FSG REIMAGINING SOCIAL CHANGE

Bristol-Myers Squibb Foundation

Sustaining and Expanding Impact
A toolkit for funders and grantees

JUNE 2019

BOSTON GENEVA MUMBAI SAN FRANCISCO SEATTLE WASHINGTON, DC FSG.ORG

HOW CAN THIS TOOLKIT HELP YOU?

- This toolkit is intended to support organizations in **building comprehensive programs** that promote **improved health outcomes and equity** by bridging medical care and community-based services.
- The toolkit specifically aims to help organizations take a **structured approach to developing and sustaining programs** by engaging new and untraditional partners as part of a sustainability plan.
- For organizations **early in their work**, this toolkit can support the **development of a strong plan for sustainability from the outset of the project** through strategic planning, early partnership development, and monitoring & evaluation design.
- For organizations **later in their work**, this toolkit can support **strategy adjustments and ongoing efforts to identify and engage partners** for sustaining work beyond a specific grant.

TOOLKIT MODULES

INTRODUCTION
Understand sustainability and how to approach sustainability planning

1 **DEVELOP A SUSTAINABILITY VISION**
Define a long-term vision for your work beyond an individual grant

2 **ESTABLISH SUSTAINABILITY GOALS**
Embed sustainability goals and activities in your project strategy

3 **EXPLORE THE SYSTEM**
Identify and prioritize potential partners for sustainability

4 **PLAN PARTNER ENGAGEMENT**
Develop an action plan to engage high-priority sustainability partners

5 **CRAFT A DATA-DRIVEN PITCH**
Develop compelling messages and use evidence to attract partners

STRUCTURE OF EACH MODULE

Each module is organized into **four sections** including **key concepts** and relevant **exercises**, **examples**, and **templates** to guide your team through each step in the sustainability planning process.

CONTENT	**INTRODUCTION**	Context for how the module can support your team's work on sustainability
RESOURCES & TOOLS	**EXERCISE**	Guidance on how to use a relevant tool to facilitate reflection and planning for your team
	EXAMPLE	An example of a completed version of the tool from another health equity project
	TEMPLATE	A blank tool template for your team to complete

GUIDANCE FOR USING THE TOOLKIT

- The tools are **best used with a group**.
  - These tools yield the strongest insights when they combine multiple perspectives.
  - They support teams in developing a common understanding of the path forward.
  - Ideally, your group would include the core team involved in planning and implementing the project. You may also choose to include other partners.
- We encourage you to **set aside enough time** for using each tool. It takes **approximately 1.5 hours to complete** each tool and hold an accompanying discussion.
- We invite you to use the tools **in the order that is most relevant to you**.
  - The tools **build on one another** and it can be helpful to use them in sequence, particularly if you are just beginning to plan for sustainability.
  - Using one tool (e.g., partner action planning) may make you want to revisit others (e.g., the sustainability goals in your logic model) – the tools are **interlinked.**
  - However, if you would prefer to use the tools "a la carte," we encourage you to **start by identifying where you could use more support**. The next two pages include a **self-assessment** that will help you determine where to focus your efforts.

– These tools are intended to support iterative planning over time. We encourage you to **revisit the modules to refine your thinking** as your project progresses.

SUSTAINABILITY SELF-ASSESSMENT (1/2)

The self-assessment is intended to support you in focusing your sustainability planning efforts. We suggest that you take 10-15 minutes to fill out the next two pages before using the toolkit.

