same attention that they are giving to design, implementation, and evaluation.

Using these factors to answer the sustainability question can be easy. This is because many of the activities that you will have described in the project description section of your grant proposal already or can have a sustainability component. These activities can include changes to forms, training staff to work in new ways, and status reports that you will be providing to people involved in the project. The following example is based on an actual grant proposal and shows how these sustainability activities can be described.

You will notice that in the description on the next page the names for the sustainability factors appear slightly different from the way that we have listed them in the toolkit. For instance, *systems changes* has been used for *Organizational Infrastructure*. This is because the term *system changes* is more immediately recognizable in this context. *Staff involvement* was used because the term *Staff* by itself did not have much meaning. Finally, promoting the value of the changes has been used for *Perceived Value* because that is also a phrase that is more easily understood by grant reviewers.

The key is to use whatever terms work for you and your project. It is more important that the grant reviewers be able to understand the description of your sustainability activities quickly than it is to use the exact names of the factors

ANSWERING THE SUSTAINABILITY QUESTION IN GRANT PROPOSALS

– continued

EXAMPLE OF HOW TO ANSWER THE SUSTAINABILITY QUESTION FOR GRANT PROPOSALS

In order to maintain the improvements in the number of low-income pregnant women who receive smoking cessation services from our home care staff, we will be focusing on three specific sustainability factors: systems changes, staff involvement, and promoting the value of the changes that have been made.

We will be addressing systems changes by redesigning our intake and follow-up forms that are used by our home care staff during client visits. The new forms will require staff to document the details of the cessation activities that take place during home visits with pregnant women who smoke. These new forms will continue to be used after the end of the grant period.

Sustainability also will be strengthened by involving the home care staff in the development of the cessation activities that they will be using with their clients. This early and ongoing involvement of staff will ensure that they develop the skills, confidence, and interest in continuing these cessation activities.

We will also work to make sure that the value of adding cessation activities to the home care is clearly recognized by all those involved in the improvement project. This includes the home care staff, the clients, leadership within our organization, partners, and our funders. We will provide ongoing feedback to these individuals about the positive impact the cessation activities are having. We will provide this feedback in staff updates and brief email reports using both graphs and case reports.

USING THE TOOLS

We have included a number of tools that you can use to develop a plan for addressing sustainability. We encourage you to use some or all of the tools in whatever way helps you sustain improved outcomes. The tools in the appendix are:

APPENDIX A **SUSTAINABILITY FACTORS: DEFINITIONS AND EXAMPLES**

This sheet provides an easy reference to the factors and their definitions. It can be printed out on one double-sided sheet. This sheet can help focus a meeting in which sustainability activities are going to be discussed or planned.

APPENDIX B **SUSTAINABILITY: HOW FACTORS WORK**

This sheet lists the factors as they are described in the toolkit. It includes not only the definitions of the factors but also how to use the factor to strengthen sustainability and examples.

APPENDIX C **12 SUSTAINABILITY FACTORS: DETAILED DESCRIPTION**

These sheets describe the 12 sustainability factors in detail, including a definition of the factor, a suggestion on how to use the factor to influence the sustainability of improved outcomes, and an example of how that suggestion might be implemented.

APPENDIX D **SUSTAINABILITY FACTORS: SUBCATEGORIES**

This sheet provides subcategories for the main factors that can be used to assess and plan for sustainability in more detail.

APPENDIX E **SUSTAINABILITY WORKSHEET**

This worksheet provides an easy and quick way to determine which factors you want to address and the activities you will do to address them.Refer to Appendix A – *Sustainability Factors: Definitions and Examples* or Appendix C – *12 Sustainability Factors* when completing this worksheet.

APPENDIX F **GUIDELINES FOR SUSTAINABILITY ASSESSMENT AND PLANNING WORKSHEETS**

The guide describes how to use the assessment and planning forms together to conduct a more thorough sustainability plan..

APPENDIX G **SUSTAINABILITY ASSESSMENT WORKSHEET**

This form helps conduct a more detailed assessment of each of the 12 factors as they relate to an improvement project.

APPENDIX H **SUSTAINABILITY PLANNING WORKSHEET**

This form will help you plan the sustainability activities that you will do to strengthen those factors that you have chosen.

12 SUSTAINABILITY FACTORS

MULTIPLE SUBCATEGORIES

FACTORS STRENGTHEN FACTORS

FUNDERS
HOW THE FACTORS WORK

Funders often ask potential grantees to describe in their proposals how they will sustain their work once the grant funding has ended. Yet, often times, funders do not explain what they mean by sustainability or offer sufficient guidance to help their grantees achieve it.

In this section, we will discuss the sustainability factors and discuss the funder's role in promoting the sustainability of improved outcomes. We will discuss ways to develop your organization's definition of sustainability, support sustainability, communicate sustainability definitions and expectations, and contribute to the larger field of knowledge. We also will provide samples of sustainability content that can easily be incorporated into the grant making and management processes.

Multiple subcategories

Your grantees can assess and plan for sustainability both generally and specifically. For example, they can generally assess how strong they think *Leadership* is in regards to sustaining the improved outcome. Or they could focus more specifically and assess subcategories of leadership. *Leadership* subcategories could include executives, managers, or champions. As another example, they could plan general activities for *Monitoring and Feedback* to sustain the improved outcome. Or they could focus more specifically and plan *Monitoring and Feedback* activities directed at a community, clients, staff, or other funders. You can see examples of different subcategories for each factor in the *Sustainability Factors: Subcategories* sheet in Appendix C.

Factors strengthen factors

Grantees also can strengthen factors by using other factors. As examples, they can frequently increase *Perceived Value* by providing ongoing feedback about the positive outcomes achieved (i.e., *Monitoring and Feedback*). They can increase the continuous support of *Staff* by putting *Organizational Infrastructures* in place that are easy to use by them, such as a one-step referral system. Therefore, when thinking about how to strengthen a sustainability factor, grantees should consider how the factors can work together.

The 12 sustainability factors are described in detail in the next appendix. Each factor has a definition, a suggestion on how to use the factor to influence the sustainability of improved outcomes, and an example of how that suggestion might be implemented.

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12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **PERCEIVED VALUE**

DEFINITION: Acknowledged value by those affected by the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Conduct specific activities to increase your target stakeholders' perception of the value of your work and its outcomes.

EXAMPLES: Give regular feedback on your improved outcomes to key stakeholders; present data at meetings with leadership.

FACTOR: **MONITORING AND FEEDBACK**

DEFINITION: Information on improved outcomes is collected and communicated to target audiences.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Track and communicate your improved outcomes to your target audiences on a regular basis and in easy-to-understand formats.

EXAMPLES: Host quarterly information-gathering calls to monitor project outcomes; display charts and graphs of improved outcomes in locations within an organization where target audiences will see them.

FACTOR: **LEADERSHIP**

DEFINITION: The degree to which leaders, including decision-makers and champions, are *actively* engaged in the implementation stage and beyond

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that leadership is involved in program development and activities

EXAMPLES: Have leaders present updates on improved outcomes at regular management meetings; invite leaders to participate in planning meetings.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **STAFF**

DEFINITION: Staff have the skills, confidence, and interest in continuing the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Provide staff trainings, technical assistance, and feedback on the success of the program.

EXAMPLES: Train staff on a new referral system and provide updates on its impact on patients; staff experience a new curriculum as more effective in achieving better outcomes.

FACTOR: **SHARED MODELS**

DEFINITION: Continued use of a shared model among those involved in the new ways of working.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Use a commonly accepted model to plan, implement, and evaluate program progress.

EXAMPLES: Use the Chronic Care Model at planning meetings to determine gaps in implementation; use the 40 Developmental Assets model to coordinate staff activities.

FACTOR: **ORGANIZATIONAL INFRASTRUCTURE**

DEFINITION: Degree to which organizational operations support the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Embed changes to the organization that are difficult to get rid of.

EXAMPLES: Revise job descriptions to include new job roles; allocate resources to new ways of working.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **ORGANIZATIONAL FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the organization's overall goal and operations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that staff and administrators view the new ways of working as a important part of the organization's identity and operations.

EXAMPLES: Incorporate the new ways of working into the organization's strategic plan; train staff on the purpose and importance of new ways of working.

FACTOR: **COMMUNITY FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the communities' interests, needs, and abilities.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that community members and/or organizations view the new ways of working as helpful and important to their communities.

EXAMPLES: Provide health screenings at locations accessible to community members and available at convenient times.

FACTOR: **PARTNERS**

DEFINITION: Involvement of partners who actively support new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that partners have an active role in both decision-making and the provision of resources.

EXAMPLES: Develop agreements with partners to continue to contribute staff or resources after the implementation phase.

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: SPREAD

DEFINITION: Expansion of new ways of working and improved outcomes to additional locations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that multiple locations incorporate the new ways of working.

EXAMPLES: Expand a new protocol for conducting foot exams for patients with diabetes from one community health center site to other sites.

FACTOR: FUNDING

DEFINITION: Funding beyond original project period.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Obtain additional funding to assist with the continued implementation of new ways of working.

EXAMPLES: Obtain second-year grant funding for school-based asthma education because it was effective and well received in the first year of implementation.

FACTOR: GOVERNMENT POLICIES

DEFINITION: Degree to which new ways of working and improved outcomes are supported by government policies.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Policies are enacted that make it easier to conduct new ways of working.

EXAMPLES: Secure reimbursement for providers to conduct smoking cessation with specific populations.

FUNDERS' ROLE IN SUPPORTING SUSTAINABILITY

DEFINE SUSTAINABILITY

Because it is easy for both funders and grantees to default to defining sustainability solely as continued funding for projects, services, or organizations, we encourage you to write out your definition of sustainability. If your organization does support the sustainability of projects, services, or organizations—a topic outside the scope of this toolkit—it will be important to include that in the definition. In this toolkit, we have defined sustainability as "when new ways of working and improved outcomes become the norm."[1] Choosing additional details in sample definition below can help make your definition even clearer.

SAMPLE DEFINITION:

The *[insert name of funder]* defines sustainability as when news ways of working and improved outcomes are maintained for at least *[choose one: one year/two years/other: _____] [optional: without needing ongoing funds].*

If your organization thinks that other details are important to include in your definition, please include those as well.

DETERMINE SUSTAINABILITY EXPECTATIONS

Before your organization can help its grantees sustain their improved outcomes, it needs to determine and articulate what it expects from its potential and existing grantees in terms of sustainability. There are several important questions for your organization to answer when determining sustainability expectations, including what grantees will need to submit and when. Remember that many other funders have not yet defined what they mean by sustainability or what they expect from grantees, so this information may be new to grantees. Therefore, clarity is essential. We have included a planning worksheet called *Our Organization's Approach to Sustainability* in Appendix L that can help you clarify your expectations and processes.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.

FUNDERS' ROLE IN SUPPORTING SUSTAINABILITY – continued

You will need to repeatedly communicate your new approach to sustainability before it is understood and becomes the norm.

SUPPORT SUSTAINABILITY

Your grantees are more likely to meet your expectations and sustain their improved outcomes if you provide them with support to do so. This is especially important because sustainability is a new field of inquiry and likely a new topic for grantees. For example, you may be the first or only funder to ask them to articulate the details of a sustainability plan. They may need help doing this the first time until it becomes the norm for them.

COMMUNICATE SUSTAINABILITY

As stated, the consideration of sustainability in an in-depth and detailed way is likely new to most grantees as well as to your organization's staff, leadership, and Board members. Therefore, you will need to repeatedly communicate this new approach to sustainability before it is understood and becomes the norm. We encourage you to communicate your organization's sustainability definition and expectations through multiple vehicles and embed sustainability content and tools throughout the grant making and management process. This should include content in Requests for Proposals, Frequently Asked Questions, reviewer guidelines and assessment forms, reporting guidelines, website, etc. You also may want to communicate to Board members, leaders, and stakeholders about your organizations new approach, activities, and progress related to sustainability. Appendices H-K includes sample content that you can adapt for your use.

CONTRIBUTE TO THE FIELD

Because sustainability is a new field, your organization has an opportunity to make an important contribution to the emerging body of knowledge about sustainability and to the general field of grant making. You may consider convening other funders to discuss your sustainability approach, publishing articles on your experience and outcomes, conducting and publishing evaluations and/or case studies of how grantees have sustained their outcomes, and presenting at conferences.

EMBED YOUR NEW SUSTAINABILITY APPROACH INTO YOUR ORGANIZATION

Like your grantees, you may have to establish new ways of working within your organization before you can better support sustainability. To facilitate that, you can use many of the sustainability factors. It may be helpful to involve staff, leaders, and Board members in the process of deciding how your organization will approach sustainability; train them on the topic, definition, and tools; and include the topic of sustainability and measures of your organization's progress in the area in regular communications, presentations, updates, and monitoring and feedback mechanisms.

APPENDICES

TOOLS FOR GRANTEES

APPENDIX A Sustainability Factors: Definitions and Examples

APPENDIX B Sustainability: How Factors Work

APPENDIX C 12 Sustainability Factors: Detailed Description

APPENDIX D Sustainability Factors: Subcategories

APPENDIX E Sustainability Worksheet

APPENDIX F Guidelines for Sustainability Assessment and Planning Worksheets

APPENDIX G Sustainability Assessment Worksheet

APPENDIX H Sustainability Planning Worksheet

TOOLS FOR FUNDERS

APPENDIX I Sustainability Factors: Definitions and Examples

APPENDIX J Sustainability: How Factors Work

APPENDIX K 12 Sustainability Factors: Detailed Description

APPENDIX L Funder Worksheet: Our Organization's Approach to Sustainability

APPENDIX M Samples of Sustainability Content For Funders

- Sample Definition
- Request for Proposal Guidelines
- Application Instructions
- FAQ: Questions & Answers
- Reviewer Guidelines
- Reviewer Assessment Forms
- Reporting Guidelines

APPENDIX A

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

SUSTAINABILITY DEFINITION:

When new ways of working and improved outcomes become the norm.[1]

PERCEIVED VALUE – acknowledged value by those affected by the new ways of working and improved outcomes. Examples include project activities being considered potentially beneficial by clients, service providers, or community members.

MONITORING AND FEEDBACK – monitoring is conducted on a regular basis and feedback is shared in easy to understand formats. Examples include information-gathering calls to monitor the project, and feedback provided to key staff using easy-to-understand formats (e.g., graphs).

LEADERSHIP – the degree to which leaders (including decision-makers and champions) continue to be actively engaged beyond the implementation stage. Examples include ongoing attendance at meetings focused on the new ways of working and ongoing monitoring of outcomes.

STAFF – staff has the skills, confidence, and interest in continuing the new ways of working and improved outcomes. Examples include staff being able to use a new referral system capably or thinking that a new curriculum is more effective in achieving better outcomes.

SHARED MODELS – continued use of a shared model among those involved in the new ways of working. Examples include the Chronic Care Model, the 40 Developmental Assets, the 5As, or Plan-Do-Study-Act (PDSA).

ORGANIZATIONAL INFRASTRUCTURE – degree to which organizational operations support the new ways of working and improved outcomes. Examples include rewriting job descriptions to support the project activities and channeling resources to project activities through the organization's business plan.

ORGANIZATIONAL FIT – degree to which the new ways of working and improved outcomes match the organization's overall goal and operations. Examples include project activities becoming part of the organization's strategic plan.

COMMUNITY FIT – degree to which the new ways of working and improved outcomes match community interests, needs, and abilities. Examples include an expressed desire for new or improved services and outcomes.

PARTNERS – involvement of partners who actively support new ways of working and improved outcomes. Examples include partners who continue to contribute staff or resources after the implementation phase.

SPREAD – expansion of new ways of working and improved outcomes to additional locations. Examples include expanding activities planned for one community agency or department to new agencies or departments.

FUNDING – funding beyond original project period. Examples include extensions of original grant funding or funding to expand project activities to additional populations or communities.

GOVERNMENT POLICIES – degree to which new ways of working and improved outcomes are supported by government policies. Examples include reimbursement for a new service or incorporating outcome measures into surveillance systems.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.

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APPENDIX B

SUSTAINABILITY: HOW FACTORS WORK

12 SUSTAINABILITY FACTORS

PERCEIVED VALUE

MONITORING AND FEEDBACK

LEADERSHIP

STAFF

SHARED MODELS

ORGANIZATIONAL INFRASTRUCTURE

ORGANIZATIONAL FIT

COMMUNITY FIT

PARTNERS

SPREAD

FUNDING

GOVERNMENT POLICIES

Multiple subcategories

Your grantees can assess and plan for sustainability both generally and specifically. For example, they can generally assess how strong they think *Leadership* is in regards to sustaining the improved outcome. Or they could focus more specifically and assess subcategories ofleadership. *Leadership* subcategories could include executives, managers, or champions. As another example, they could plan general activities for *Monitoring and Feedback* to sustain the improved outcome. Or they could focus more specifically and plan *Monitoring and Feedback* activities directed at a community, clients, staff, or other funders. You can see examples of different subcategories for each factor in the *Sustainability Factors: Subcategories* sheet in Appendix C.

Factors strengthen factors

Grantees also can strengthen factors by using other factors. As examples, they can frequently increase *Perceived Value* by providing ongoing feedback about the positive outcomes achieved (i.e., *Monitoring and Feedback*). They can increase the continuous support of *Staff* by putting *Organizational Infrastructures* in place that are easy to use by them, such as a one-step referral system. Therefore, when thinking about how to strengthen a sustainability factor, grantees should consider how the factors can work together.

The 12 sustainability factors are described in detail in the next appendix. Each factor has a definition, a suggestion on how to use the factor to influence the sustainability of improved outcomes, and an example of how that suggestion might be implemented.

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APPENDIX C

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **PERCEIVED VALUE**

DEFINITION: Acknowledged value by those affected by the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Conduct specific activities to increase your target stakeholders' perception of the value of your work and its outcomes.

EXAMPLES: Give regular feedback on your improved outcomes to key stakeholders; present data at meetings with leadership.

FACTOR: **MONITORING AND FEEDBACK**

DEFINITION: Information on improved outcomes is collected and communicated to target audiences.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Track and communicate your improved outcomes to your target audiences on a regular basis and in easy-to-understand formats.

EXAMPLES: Host quarterly information-gathering calls to monitor project outcomes; display charts and graphs of improved outcomes in locations within an organization where target audiences will see them.

FACTOR: **LEADERSHIP**

DEFINITION: The degree to which leaders, including decision-makers and champions, are *actively* engaged in the implementation stage and beyond

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that leadership is involved in program development and activities

EXAMPLES: Have leaders present updates on improved outcomes at regular management meetings; invite leaders to participate in planning meetings.

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APPENDIX C

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **STAFF**

DEFINITION: Staff have the skills, confidence, and interest in continuing the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Provide staff trainings, technical assistance, and feedback on the success of the program.

EXAMPLES: Train staff on a new referral system and provide updates on its impact on patients; staff experience a new curriculum as more effective in achieving better outcomes.

FACTOR: **SHARED MODELS**

DEFINITION: Continued use of a shared model among those involved in the new ways of working.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Use a commonly accepted model to plan, implement, and evaluate program progress.

EXAMPLES: Use the Chronic Care Model at planning meetings to determine gaps in implementation; use the 40 Developmental Assets model to coordinate staff activities.

FACTOR: **ORGANIZATIONAL INFRASTRUCTURE**

DEFINITION: Degree to which organizational operations support the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Embed changes to the organization that are difficult to get rid of.

EXAMPLES: Revise job descriptions to include new job roles; allocate resources to new ways of working.

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APPENDIX C

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **ORGANIZATIONAL FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the organization's overall goal and operations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that staff and administrators view the new ways of working as a important part of the organization's identity and operations.

EXAMPLES: Incorporate the new ways of working into the organization's strategic plan; train staff on the purpose and importance of new ways of working.

FACTOR: **COMMUNITY FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the communities' interests, needs, and abilities.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that community members and/or organizations view the new ways of working as helpful and important to their communities.

EXAMPLES: Provide health screenings at locations accessible to community members and available at convenient times.

FACTOR: **PARTNERS**

DEFINITION: Involvement of partners who actively support new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that partners have an active role in both decision-making and the provision of resources.

EXAMPLES: Develop agreements with partners to continue to contribute staff or resources after the implementation phase.

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APPENDIX C

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **SPREAD**

DEFINITION: Expansion of new ways of working and improved outcomes to additional locations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that multiple locations incorporate the new ways of working.

EXAMPLES: Expand a new protocol for conducting foot exams for patients with diabetes from one community health center site to other sites.

FACTOR: **FUNDING**

DEFINITION: Funding beyond original project period.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Obtain additional funding to assist with the continued implementation of new ways of working.

EXAMPLES: Obtain second-year grant funding for school-based asthma education because it was effective and well received in the first year of implementation.

FACTOR: **GOVERNMENT POLICIES**

DEFINITION: Degree to which new ways of working and improved outcomes are supported by government policies.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Policies are enacted that make it easier to conduct new ways of working.