	Sustainability Pathways *[Note: Your responses can highlight areas of focus in using each module]*	**1. Which pathways are part of your plan, or have strong potential to be added?**	**2. Of the pathways that are part of your plan, how well-equipped are you to pursue them?**		
			Very well	Somewhat	Not at all
a.	Working with payers to change reimbursement eligibility				
b.	Influencing organizational or institutional policies				
c.	Securing additional philanthropic funding				
d.	Securing state and/or federal government grant funding				
e.	Engaging health systems leaders to change practices				
f.	Engaging health care administrators to reshape organizational resource allocation and funding flows				
g.	Conducting and disseminating research that captures effectiveness of a new approach				
h.	Building community and practitioner buy-in to continue				
i.	Advocating for changes to state and/or local government policy				
j.	Advocating for changes to federal government policy				

3. Of the pathways you marked *Somewhat* or *Not at all*, what would help you become better equipped to pursue them?

SUSTAINABILITY SELF-ASSESSMENT (2/2)

4. To what extent has your team completed the following activities for your project?

	Sustainability-Related Activities *[Note: These correspond to each module]*	Completely	Somewhat	Not at all	N/A
a.	Define a long-term vision for your work beyond an individual grant that includes aspirations for impact, sustainability, and scale				
b.	Embed sustainability goals and activities in your project's strategy and logic model				
c.	Understand the broad system of actors that influences your work to illuminate new opportunities for partnership				
d.	Develop an action plan to engage high-priority partners (i.e., prioritize partners, identify shared goals, develop specific engagement plans)				
e.	Develop compelling evidence and messages to attract partners (i.e., develop messages that speak to partner priorities, identify data to support your key messages)				
f.	*[Optional]* Execute on other sustainability strategies or activities your team has planned, not directly related those listed above				

5. What do you anticipate being your team's greatest strengths in pursuing sustainability of your project?

6. What do you anticipate being your team's greatest challenges in pursuing sustainability of your project?

Introduction

Understand sustainability and how to approach sustainability planning

WHY PLAN FOR SUSTAINABILITY?

Intentionally building sustainability strategies, activities, and partnerships into your work will help you achieve impact goals as well as continuation of your program.

Example: a big sustainability challenge
An organization without a sustainability plan

- Consistently delivered a strong program and **scaled the work to 12 new sites** in multiple states over the course of a 3-year grant
- **Worked towards opportunities for sustainability on an ad-hoc basis**, but primarily focused on delivering the program
- By the end of the grant, they were **unprepared to maintain the program across all sites** and needed additional funding, however they felt unprepared to do so in several ways:
  - **Did not have a robust data collection approach,** so had **insufficient evidence of impact** relevant to other donors
  - **Had not established agreements with partner sites** for sharing program costs beyond the initial grant—so partners were unwilling or unable to pay

Example: a sustainability success story
Marshall University Appalachian Diabetes Program

- **Expanded the use of community health workers** (CHWs) to improve diabetes care for underserved groups in the Appalachian region
- **Built relationships with target communities** to expand patient involvement in the program and **discussed payment for CHWs with health care providers and payers from the outset,** resulting in regular meetings with payers
- **Collected clinical and population level data** from the outset to **prove the effectiveness and cost-saving capabilities of the model,** which ultimately led insurance companies to offer enhanced reimbursements for CHWs
- **Leveraged innovative funding models**, such as impact investing, to explore avenues for underwriting long-term program costs in ways that suited the needs of key partners

TWO COMPONENTS OF SUSTAINABILITY

Sustaining your work can have two equally important components, and you may aspire to one or both. Both components rely on partnership.

Deepen implementation of your program and secure ongoing resources

Ensure patients, health systems, and other partners are willing and able to continue the work

- Improve the **effectiveness, comprehensiveness, and reach** of your project
- **Institutionalize effective practices/policies** in the organizations with which you are currently working
- Secure **sustained resources and resources for the project** (e.g., from hospital budgets, community benefit, philanthropy, payers, or governments)

Work with others to scale, expand, or replicate your program

Pursue changes in policies, practices, or resources to reach more people with your program

- Work with your organization or others to directly **replicate** the program in new communities and/or **expand** it to new disease areas (e.g., different cancer types)
- Support **dissemination and uptake of effective practices** from your program among relevant practitioners or policymakers
- Shift **public policy** to support effective practices