EXAMPLES: Secure reimbursement for providers to conduct smoking cessation with specific populations.

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APPENDIX D

SUSTAINABILITY FACTORS: SUBCATEGORIES

The sustainability factors can be assessed and planned for both generally and specifically. For example, you could generally assess how strong you think *Leadership* is overall in regards to sustaining the improved outcome. Or you could focus more specifically and assess subcategories of leadership. *Leadership* subcategories could include executives, managers, or champions. As another example, you could plan general activities for *Monitoring and Feedback* to sustain the improved outcome. Or you could focus more specifically and plan *Monitoring and Feedback* activities directed at a community, clients, staff, or funders.

The following are examples of subcategories that might be addressed with each factor. All of the examples may not be relevant to your improved outcome, and there may be additional ones that you want to consider.

PERCEIVED VALUE to:	SHARED MODELS for:	PARTNERS
• Community • Clients/patients • Staff • Leaders	• Planning Meetings • Strategic Plans • Grant Development	• Active Involvement • Resources • Staff Support
MONITORING AND FEEDBACK to:	**ORGANIZATIONAL INFRASTRUCTURE**	**SPREAD to:**
• Community • Clients/patients • Staff • Leaders	• Systems • Job Descriptions • Business Plan • Performance Assessment	• Departments • Sites • Organization
LEADERSHIP	**ORGANIZATIONAL FIT**	**FUNDING**
• Executives • Managers • Champions	• Mission Statement • Strategic Plan • Business Plan	• Fees • Reimbursement • Grants • Government
STAFF	**COMMUNITY FIT**	**GOVERNMENT POLICIES**
• Front-line • Administrative • Volunteers.	• Interests and Needs • Access (e.g., transportation) • Cost • Format (e.g., group or individual)	• Local • State • Federal

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APPENDIX E

SUSTAINABILITY WORKSHEET

Choose three or four factors that you believe would help strengthen the sustainability of your improvements. Use the *Sustainability: How Factors Work* sheet to help you think about and choose the factors. (See Appendix J.)

Remember that you can address more factors later.

Make a note in the second column about why you think it is important to strengthen that factor. Examples: You chose to strengthen *Perceived Value* because the leaders that need to support improvements do not know about them or you chose to strengthen *Organizational Infrastructure* because the new ways of working need to be written into job descriptions to make them officially part of peoples' duties.

Address a factor generally or specify a subcategory within that factor. If you decide to focus on a subcategory within a factor, you should circle which one (or write it in if it is not listed). Examples: You can address *Monitoring and Feedback* generally or focus on providing more monitoring and feedback just to staff. You can address *Organizational Fit* generally or focus on just on the mission statement.

List activities that you will conduct to strengthen the factor. Use the *Sustainability: How Factors Work* to find examples. Consider that one factor can often be used to strengthen another (e.g., *Feedback* strengthens *Perceived Value*).

SUSTAINABILITY FACTOR	WHY THE FACTOR IS IMPORTANT TO SUSTAINABILITY	ACTIVITIES TO STRENGTHEN THE FACTOR Describe activities that will strengthen this factor
PERCEIVED VALUE to the: community • clients/patients • staff • leaders •		
MONITORING AND FEEDBACK to the: community • clients •		

Sample

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APPENDIX E

SUSTAINABILITY WORKSHEET

SUSTAINABILITY FACTOR	WHY THE FACTOR IS IMPORTANT TO SUSTAINABILITY	ACTIVITIES TO STRENGTHEN THE FACTOR Describe activities that will strengthen this factor
PERCEIVED VALUE to the: community • clients/patients • staff • leaders •		
MONITORING AND FEEDBACK to the: community • clients/patients • staff • leaders •		
LEADERSHIP executives • managers • champions •		
STAFF front-line • administrative • volunteers •		

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APPENDIX E

SUSTAINABILITY WORKSHEET

SUSTAINABILITY FACTOR	WHY THE FACTOR IS IMPORTANT TO SUSTAINABILITY	ACTIVITIES TO STRENGTHEN THE FACTOR Describe activities that will strengthen this factor
SHARED MODELS for: planning meetings • strategic plans • grant development •		
ORGANIZATIONAL INFRASTRUCTURE systems • job descriptions • business plan • performance assessment •		
ORGANIZATIONAL FIT mission statement • strategic plans • business plan •		
COMMUNITY FIT interest/needs access • (e.g., transportation cost) format • (e.g., group or individual)		

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APPENDIX E

SUSTAINABILITY WORKSHEET

SUSTAINABILITY FACTOR	WHY THE FACTOR IS IMPORTANT TO SUSTAINABILITY	ACTIVITIES TO STRENGTHEN THE FACTOR Describe activities that will strengthen this factor
PARTNERS active involvement • resources • staff support •		
SPREAD to: departments • sites • organizationst •		
FUNDING fees • reimbursement • grants • government •		
GOVERNMENT POLICIES local • state • federal •		

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APPENDIX F

GUIDELINE FOR SUSTAINABILITY ASSESSMENT AND PLANNING WORKSHEETS

The assessment and planning worksheets provide tools that you can use to plan for sustaining improved outcomes.

ASSESSMENT WORKSHEET OBJECTIVE

Use this worksheet to determine which factors are currently supporting the sustainability of your improved outcomes, important to sustainability, and that you have the ability to strengthen.

PLANNING WORKSHEET OBJECTIVE

Use this worksheet to determine what sustainability factors you are going to work on and what sustainability activities you are going to do.

DIRECTIONS

STEP ONE Refer to *Sustainability: How the Factors Work* or *Sustainability Factors: Definitions* when completing the worksheets. Both of these sheets provide descriptions of the sustainability factors.

STEP TWO Starting with the *Assessment of Sustainability Factors Worksheet*, go through each factor and place a checkmark in the column that best reflects how much of a *current impact* you believe that factor is having on the sustainability of your improved outcomes.

- The first column (–) indicates a factor that you consider to have a weak impact on sustainability. An example would be leadership knowing very little about the improved outcomes that had recently taken place.
- The second column (0) indicates a factor that you consider neutral in regards to its impact on sustainability. An example would be leadership expressing support for the improved outcomes that had recently taken place but rarely discussing those improvements in meetings or supported future work.
- The third column (+) indicates a factor that you consider strong in regards to its impact on sustainability. An example would be if leadership was continuing to attend meeting in which the improved outcomes are discussed and offered resources to assist with continuation of those improvements.
- The fourth column (N/A) indicates a factor that is not relevant to your sustainability. An example would be the factor *Community Fit* when the improvements were just taking place within an organization.

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APPENDIX F

GUIDELINE FOR SUSTAINABILITY ASSESSMENT AND PLANNING WORKSHEETS

STEP THREE Use the *Comments* column to make notes that you can refer to when returning to this worksheet. The notes may have to do with the factor's current level of support, its importance, or your ability to influence.

STEP FOUR Continuing with the *Assessment Worksheet*, score each factor as to its *importance* and your ability to influence it.

- Importance – score how important you believe that factor is to sustaining your improved outcomes. The range of importance goes from 1 for having no importance at all to 5 for being very important. An example of something that might score low in importance would be *Government Policy* if you were simply trying to increase referrals from one department in a health center to another department within that center. An example of when *Government Policy* might score high would be if you were trying to get providers to conduct more health screenings and you knew there it would happen more often if there was increased government reimbursement for that activity.

- Ability – score how much you believe you can improve that factor's impact on sustainability. The range for ability goes from 1 for not being able to improve it to 5 for being very able to improve its impact on sustainability. An example of something that might score low would be *Spread* if you did not have much access to other organizations or communities. An example of something that might score high would be *Staff* if you had direct access to staff and knew that providing them more feedback would increase their interest in the improvements that had been made.

STEP FIVE Write the name of those sustainability factors that scored high in both importance and ability on the *Assessment Worksheet* in the blank spaces in the *Sustainability Planning Worksheet*. Scores of 4 and 5 should be considered high. It may be most effective to initially limit the number of factors you transfer to the planning sheet to three or four. However, it is possible that more than three or four factors will have high scores. If that happens, you will need to decide if you want to first prioritize some factors over others or decide to focus on more than three or four from the start.

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APPENDIX F

GUIDELINE FOR SUSTAINABILITY ASSESSMENT AND PLANNING WORKSHEETS

STEP SIX Complete each row on the *Sustainability Planning Worksheet* for those factors that you have written in.

- **Sustainability Activities** – list activities that you believe will increase the likelihood that the factor will have a positive impact on sustainability. It will be helpful to refer to *Sustainability: How the Factors Work* when listing and planning for these activities. Examples of sustainability activities are included on that sheet.

  Consider how activities related to one factor can help strengthen another factor. For example, you might use Monitoring and Feedback to strengthen *Perceived Value*. *Leadership* can be used to strengthen *Organizational Infrastructure*. *Community Fit* can be used to strengthen *Partners*.

- **Lead staff** – list who will be responsible for the activities for each factor.
- **Timeframe** – list when the activities will start and end or indicate if the activities are ongoing.

THINGS TO CONSIDER WHEN COMPLETING THE WORKSHEETS

The worksheets list 12 sustainability factors. These are best thought of as a *menu* of factors and not a *to-do* list. The objective is to review the 12 factors and then determine which three or four (or more) factors are most likely to help with sustainability.

The worksheets are designed to be completed using just the information that is available to you. Both the assessment and planning sheets can usually be filled out during a single meeting time. More detailed assessment and planning can be undertaken as needed.

The list of factors may or may not address all of the factors that are important for a given project. Additional sustainability factors can be added to the worksheets if this will help with planning.

Many of the factors have subcategories. For example, *Organizational Infrastructure* includes numerous components such as job descriptions, business model, systems, etc. It may be helpful to list these subcategories separately when planning your sustainability activities.

A factor may also have a number of different groups to which they could refer. For example, *Perceived Value* can refer to the value that is attributed to the improved outcomes by leaders, providers, or community members. It may be helpful to break these groups out separately when planning your sustainability activities.

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APPENDIX G

SUSTAINABILITY ASSESSMENT WORKSHEET

CURRENT STRENGTH OF FACTOR: **–** (weak) **0** (neutral) **+** (strong) **N/A** (not apply)

IMPORTANCE: **1** (very little) **2** (little) **3** (somewhat) **4** (important) **5** (very important)

ABILITY TO INFLUENCE: **1** (very difficult) **2** (difficult) **3** (somewhat) **4** (able) **5** (very able)

SUSTAINABILITY FACTOR	–	O	+	N/A	COMMENTS	IMPORTANCE 1-5	ABILITY 1-5
PERCEIVED VALUE							
MONITORING AND FEEDBACK							
LEADERSHIP							
STAFF							
SHARED MODELS							
ORGANIZATIONAL INFRASTRUCTURE							

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APPENDIX G

SUSTAINABILITY ASSESSMENT WORKSHEET

CURRENT STRENGTH OF FACTOR: **–** (weak) **0** (neutral) **+** (strong) **N/A** (not apply)

IMPORTANCE: **1** (very little) **2** (little) **3** (somewhat) **4** (important) **5** (very important)

ABILITY TO INFLUENCE: **1** (very difficult) **2** (difficult) **3** (somewhat) **4** (able) **5** (very able)

SUSTAINABILITY FACTOR	–	O	+	N/A	COMMENTS	IMPORTANCE 1-5	ABILITY 1-5
ORGANIZATIONAL FIT							
COMMUNITY FIT							
PARTNERS							
SPREAD							
FUNDING							
GOVERNMENT POLICIES							

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APPENDIX H

SUSTAINABILITY PLANNING WORKSHEET

Transfer those sustainability factors from the *Sustainability Assessment Worksheet* that you have determined are important to be improved and you are able to do so. It may be most effective to initially limit the number of factors you transfer to this planning sheet to three or four. As those factors are strengthened, you may then decide to work on more factors.

SUSTAINABILITY FACTOR	SUSTAINABILITY ACTIVITIES	LEAD	TIMEFRAME

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APPENDIX I

SUSTAINABILITY FACTORS:
DEFINITIONS AND EXAMPLES

SUSTAINABILITY DEFINITION:

When new ways of working and improved outcomes become the norm.[1]

PERCEIVED VALUE – acknowledged value by those affected by the new ways of working and improved outcomes. Examples include project activities being considered potentially beneficial by clients, service providers, or community members.

MONITORING AND FEEDBACK – monitoring is conducted on a regular basis and feedback is shared in easy to understand formats. Examples include information-gathering calls to monitor the project, and feedback provided to key staff using easy-to-understand formats (e.g., graphs).

LEADERSHIP – the degree to which leaders (including decision-makers and champions) continue to be actively engaged beyond the implementation stage. Examples include ongoing attendance at meetings focused on the new ways of working and ongoing monitoring of outcomes.

STAFF – staff has the skills, confidence, and interest in continuing the new ways of working and improved outcomes. Examples include staff being able to use a new referral system capably or thinking that a new curriculum is more effective in achieving better outcomes.

SHARED MODELS – continued use of a shared model among those involved in the new ways of working. Examples include the Chronic Care Model, the 40 Developmental Assets, the 5As, or Plan-Do-Study-Act (PDSA).

ORGANIZATIONAL INFRASTRUCTURE – degree to which organizational operations support the new ways of working and improved outcomes. Examples include rewriting job descriptions to support the project activities and channeling resources to project activities through the organization's business plan.

ORGANIZATIONAL FIT – degree to which the new ways of working and improved outcomes match the organization's overall goal and operations. Examples include project activities becoming part of the organization's strategic plan.

COMMUNITY FIT – degree to which the new ways of working and improved outcomes match community interests, needs, and abilities. Examples include an expressed desire for new or improved services and outcomes.

PARTNERS – involvement of partners who actively support new ways of working and improved outcomes. Examples include partners who continue to contribute staff or resources after the implementation phase.

SPREAD – expansion of new ways of working and improved outcomes to additional locations. Examples include expanding activities planned for one community agency or department to new agencies or departments.

FUNDING – funding beyond original project period. Examples include extensions of original grant funding or funding to expand project activities to additional populations or communities.

GOVERNMENT POLICIES – degree to which new ways of working and improved outcomes are supported by government policies. Examples include reimbursement for a new service or incorporating outcome measures into surveillance systems.

1 Sustainability: Model and Guide. National Health Service Institute for Innovation and Improvement. (2007). Note: When our work in sustainability began, the Sustainability: Model and Guide was publicly available online. Access is now limited to those working in the United Kingdom.

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APPENDIX J

SUSTAINABILITY: HOW FACTORS WORK

12 SUSTAINABILITY FACTORS

PERCEIVED VALUE

MONITORING AND FEEDBACK

LEADERSHIP

STAFF

SHARED MODELS

ORGANIZATIONAL INFRASTRUCTURE

ORGANIZATIONAL FIT

COMMUNITY FIT

PARTNERS

SPREAD

FUNDING

GOVERNMENT POLICIES

Multiple subcategories

Your grantees can assess and plan for sustainability both generally and specifically. For example, they can generally assess how strong they think *Leadership* is in regards to sustaining the improved outcome. Or they could focus more specifically and assess subcategories ofleadership. *Leadership* subcategories could include executives, managers, or champions. As another example, they could plan general activities for *Monitoring and Feedback* to sustain the improved outcome. Or they could focus more specifically and plan *Monitoring and Feedback* activities directed at a community, clients, staff, or other funders. You can see examples of different subcategories for each factor in the *Sustainability Factors: Subcategories* sheet in Appendix C.

Factors strengthen factors

Grantees also can strengthen factors by using other factors. As examples, they can frequently increase *Perceived Value* by providing ongoing feedback about the positive outcomes achieved (i.e., *Monitoring and Feedback*). They can increase the continuous support of *Staff* by putting *Organizational Infrastructures* in place that are easy to use by them, such as a one-step referral system. Therefore, when thinking about how to strengthen a sustainability factor, grantees should consider how the factors can work together.

The 12 sustainability factors are described in detail in the next appendix. Each factor has a definition, a suggestion on how to use the factor to influence the sustainability of improved outcomes, and an example of how that suggestion might be implemented.

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APPENDIX K

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **PERCEIVED VALUE**

DEFINITION: Acknowledged value by those affected by the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Conduct specific activities to increase your target stakeholders' perception of the value of your work and its outcomes.

EXAMPLES: Give regular feedback on your improved outcomes to key stakeholders; present data at meetings with leadership.

FACTOR: **MONITORING AND FEEDBACK**

DEFINITION: Information on improved outcomes is collected and communicated to target audiences.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Track and communicate your improved outcomes to your target audiences on a regular basis and in easy-to-understand formats.

EXAMPLES: Host quarterly information-gathering calls to monitor project outcomes; display charts and graphs of improved outcomes in locations within an organization where target audiences will see them.

FACTOR: **LEADERSHIP**

DEFINITION: The degree to which leaders, including decision-makers and champions, are *actively* engaged in the implementation stage and beyond

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that leadership is involved in program development and activities

EXAMPLES: Have leaders present updates on improved outcomes at regular management meetings; invite leaders to participate in planning meetings.

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APPENDIX K

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **STAFF**

DEFINITION: Staff have the skills, confidence, and interest in continuing the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Provide staff trainings, technical assistance, and feedback on the success of the program.

EXAMPLES: Train staff on a new referral system and provide updates on its impact on patients; staff experience a new curriculum as more effective in achieving better outcomes.

FACTOR: **SHARED MODELS**

DEFINITION: Continued use of a shared model among those involved in the new ways of working.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Use a commonly accepted model to plan, implement, and evaluate program progress.

EXAMPLES: Use the Chronic Care Model at planning meetings to determine gaps in implementation; use the 40 Developmental Assets model to coordinate staff activities.

FACTOR: **ORGANIZATIONAL INFRASTRUCTURE**

DEFINITION: Degree to which organizational operations support the new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Embed changes to the organization that are difficult to get rid of.

EXAMPLES: Revise job descriptions to include new job roles; allocate resources to new ways of working.

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APPENDIX K

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: **ORGANIZATIONAL FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the organization's overall goal and operations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that staff and administrators view the new ways of working as a important part of the organization's identity and operations.

EXAMPLES: Incorporate the new ways of working into the organization's strategic plan; train staff on the purpose and importance of new ways of working.

FACTOR: **COMMUNITY FIT**

DEFINITION: Degree to which the new ways of working and improved outcomes match the communities' interests, needs, and abilities.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that community members and/or organizations view the new ways of working as helpful and important to their communities.

EXAMPLES: Provide health screenings at locations accessible to community members and available at convenient times.

FACTOR: **PARTNERS**

DEFINITION: Involvement of partners who actively support new ways of working and improved outcomes.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that partners have an active role in both decision-making and the provision of resources.

EXAMPLES: Develop agreements with partners to continue to contribute staff or resources after the implementation phase.

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APPENDIX K

12 SUSTAINABILITY FACTORS

DETAILED DESCRIPTION

FACTOR: SPREAD

DEFINITION: Expansion of new ways of working and improved outcomes to additional locations.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Ensure that multiple locations incorporate the new ways of working.

EXAMPLES: Expand a new protocol for conducting foot exams for patients with diabetes from one community health center site to other sites.

FACTOR: FUNDING

DEFINITION: Funding beyond original project period.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Obtain additional funding to assist with the continued implementation of new ways of working.

EXAMPLES: Obtain second-year grant funding for school-based asthma education because it was effective and well received in the first year of implementation.

FACTOR: GOVERNMENT POLICIES

DEFINITION: Degree to which new ways of working and improved outcomes are supported by government policies.

HOW TO USE THE FACTOR TO INFLUENCE SUSTAINABILITY: Policies are enacted that make it easier to conduct new ways of working.

EXAMPLES: Secure reimbursement for providers to conduct smoking cessation with specific populations.

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APPENDIX L

FUNDER WORKSHEET: OUR ORGANIZATION'S APPROACH TO SUSTAINABILITY

This toolkit uses the following definition of sustainability: *when new ways of working and improved outcomes have become the norm.*

Our organization's definition of sustainability:

_____

_____

_____

_____

Will we require potential grantees to submit a sustainability plan?

❍ Yes ❍ No

If so, when will we require potential grantees to submit a sustainability plan?

- ❍ When they submit a letter of intent
- ❍ When they submit a grant proposal
- ❍ Immediately after their grant has been approved
- ❍ Other: _____

Will we ask grantees to measure and report on sustainability as part of their normal reporting process?

❍ Yes ❍ No

What specifically will we ask them to measure and report?