POSSIBLE PATHWAYS FOR SUSTAINABILITY

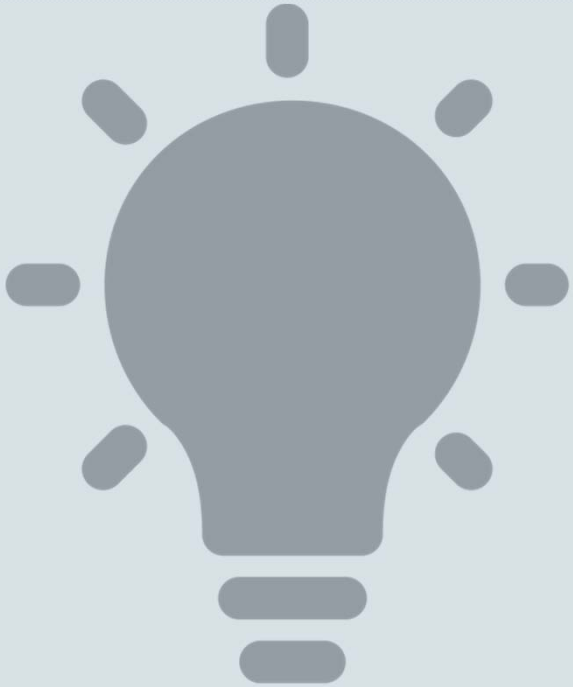
Pathways for achieving sustainability are varied. You may already be pursuing some, while others might be new. This toolkit will invite you to consider all of the below pathways as potential avenues for sustaining your program.

Sustainability Pathways

1. Building **community and practitioner** buy-in to continue the work
2. Engaging **health systems leaders** to change practices (e.g., evolving clinical care practices, expanding clinical-community partnerships)
3. Influencing **organizational or institutional policies** (e.g., instituting social determinants of health screening protocols, sustaining changes in referral processes)
4. Engaging **health care administrators** to reshape organizational resource allocation and funding flows
5. Securing additional **philanthropic funding**
6. Securing state and/or federal **government** grant funding
7. Conducting and disseminating **research** that captures effectiveness of a new intervention / approach
8. Working with **private and/or public payers** to change reimbursement eligibility

MODULE 1

Develop a Sustainability Vision



Define a long-term vision for your work beyond an individual grant

INTRODUCTION
DEVELOPING A SUSTAINABILITY VISION

Many programs have a vision for solving a specific problem, but do not include long-term aspirations for sustainability and scale.

A vision for sustainability articulates the ideal change you hope to achieve to ensure sustained impact and where, how, and for whom this change will take place.

This module will help you to:

- **Guide your work** during and after the grant period
- Ensure that sustainability is top of mind for your project team and a part of your project's **planned activities and measured outcomes**
- Keep **internal stakeholders** on the same page about what the program is aiming to achieve—not only during the grant period, but also in the long-term
- Communicate the value of your work to **potential partners and funders** and help them understand how they fit into your overarching goals

Q: What if my project has already been approved and its vision does not explicitly include sustainability?

A: Since the vision is intended to extend beyond an individual grant, you will likely not need to change your current grant agreements. However, sharing this broader vision could help your current funders understand and buy in to your long-term aspirations. This dialogue could, in itself, encourage follow-on funding while also supporting you in engaging additional funders.

EXERCISE
VISIONING (1/2)

An exercise (based on a method called Appreciative Inquiry) can help your team expand its vision to include long-term impact and sustainability.

The next two pages include instructions and prompts for completing the exercise.

Guidance on completing the exercise

1. Meet with your project team.

2. **Individually reflect on the prompt** (see next page) and consider the questions. Provide the "sustainability pathways" list (page 11) as a helpful thought starter. (*10 min*)

3. Ask people to **share their individual reflections**. When sharing reflections, it is important that all participants **speak in the present tense, as if the future was now**. (*30 min*)

4. **Discuss themes** across the reflections and **synthesize the key points** into a 1-2 sentence, guiding vision for sustainability. *(30 min)*

Note: If there are divergent points of view, consider which ideas seem the most viable given your internal or external context (e.g., existing assets, expertise, and networks, extent that the state health care policy environment is conducive to efforts to address health equity).