❍ Sustainability measures? Specify:

_____

_____

_____

_____

When? (*Choose as many as apply.*)

- ❍ In the interim report(s)
- ❍ In the final report
- ❍ During monitoring calls
- ❍ During site visits

❍ Sustainability measures? Specify:

_____

_____

_____

_____

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APPENDIX L

FUNDER WORKSHEET: OUR ORGANIZATION'S APPROACH TO SUSTAINABILITY

Our organization will provide the following kinds of sustainability support:

- ❍ Technical assistance
  - ❍ Web-based assistance
  - ❍ In-person through:
    - ❍ External consultant(s)
    - ❍ Internal staff
    - ❍ Telephonic assistance
- ❍ Workshops
- ❍ Hard copy and/or web-based tools
- ❍ Funding for evaluating sustainability after implementation
- ❍ Assistance with pursuing policies that support improved outcomes (*may apply only to select grants*)

How will we embed this new approach to sustainability into our organization?
(*Choose as many as apply, indicate specific activities, and indicate staff responsible*):

Select 2-4 factors you will work on first	SUSTAINABILITY FACTOR	SPECIFIC ACTIVITIES	STAFF RESPONSIBLE
❍	PERCEIVED VALUE		
❍	MONITORING AND FEEDBACK		
❍	LEADERSHIP		
❍	STAFF		

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APPENDIX L

FUNDER WORKSHEET: OUR ORGANIZATION'S APPROACH TO SUSTAINABILITY

Select 2-4 factors you will work on first	SUSTAINABILITY FACTOR	SPECIFIC ACTIVITIES	STAFF RESPONSIBLE
❍	SHARED MODELS		
❍	ORGANIZATIONAL INFRASTRUCTURE		
❍	ORGANIZATIONAL FIT		
❍	COMMUNITY FIT		
❍	PARTNERS		
❍	SPREAD		
❍	FUNDING		
❍	GOVERNMENT POLICIES		

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APPENDIX M

SAMPLES OF SUSTAINABILITY CONTENT FOR FUNDERS

SAMPLE DEFINITION

REQUEST FOR PROPOSAL GUIDELINES

APPLICATION INSTRUCTIONS

FAQ: QUESTIONS AND ANSWERS

REVIEWER GUIDELINES

REVIEWER ASSESSMENT FORMS

REPORTING GUIDELINES

SAMPLE DEFINITION

The Sample Foundation defines sustainability as when news ways of working and improved outcomes are maintained for at least one year after implementation.

REQUEST FOR PROPOSAL GUIDELINES

All proposals must include a sustainability plan using the sustainability plan template provided [insert link].

The Sample Foundation gives preference to projects that describe a reasonable plan to sustain improved outcomes for at least a year after the grant period ends and without additional funding.

The most promising proposals will demonstrate a clear and reasonable plan for sustaining the improved outcomes achieved during the grant period.

APPLICATION INSTRUCTIONS

Sustainability *(2 page maximum)*

Describe how this project will sustain the improved outcomes outlined in the project description. Please download, complete, and upload a sustainability plan template. Please also include sustainability activities in the project work plan and timeline.

FAQ: QUESTIONS AND ANSWERS

How important is the sustainability of my improved outcomes?

A plan for sustaining improved outcomes using the template provided is required *[insert link]*. Many proposals are turned down because they have not submitted a sustainability plan or their sustainability plan does not demonstrate how they will sustain improved outcomes. Stating that you would seek additional grants from other funders is not an adequate sustainability plan. If elements of the project (e.g., specific services) require ongoing funding, please describe a viable "business plan" for securing and sustaining that funding after the grant period ends.

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APPENDIX M

SAMPLES OF SUSTAINABILITY CONTENT FOR FUNDERS

SAMPLE DEFINITION

REQUEST FOR PROPOSAL GUIDELINES

APPLICATION INSTRUCTIONS

FAQ: QUESTIONS AND ANSWERS

REVIEWER GUIDELINES

REVIEWER ASSESSMENT FORMS

REPORTING GUIDELINES

FAQ: QUESTIONS AND ANSWERS - continued

Could you provide some examples of how projects have sustained improved outcomes?

A good example of a project that sustained improved outcomes is the Sample Organization's Sample Project. This project's objective was to improve clinical outcomes for patients with diabetes the Sample Family Health Center in Buffalo, New York by expanding the role of existing medical assistants. To support the sustainability of the improved outcomes, the project chose to focus on the following sustainability factors: *Monitoring and Feedback*, *Staff*, and *Organizational Infrastructure*. Examples of their sustainability activities include:

- ***Monitoring and Feedback:*** The project selected achievement targets for six clinical measures and tracked them through an electronic medical record system. The results were compiled into easy-to-understand charts and reviewed on a monthly basis during meetings with clinical staff and health center leadership. For the targets that were not met, the project presented plans to improve the measures.
- ***Staff:*** The medical assistants were included early on in the planning and implementation of the project. This resulted in stronger interest in the ongoing success of the project and increased confidence in their ability to conduct their new job duties.
- ***Organizational Infrastructure:*** The job descriptions for the medical assistants were revised to include their new duties. Improvement of the clinical measures was included in performance reviews and bonus systems.

REVIEWER GUIDELINES

The Sample Foundation defines sustainability as [insert definition]. When assessing the sustainability of a proposal, please use this definition. Please do not assess sustainability based on the likelihood of project activities or services continuing past the grant period.

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APPENDIX M

SAMPLES OF SUSTAINABILITY CONTENT FOR FUNDERS

SAMPLE DEFINITION

REQUEST FOR PROPOSAL GUIDELINES

APPLICATION INSTRUCTIONS

FAQ: QUESTIONS AND ANSWERS

REVIEWER GUIDELINES

REVIEWER ASSESSMENT FORMS

REPORTING GUIDELINES

REVIEWER ASSESSMENT FORMS

Sustainability – What is the likelihood that the improved outcomes achieved during the grant period will be sustained after the grant period ends? One (1) is not at all likely and ten (10) is absolutely likely.

1	2	3	4	5	6	7	8	9	10

Note: Sustainability and project replication are two distinct areas that require different strategies and should be separated in review criteria.

REPORTING GUIDELINES

Sustainability Activities *(1 page maximum)*

Describe the major sustainability activities of the project. Refer to your original sustainability plan as necessary. Indicate which activities you successfully completed and how the activities supported sustainability. Also indicate which activities you either did not complete or that changed in nature.

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RESOURCES

The following resources include journal articles and foundation reports. We have included resources on improved outcomes and also on programs and organizations. We included resources on programs and organizations because there is not much available on sustaining improved outcomes and because all three types of sustainability overlap greatly.

Note: When our work in sustainability began, the *Sustainability: Model and Guide. NHS Institute for Innovation and Improvement* was available publicly. This is no longer the case. Access to the guide is restricted to those working in the United Kingdom. While the information provided in that guide is helpful, we believe most of the concepts and factors can be obtained through the other resources provided. We have included the *Sustainability: Model and Guide* in the resources with the hope that it will become available again in the future.

IMPROVED OUTCOMES

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PROGRAMS

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RESOURCES – continued

PROGRAMS – continued

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Sustainability Through Adaptability: Building Strong Foundations for the Future by Cementing Partnerships Now

Aligning Forces for Quality

Adaptability Handouts

Step One: Assess Your Alliance's Overall Readiness to Sustain

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Leadership Readiness Checklist

All key leaders meet or exceed expectations when it comes to:

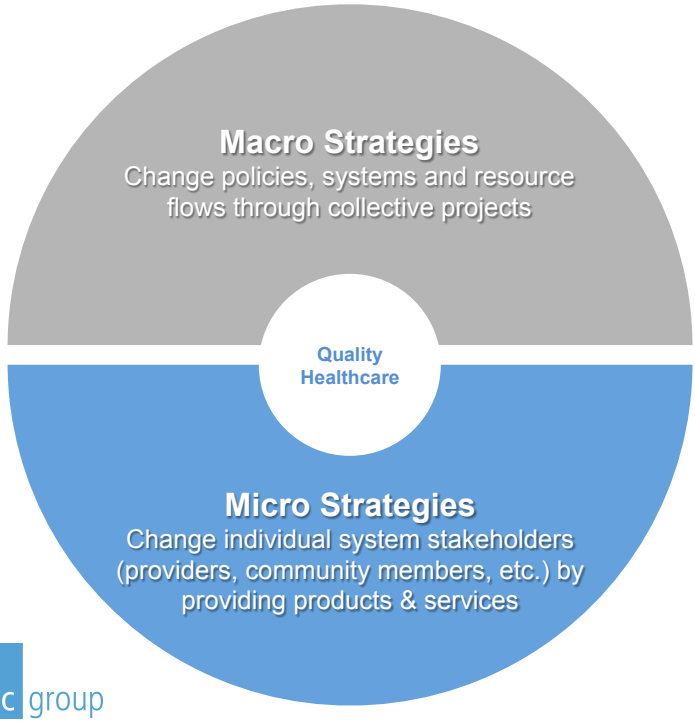
- ❑ Effectively communicating mission and vision to internal and external stakeholders
- ❑ Effectively engaging internal (Alliance) and external stakeholders in planning
- ❑ Prioritizing cost-effectiveness (cost-per-outcome/impact) over productivity/cost-per-output/level of effort
- ❑ Quickly making decisions and taking immediate action to adapt to when things are working
- ❑ Holding all leaders accountable for achieving community outcomes

Learning Readiness Checklist

All Alliance leaders and key stakeholders meet or exceed expectations when it comes to:

- ❑ Gathering sophisticated project, service, product and other business-related data, including cost (time and money)
- ❑ Analyzing data to determine what works, for whom, with what resources
- ❑ Engaging all key stakeholders in data-driven community, strategic and business planning
- ❑ Measuring and managing project, service, and/or product delivery/ implementation performance

Step Two: What Does Your Alliance Want to Sustain?



- ❑ *Macro* Strategies – Policy/Advocacy, System Change Projects
- ❑ *Micro* Strategies – Products & Services
- ❑ *Both*

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Step Three: Assess Who Will Provide Resources, Moving Forward

Resources for policy, advocacy and system reform projects
Does your Alliance (partners, leaders and stakeholders) have access to:

- ❑ At least 2-3 private foundations that will fund policy, advocacy, systems change work?
- ❑ At least 1-2 private foundations that will fund multi-year general operations?
- ❑ Many individual donors with deeper pockets (i.e., larger check writers) who are interested in funding policy, advocacy and system reform work for the long haul? (not your typical charitable donor)
- ❑ Individuals willing to pay membership dues to have their voices heard, be advocated for, be part of a movement and/or stay on top of current and game changing policy news and issues relevant to what they do
- ❑ Community leaders, stakeholders and residents who can and will provide in-kind and pro bono support for the long haul

If the answer is “yes” to at least two of these, then sustainability is more likely. Significant growth will require three or more of these.

Step Three: Assess Who Will Provide Resources (Cont.)

Resources for programs, products and/or services
Does your Alliance (partners, leaders and stakeholders) have access to:

- ❑ At least 3-4 institutional grantmakers (e.g., government agencies, corporations private foundations, community foundations, etc.) that fund and/or "proxy" pay for your types of programs, products, services?
- ❑ Many small-check-writing Individual donors – providing at least 20% of the costs of service provision – who can see how their check buys them one or more individual outcomes for persons in the community with whom they can connect/understand/relate to their story?
- ❑ Consumers who will pay for the program, product and/or service, either through cash or a third-party payer, such that at least 20% of revenues derives from this "fee-for-service"?
- ❑ Community leaders, stakeholders and residents who can and will provide in-kind and pro bono support for the long haul

If the answer is "yes" to at least two of these, then sustainability is more likely. Growth will require long-term (multi-year) relationships with institutional grantmakers, or a business revenue model that can count on a large majority of dollars coming from fee-for-service and/or individual donors.

Step Four: Decide Upon the Right Business Model for Sustainability and Growth

If it is feasible to sustain and/or grow your products, programs and/or services (refer to previous checklist), then…

Next Steps Checklist:

- ❑Finish designing (R&D'ing) products, programs and/or services
- ❑Codify the performance measurement and management process
- ❑Conduct market research
- ❑Sell to early or stage two adopters
- ❑Determine partnership model, if needed
  - ❑Joint venture
  - ❑Business line w/in an existing business (nonprofit or for-profit)
  - ❑No partnership; independent business (nonprofit or for-profit)
- ❑Determine most realistic revenue model
- ❑Develop business plan

Step Four: Decide Upon the Right Business Model for Sustainability and Growth (Cont.)

If it is feasible to sustain and/or grow your products, programs and/or services (refer to previous checklist), then…

Next Steps Checklist:

- ❑Develop formal environmental, policy, population, epidemiological and other community needs data gathering processes that can be replicated, as needed, to serve leaders in the design of continuing and new projects, moving forward
- ❑Codify partner engagement processes, decision-making structures and communication tools
- ❑Codify project implementation management processes and tools
- ❑Determine most realistic revenue model (refer to previous checklist)
- ❑Develop strategic plan

Getting To “Yes”: Interest-Based Negotiations

Getting to YES:
Negotiating Agreement Without Giving In
by:
Roger Fisher and William Ury

Citation: *Roger Fisher and William Ury, Getting to Yes: Negotiating Agreement Without Giving In, (New York: Penguin Books, 1983).*

In this classic text, Fisher and Ury describe their four principles for effective negotiation. They also describe three common obstacles to negotiation and discuss ways to overcome those obstacles.

Fisher and Ury explain that a good agreement is one which is wise and efficient, and which improves the relationship of those involved. Wise agreements satisfy the parties' interests and are fair and lasting. The authors' goal is to develop a method for reaching good agreements. Negotiations often take the form of positional bargaining, where each party opens with their position on an issue. The parties then bargain from their separate opening positions to agree on one position. Haggling over a price is a typical example of positional bargaining. Fisher and Ury argue that positional bargaining does not tend to produce good agreements. It is an inefficient means of reaching agreements, and the agreements tend to neglect the parties' *interests.* It encourages stubbornness and as such tends to harm the parties' relationship. Principled negotiation provides a better way of reaching good agreements. Fisher and Ury developed four principles of negotiation. Their process of principled negotiation can be used effectively on almost any type of dispute.

Their four principles are:

1) Separate the people from the problem;
2) Focus on interests rather than positions;
3) Generate a variety of options before settling on an agreement; and
4) Insist that the agreement be based on objective criteria.

These principles should be observed at each stage of the negotiation process. The process begins with the analysis of the situation or problem, of the other parties' interests and perceptions, and of the existing options. The next stage is to plan ways of responding to the situation and the other parties. Finally, the parties discuss the problem trying to find a mutually agreeable solution.

1. Separating People and Issues

Fisher and Ury's first principle is to separate the people from the issues. People tend to become personally involved with the issues and with their side's positions. And so they will tend to take responses to those issues and positions as personal attacks. Separating the people from the issues allows the parties to address the issues without damaging their relationship. It also helps them to get a clearer view of the substantive problem.

The authors identify three basic sorts of people problems. First are differences of perception among the parties. Since most conflicts are based in differing interpretations of the facts, it is crucial for both sides to understand the other's viewpoint. The parties should try to put themselves in the other's place. The parties should not simply assume that their worst fears will become the actions of the other party. Nor should one side blame the other for the problem. Each side should try to make proposals which would be appealing to the other side. The more that the parties are involved in the process; the more likely they are to be involved in and to support the outcome.

Emotions are a second source of people problems. Negotiation can be a frustrating process. People often react with fear or anger when they feel that their interests are threatened. The first step in dealing with emotions is to acknowledge them, and to try to understand their source. The parties must acknowledge the fact that certain emotions are present, even when they don't see those feelings as reasonable. Dismissing another's feelings as unreasonable is likely to provoke an even more intense emotional response. The parties must allow the other side to express their emotions. They must not react emotionally to emotional outbursts. Symbolic gestures such as apologies or an expression of sympathy can help to defuse strong emotions.

Communication is the third main source of people problems. Negotiators may not be speaking to each other, but may simply be grandstanding for their respective constituencies. The parties may not be listening to each other, but may instead be planning their own responses. Even when the parties are speaking to each other and are listening, misunderstandings may occur. To combat these problems, the parties should employ active listening. The listeners should give the speaker their full attention, occasionally summarizing the speaker's points to confirm their understanding. It is important to remember that understanding the other's case does not mean agreeing with it. Speakers should direct their speech toward the other parties and keep focused on what they are trying to communicate. Each side should avoid blaming or attacking the other, and should speak about themselves.

Generally the best way to deal with people problems is to prevent them from arising. People problems are less likely to come up if the parties have a good relationship, and think of each other as partners in negotiation rather than as adversaries.

2. Focus on Interests

Good agreements focus on the parties' interests, rather than their positions. As Fisher and Ury explain, "Your position is something you have decided upon. Your interests are what caused you to so decide." Defining a problem in terms of positions means that at least one party will "lose" the dispute. When a problem is defined in terms of the parties' underlying interests it is often possible to find a solution which satisfies both parties' interests.

The first step is to identify the parties' interests regarding the issue at hand. This can be done by asking why they hold the positions they do, and by considering why they don't hold some other possible position. Each party usually has a number of different interests underlying their positions. And interests may differ somewhat among the individual members of each side. However, all people will share certain basic interests or needs, such as the need for security and economic well-being.

Once the parties have identified their interests, they must discuss them together. If a party wants the other side to take their interests into account, that party must explain their interests clearly. The other side will be more motivated to take those interests into account if the first party shows that they are

paying attention to the other side's interests. Discussions should look forward to the desired solution, rather than focusing on past events. Parties should keep a clear focus on their interests, but remain open to different proposals and positions.

3. Generate Options

Fisher and Ury identify four obstacles to generating creative options for solving a problem. Parties may decide prematurely on an option and so fail to consider alternatives. The parties may be intent on narrowing their options to find the single answer. The parties may define the problem in win-lose terms, assuming that the only options are for one side to win and the other to lose. Or a party may decide that it is up to the other side to come up with a solution to the problem.

The authors also suggest four techniques for overcoming these obstacles and generating creative options. First it is important to separate the invention process from the evaluation stage. The parties should come together in an informal atmosphere and brainstorm for all possible solutions to the problem. Wild and creative proposals are encouraged. Brainstorming sessions can be made more creative and productive by encouraging the parties to shift between four types of thinking: stating the problem, analyzing the problem, considering general approaches, and considering specific actions. Parties may suggest partial solutions to the problem. Only after a variety of proposals have been made should the group turn to evaluating the ideas. Evaluation should start with the most promising proposals. The parties may also refine and improve proposals at this point.

Participants can avoid falling into a win-lose mentality by focusing on shared interests. When the parties' interests differ, they should seek options in which those differences can be made compatible or even complementary. The key to reconciling different interests is to "look for items that are of low cost to you and high benefit to them, and vice versa." Each side should try to make proposals that are appealing to the other side, and that the other side would find easy to agree to. To do this it is important to identify the decision makers and target proposals directly toward them. Proposals are easier to agree to when they seem legitimate, or when they are supported by precedent. Threats are usually less effective at motivating agreement than are beneficial offers.

4. Use Objective Criteria

When interests are directly opposed, the parties should use objective criteria to resolve their differences. Allowing such differences to spark a battle of wills will destroy relationships, is inefficient, and is not likely to produce wise agreements. Decisions based on reasonable standards make it easier for the parties to agree and preserve their good relationship.

The first step is to develop objective criteria. Usually there are a number of different criteria which could be used. The parties must agree which criteria are best for their situation. Criteria should be both legitimate and practical. Scientific findings, professional standards, or legal precedent are possible sources of objective criteria. One way to test for objectivity is to ask if both sides would agree to be bound by those standards. Rather than agreeing in substantive criteria, the parties may create a fair procedure for resolving their dispute. For example, children may fairly divide a piece of cake by having one child cut it, and the other choose their piece.

There are three points to keep in mind when using objective criteria. First each issue should be approached as a shared search for objective criteria. Ask for the reasoning behind the other party's

suggestions. Using the other parties' reasoning to support your own position can be a powerful way to negotiate. Second, each party must keep an open mind. They must be reasonable, and be willing to reconsider their positions when there is reason to. Third, while they should be reasonable, negotiators must never give in to pressure, threats, or bribes. When the other party stubbornly refuses to be reasonable, the first party may shift the discussion from a search for substantive criteria to a search for procedural criteria.

When the Other Party Is More Powerful

No negotiation method can completely overcome differences in power. However, Fisher and Ury suggest ways to protect the weaker party against a poor agreement, and to help the weaker party make the most of their assets.

Often negotiators will establish a "bottom line" in an attempt to protect themselves against a poor agreement. The bottom line is what the party anticipates as the worst acceptable outcome. Negotiators decide in advance of actual negotiations to reject any proposal below that line. Fisher and Ury argue against using bottom lines. Because the bottom line figure is decided upon in advance of discussions, the figure may be arbitrary or unrealistic. Having already committed oneself to a rigid bottom line also inhibits inventiveness in generating options.