EXERCISE
VISIONING (2/2)

Visioning Prompt and Reflection Questions

Imagine that it is the year 2025. You have just received the latest issue of *Health Affairs* and you see that the cover story is celebrating your work for improving patient outcomes by eliminating socio-economic, geographic, racial, and/or ethnic disparities in health care for serious, complex diseases.

On your way into work, you run into a colleague who mentions the *Health Affairs* cover story and you begin to talk about why you and your partners were so successful and **how you were able to sustain and scale the program's impact** beyond the first grant.

Your colleague asks you several questions:

- What were the **most significant changes that enabled you to continue delivering your program** (e.g., changes in health systems, the types of reimbursements available to cover services, policy changes, greater community buy-in)?
- What contributed to **so many people being positively impacted** by the type of solution that you were implementing? How did you achieve such extensive reach?
- **Who** was critical to achieving sustainability of the program? What helped you be **effective** in engaging these partners (e.g., alignment on common goals, shared resources, data that "made the case" for the intervention, published research that demonstrated results)?

EXAMPLE
VISION THAT INCORPORATES SUSTAINABILITY

Example: A health system working to improve vulnerable populations' access to specialty care for cardiovascular disease in Camden, New Jersey

Vision

All Camden, NJ residents with cardiovascular disease, especially those that are low-income and vulnerable, will have **health outcomes equal to or better** than patients receiving specialty care in the surrounding region.

A definition of the scale and scope of the problem that you are trying to solve

An ambitious goal requiring greater action beyond an individual program or initiative

TEMPLATE
VISION

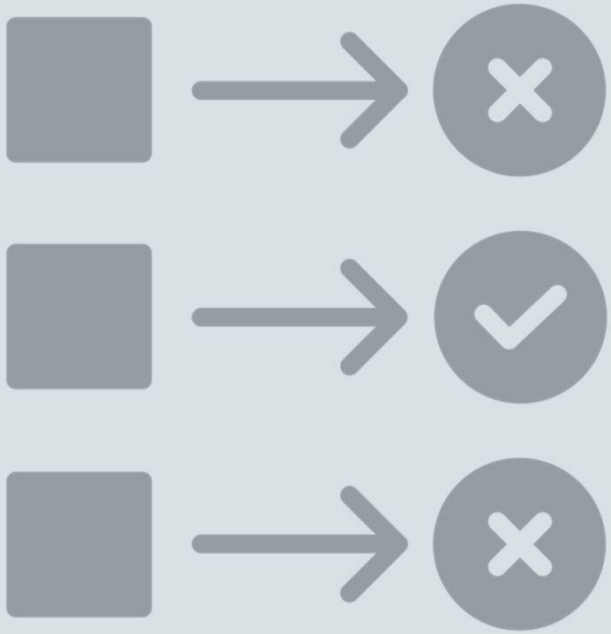
Vision

A definition of the scale and scope of the problem that you are trying to solve

An ambitious goal requiring greater action beyond an individual program or initiative

MODULE 2

Establish Sustainability Goals



Embed sustainability goals and activities in your project strategy

INTRODUCTION
ESTABLISHING SUSTAINABILITY GOALS

A logic model is a graphical depiction of your strategy, with planned actions and goals. Embedding sustainability in your logic model, particularly after expanding your vision, provides your team with a tangible plan that can keep you on-track and accountable to a set of sustainability goals.