Instead the weaker party should concentrate on assessing their best alternative to a negotiated agreement (BATNA). The authors note that "the reason you negotiate is to produce something better than the results you can obtain without negotiating." The weaker party should reject agreements that would leave them worse off than their BATNA. Without a clear idea of their BATNA a party is simply negotiating blindly. The BATNA is also key to making the most of existing assets. Power in a negotiation comes from the ability to walk away from negotiations. Thus the party with the best BATNA is the more powerful party in the negotiation. Generally, the weaker party can take unilateral steps to improve their alternatives to negotiation. They must identify potential opportunities and take steps to further develop those opportunities. The weaker party will have a better understanding of the negotiation context if they also try to estimate the other side's BATNA. Fisher and Ury conclude that "developing your BATNA thus not only enables you to determine what is a minimally acceptable agreement, it will probably raise that minimum."

When the Other Party Won't Use Principled Negotiation

Sometimes the other side refuses to budge from their positions, makes personal attacks, seeks only to maximize their own gains, and generally refuses to partake in principled negotiations. Fisher and Ury describe three approaches for dealing with opponents who are stuck in positional bargaining. First, one side may simply continue to use the principled approach. The authors point out that this approach is often contagious.

Second, the principled party may use "negotiation jujitsu" to bring the other party in line. The key is to refuse to respond in kind to their positional bargaining. When the other side attacks, the principles party should not counter attack, but should deflect the attack back onto the problem. Positional bargainers usually attack either by asserting their position, or by attacking the other side's ideas or people. When they assert their position, respond by asking for the reasons behind that position. When they attack the other side's ideas, the principle party should take it as constructive criticism and invite further feedback

and advice. Personal attacks should be recast as attacks on the problem. Generally the principled party should use questions and strategic silences to draw the other party out.

When the other party remains stuck in positional bargaining, the one-text approach may be used. In this approach a third party is brought in. The third party should interview each side separately to determine what their underlying interests are. The third party then assembles a list of their interests and asks each side for their comments and criticisms of the list. She then takes those comments and draws up a proposal. The proposal is given to the parties for comments, redrafted, and returned again for more comments. This process continues until the third party feels that no further improvements can be made. At that point, the parties must decide whether to accept the refined proposal or to abandon negotiations.

When the Other Party Uses Dirty Tricks

Sometimes parties will use unethical or unpleasant tricks in an attempt to gain an advantage in negotiations such as good guy/bad guy routines, uncomfortable seating, and leaks to the media. The best way to respond to such tricky tactics is to explicitly raise the issue in negotiations, and to engage in principled negotiation to establish procedural ground rules for the negotiation.

Fisher and Ury identify the general types of tricky tactics. Parties may engage in deliberate deception about the facts, their authority, or their intentions. The best way to protect against being deceived is to seek verification the other side's claims. It may help to ask them for further clarification of a claim, or to put the claim in writing. However, in doing this it is very important not to be seen as calling the other party a liar; that is, as making a personal attack. Another common type of tactic is psychological warfare. When the tricky party uses a stressful environment, the principled party should identify the problematic element and suggest a more comfortable or fair change. Subtle personal attacks can be made less effective simply by recognizing them for what they are. Explicitly identifying them to the offending party will often put an end to subtle attacks. Threats are a way to apply psychological pressure. The principled negotiator should ignore them where possible, or undertake principled negotiations on the use of threats in the proceedings.

The last class of trick tactics is positional pressure tactics which attempt to structure negotiations so that only one side can make concessions. The tricky side may refuse to negotiate, hoping to use their entry into negotiations as a bargaining chip, or they may open with extreme demands. The principled negotiator should recognize this as a bargaining tactic, and look into their interests in refusing to negotiate. They may escalate their demands for every concession they make. The principled negotiator should explicitly identify this tactic to the participants, and give the parties a chance to consider whether they want to continue negotiations under such conditions. Parties may try to make irrevocable commitments to certain positions, or to make-take-it-or-leave-it offers. The principled party may decline to recognize the commitment or the finality of the offer, instead treating them as proposals or expressed interests. Insist that any proposals be evaluated on their merits, and don't hesitate to point out dirty tricks.

Friday Morning

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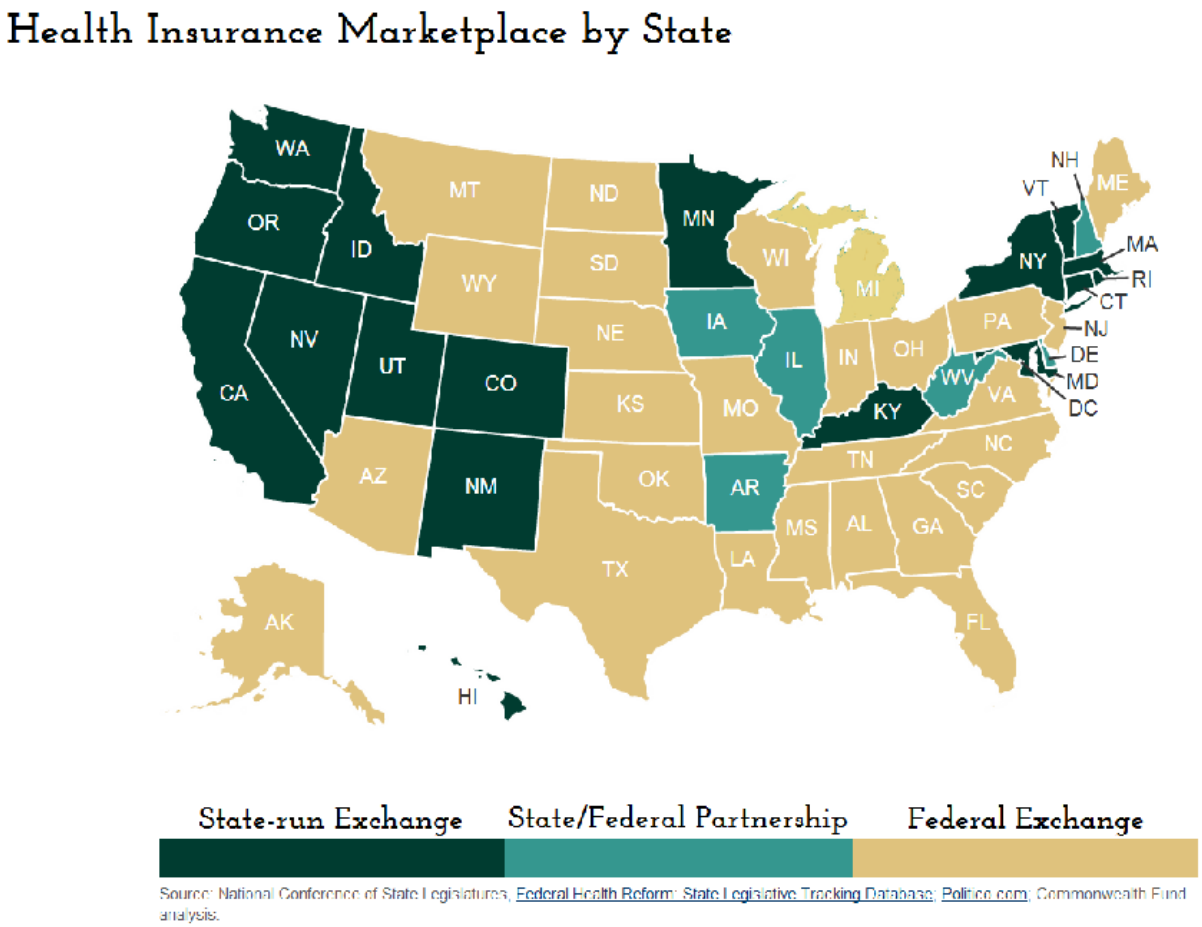
Friday Morning

Health Insurance Exchanges: What To Expect When You're Expecting



*Source is the Kaiser Family Foundation State Health Exchange Profiles (http://healthreform.kff.org/state-exchange-profiles-page.aspx), unless otherwise stated.

Federal Exchange Overview

Marketplace Type	The Secretary of HHS will establish and operate a Federally Facilitated Exchange (FFE) in any State that does not elect to do so, or will not have an operable Exchange for the 2014 coverage year. (http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf)
Alignment with state laws	To the greatest extent possible, HHS will preserve the traditional responsibilities of State insurance departments. HHS will harmonize FFE policies with existing State programs and laws wherever possible. (http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf)
Active vs. Passive Health Plan Purchaser	Passive. In the first year HHS intends to certify any health plan that meets all certification standards. In future years, HHS will analyze the certification process and may identify improvements or changes. (http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf)
Federal functions	HHS will carry out all Exchange functions, including certifying and monitoring qualified health plans; determining consumer eligibility for enrollment and for subsidies; and supporting consumers to compare, select and enroll in a health plan.
Eligibility	The FFEs will use a single application to determine eligibility for Medicaid, CHIP and federal subsidies. (http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84)
Consumer Assistance and Outreach	FFEs will assist consumers to compare, select and enroll in a health plan. HHS will establish and fund a Navigator program in each FFE state by awarding grants to eligible entities. Navigators will also conduct public education and outreach about Exchanges, and provide referrals to other resources. It is HHS' intent to award Navigator grants prior to 2014 with the goal of establishing a fully operational Navigator program in every FFE by October 1, 2013. (http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf)
Quality reporting	Quality information is expected to be available for plans sold through FFEs in the 2016 open enrollment period. In the interim, FFEs will display available information on patient experience of care (CAHPS) available from accredited commercial and/or Medicaid product lines. Other information drawn from the accreditation data, such as clinical measures results, will not be displayed. HHS will solicit stakeholder input on the most effective ways to align quality reporting and display requirements with related measurement and reporting initiatives across HHS. (http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf)
Tools to Reduce Adverse Selection	In a federally facilitated Exchange, the federal government will only have a direct role in regulating the health insurance plans that are sold through that Exchange–and not over other health plans in the state that aren't sold through the Exchange. There is a risk that healthy people in a particular state may opt for cheaper plans outside the Exchange, while sicker people opt for the Exchange coverage–a phenomenon known as "adverse selection." There are risk-adjustment mechanisms in the health care law that could mitigate the gains and losses to different health plans, but these may take a while to work. (http://healthaffairs.org/blog/2013/02/08/health-policy-brief-federally-facilitated-exchanges/).

California

Marketplace Type	Covered California. Established September 30, 2010.
Structure	Independent public entity
Governance	Five-member board including State Secretary of Health and Human Services, two gubernatorial appointees, two legislative appointees.
Active vs. Passive Health Plan Purchaser	Active. The Board will selectively contract for health coverage offered through the Exchange, "seek[ing] to contract with carriers so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service." California has experience acting as an active purchaser from other programs, such as the Children's Health Insurance Program (CHIP), small-business purchasing pool, and the state employee purchasing pool.
Consumer Assistance and Outreach	The Navigator program will include two distinct components: Certified Enrollment Assisters (Navigators) will be compensated by the Exchange and at a minimum will include non-profit organizations, community clinics, County Social Services offices employing Eligibility Workers, and labor unions. Direct Benefit Assisters will not be paid by the Exchange and will include health insurance agents, hospitals, and providers. Training and certification guidelines for both types of Assisters have been developed. Between January and July 2013, the state plans to educate consumers and launch a media campaign promoting the benefits of coverage.
Tools to Reduce Adverse Selection	Insurers must sell a plan at each benefit level (bronze, silver, gold, platinum) and must sell all marketplace products outside the marketplace as well.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	Board must coordinate enrollment in marketplace and public insurance programs with relevant state agencies, specifically the Medi-Cal program and the Healthy Families Program.
Exchange Funding	Fees collected from plans operating in marketplace

Massachusetts

Marketplace Type	Commonwealth Health Insurance Connector Authority. Established April 12, 2006.
Structure	Independent state agency
Governance	11-member board, including the Secretary for Administration and Finance, Director of Medicaid, Commissioner of Insurance, and Executive Director of the Group Insurance Commission. The Governor appoints an actuary, a health economist, a representative of small business, and an underwriter. The Attorney General appoints an employee health benefits specialist, a representative of health consumers, and a representative of organized labor.
Active vs. Passive Health Plan Purchaser	Active. Plans operating within the marketplace must meet standards for quality, value, and adequacy of provider networks. (http://www.commonwealthfund.org/Maps-and-Data/State-Exchange-Map.aspx)
Consumer Assistance and Outreach	Massachusetts Navigator program will strive to maintain or improve upon the current near-universal health insurance coverage in Massachusetts by actively supporting outreach to particularly vulnerable populations, including, but not limited to, non-elderly men, residents with family income less than 400% FPL, and racial and ethnic minority groups that have higher uninsured rates. The Health Connector envisions that Navigators will primarily focus on assisting those individuals, families and small businesses who will experience changes in their coverage options during the grant period. (http://www.masshealthmtf.org/news/notice-grant-opportunity-massachusetts-navigator-program)
Tools to Reduce Adverse Selection	Massachusetts will administer the Connector's risk adjustment program, using the state's existing All-Payer Claims Database.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	The Connector coordinates with MassHealth, which includes Medicaid and CHIP. The Connector uses a single application for all public insurance programs.
Exchange Funding	Fees collected from plans operating in marketplace

Minnesota

Marketplace Type	MNSure. Established March 20, 2013
Structure	Agency within the Executive Branch.
Governance	Seven-member board, including the Commissioner of Human Services. The Governor to appoint a consumer eligible for individual coverage; a consumer eligible for public coverage; a small employer; an expert in health administration or finance; an expert in public health; and an expert in the individual and small group insurance markets.
Active vs. Passive Health Plan Purchaser	Passive. The Exchange will function as a clearinghouse in the first year of operation, accepting all plans that meet the minimum standards.
Consumer Assistance and Outreach	In January 2013, the state launched a consumer-friendly website for the Exchange. The state also released an RFP for a Public Awareness Marketing/Outreach Campaign, to run from June 2013 to March 2014. The remaining requirements of the Navigator program will be met by an existing outreach and assistance program operated by the Department of Human Services until other programs are established by the board.
Tools to Reduce Adverse Selection	The federal government will operate the state Exchange's reinsurance program and the risk adjustment program for 2014 and 2015. The Exchange will explore using the state's existing all payer claims database to develop a risk adjustment methodology that could be implemented in the future.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	Minnesota plans to develop a single, integrated eligibility determination system that would sort applicants into the appropriate coverage program, including Medicaid, the Children's Health Insurance Program (CHIP), the Exchange, and potentially the Basic Health Program.
Exchange Funding	Fees for plans selling in the marketplace Minnesota, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions

New Mexico

Marketplace Type	Established March 28, 2013.
Structure	Quasi-governmental, subject to oversight by the Department of Insurance. (New Mexico Health Insurance Alliance).
Governance	13-member governing board. The governor will name six members, including the secretary of the Human Services Department. Legislative leaders will appoint six members. The state superintendent of insurance also is on the board but will vote only to break ties. The board must include two insurance industry representatives as well as a health care provider and consumer advocate.
Active vs. Passive Health Plan Purchaser	Active. Quality Improvement and quality measures will be part of accreditation. The Exchange also intends to collect consumer satisfaction data post-2014. (http://www.hsd.state.nm.us/pdf/hcr/Section%204.0%20-%20Notes.pdf). The state will explore basing standards for qualified health plans on the Albuquerque Coalition for Healthcare Quality's compilation of performance and quality measurements of hospital and providers.
Consumer Assistance and Outreach	The Exchange and Department of Insurance will oversee the Navigator program. Navigators will come from consumer-focused non-profit groups, as well as other eligible public or private entities (e.g., commercial and farming organizations, chambers of commerce, unions, IHS, Indian tribes, etc.), and will be paid through grant funds.
Tools to Reduce Adverse Selection	The state intends to administer a risk adjustment and reinsurance program during the first year of operation.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	New Mexico is actively engaged in the process of developing a single, streamlined application for Medicaid/CHIP and insurance affordability programs (IAPs) that will be available to consumers via the Exchange. New Mexico is also participating in the Enroll UX 2014 project, which is a public-private partnership creating design standards for exchanges that all states can use.
Exchange Funding	New Mexico, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.

New York

Marketplace Type	The New York Health Benefit Exchange. Established April 12, 2012.
Structure	Governmental agency within the New York Department of Health
Governance	Five regional advisory committees have been established, representing Western NY, Central NY/Finger Lakes, Capital District/Mid-Hudson/Northern NY, New York City/Metro, and Long Island. Committee members include consumer advocates, small business, health care providers, agents, brokers, insurers, and labor organizations.
Active vs. Passive Health Plan Purchaser	Active. The Department of Health will use existing HEDIS performance data and patient experience (CAHPS) information as part of the certification process for participating health plans.
Quality reporting	The Department of Health's Office of Quality and Patient Safety has drafted a proposal for reporting quality information.
Consumer Assistance and Outreach	New York will expand its existing call center, New York Health Options, to support the Exchange. The Exchange will operate a Navigator program and an In Person Assistance (IPA) program, and will select program entities through a competitive procurement process. The IPA program will be financed with federal funds, while the Navigator program will be funded with revenue from the Exchange.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	By October 2013, the Exchange will process eligibility and enrollment for the Exchange and newly eligible Medicaid enrollees only. Current Medicaid beneficiaries will initially be processed through the existing system and eventually be moved into a single, consolidated system. New York is also one of 11 states participating in the "Enroll UX 2014" project, which is a public-private partnership creating design standards for exchanges that all states can use.
Exchange Funding	Federal grant funds through 2014; the Exchange must be financially self-sustaining by 2015. New York, along with nine other states, is receiving technical assistance from the Robert Wood Johnson Foundation through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.

Oregon

Marketplace Type	Cover Oregon. Established June 17, 2011.
Structure	Quasi-governmental public corporation
Governance	Nine-member board, including the Director of the Oregon Health Authority and the Director of the Department of Consumer and Business Services. The Governor appoints seven additional members. Legislation also mandated creation of a standing Consumer Advisory Committee.
Active vs. Passive Health Plan Purchaser	Active.
Quality reporting	The Exchange will display quality information about participating health plans, including aggregate information on patient experience (CAHPS) and two encounter-based utilization scores. The Exchange will make changes to what quality information in collected and reported once the federal government releases its requirements.
Consumer Assistance and Outreach	The Exchange will engage local organizations to conduct consumer outreach through a Community Partner Program. Some Community Partners will be associated with a Navigator that provides enrollment assistance, while other Community Partners may focus only on outreach and public education. Funds will be available for some Community Partners through performance-based grants and RFPs for these grants will be posted in early 2013.
Tools to Reduce Adverse Selection	Oregon is considering administering its own risk adjustment and reinsurance programs. Cover Oregon and the Oregon Insurance Division are investigating risk adjustment methodologies, a data model, and potential risk adjustment and reinsurance entities.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	The state will create a single entry point for Medicare/CHIP eligible beneficiaries into the marketplace.
Exchange Funding	Fees collected from plans and state programs operating in marketplace Oregon, along with nine other states, is receiving technical assistance from RWJF through the State Health Reform Assistance Network; this assistance includes help with setting up health insurance Exchanges, expanding Medicaid to newly eligible populations, streamlining eligibility and enrollment systems, instituting insurance market reforms and using data to drive decisions.

Washington

Marketplace Type	Washington Healthplanfinder (May 26, 2011)
Structure	Public-private partnership separate and distinct from the state.
Governance	11-member board appointed by the governor.
Active vs. Passive Health Plan Purchaser	Active.
Quality reporting	The board has identified a set of factors, including patient experience (CAHPS) information and HEDIS quality measures, to help consumers make informed decisions, and for provider reimbursement and promotion of primary care.
Consumer Assistance and Outreach	Community-based organizations, tribal councils, brokers, local health departments, community health centers, nonprofit organizations, health coalitions, chambers of commerce, and labor unions will serve as Navigators. A draft RFP for a Navigator Lead Agency was released in November 2012. The state also plans to secure funding for the development of an In-person Assister Program. The Exchange has also focused on the consumer rating system display and the display and delivery of information about Navigators to consumers.
Tools to Reduce Adverse Selection	The state is considering administering its own risk adjustment and reinsurance programs.
Coordination with Medicaid and the Children's Health Insurance Program (CHIP)	The state will design a system with a single point of entry for state health insurance programs that uses shared eligibility services for tax credits through the Exchange and Medicaid/CHIP, similar enrollment functions and some shared administrative functions.
Exchange Funding	Premium surcharge.

Partnering for Organizational Development: The “Secret Sauce” of Alliance Building

Sustainable Leadership in a World of "Coopi-tition"

As AF4Q communities look forward to the next stage of their work, there will be a natural shift in relationships among participating organizations – in terms of strategy and operations, in terms of public leadership and financial viability.

Each of Alliance has assembled a wide range of interested organizations and leaders who may serve on the board, work together to develop effective alliances across service and geographic boundaries, and wield influence on the regional health care delivery system.

Identify the factors that will sustain collaboration and trigger competition among the current AF4Q partners as the partnerships evolve.

	Sustain Collaboration	Trigger Competition
Current AF4Q partner organizations		
Other regional and local organizations		

Your AF4Q Board members		
Other key players in your area Policy? Political? Financial?		

Forecast:

What does your project need from key leaders of member organizations in order to manage a productive transition?

What does your project need from your AF4Q board members during this transition?

Robert Wood Johnson Foundation

Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

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