This module will help you to:

- Develop a common **sustainability plan to guide your team and partners**
- Pursue **specific, proactive sustainability strategies** in addition to core program delivery *(as logic models often center on programmatic impact and may overlook strategies that enable innovations to be sustained, scaled, or replicated)*
- **Identify new activities** that can contribute to your project's sustainability
- **Track and evaluate** progress towards sustainability goals over time
- Communicate to funder(s) **how your work will continue** beyond their initial investment

Q: What if my logic model has already been completed and approved?

A: If you have already developed a logic model for your project, you can still incorporate sustainability goals as an additional layer. Just consider what existing activities may need to be altered and/or where it would be helpful to make connections between program and sustainability activities.

EXERCISE
UPDATING YOUR LOGIC MODEL (1/2)

Note: This exercise assumes that you already have a logic model for your program and focuses on supporting you in incorporating sustainability. If you have not yet created a logic model, and need support to do so, see the Additional Resources at the end of this toolkit.

Guidance on completing the exercise

1. **Place your sustainability vision at the top** of your logic model.
2. **Add elements from your sustainability vision** to the **long-term outcomes** for your project. Long-term outcomes should include the health impact you hope to create *and* the sustainability, scale, and/or replicability of your work beyond the initial grant.
3. **Working backwards** from those long-term goals, add in **interim outcomes**, **short-term outcomes, activities, and inputs** that will help you achieve the sustainability outcomes. Also note underlying **assumptions** related to achieving your sustainability outcomes.
   - Short-term outcomes may include the results of initial partner engagement and outreach (e.g., changes in knowledge or attitudes, indicators of participation/buy-in).
   - Interim outcomes may include changes in resources, practices, or policies that contribute to sustained impact.
   - *Note: Sustainability outcomes will often require you to influence the context around your project, and you will not have as much control over them as you do for your program outcomes. That said, it is helpful to identify these changes.*
4. **Note questions** that you will need to explore further before completing the logic model.

EXERCISE
UPDATING YOUR LOGIC MODEL (2/2)

VISION: Ground your logic model in a guiding vision for program success and sustainability

Inputs	Outputs		Outcomes		
	Activity	Participation	Short-Term	Medium-Term	Long-Term

Outline the resources that will allow your team to pursue sustainability activities *(e.g., technology for collecting data, time, and materials for engaging stakeholders)*

Include the sustainability activities and stakeholder engagement outputs you would like to see *(e.g., partnership-building efforts, awareness-building among stakeholders, increase in participating providers, changes to data systems)*

Include the short-, medium-, and long-term outcomes you hope to see in realizing your sustainability vision. These outcomes should be changes you can influence through your sustainability activities (e.g., *improvements in patient or provider experience, improvements in cost-effectiveness/efficiency, improvements in system performance, supportive policy or systems changes)*

ASSUMPTIONS: Capture the underlying beliefs, values, and assumptions that are necessary for your project to be sustained, scaled, or replicated *(e.g., capacity of other stakeholders to adopt your model, applicability of model to other populations)*

EXAMPLE
LOGIC MODEL INCORPORATING SUSTAINABILITY

Example: A health system working to improve vulnerable populations' access to specialty care for cardiovascular disease in Camden, New Jersey *[Note: Sustainability-related updates are below in* **blue***]*

VISION: All Camden, NJ residents with cardiovascular disease, especially those that are low-income and vulnerable, will have health outcomes equal to or better than patients receiving specialty care in the surrounding region.

Inputs	Outputs		Outcomes		
	Activity	Participation	Short-Term	Medium-Term	Long-Term
• Grant funding • Staff (PM, LPNs, health coaches) • Health system leadership • Delivery models—shared medical appointments (SMAs), LPN-led protocols—that address access to care and social needs • **Collaboration with payers and social service agencies** • **Research expertise**	• Use screening tool to evaluate unmet social needs • Conduct SMAs • Develop and use LPN-led disease management protocols • Develop complex care intervention for high-risk patients • **Partner with social service agencies** • **Partner with payers** • **Conduct research**	• # of social needs screenings completed • # of SMAs completed • # of LPN protocol visits completed • # of complex care visits completed • **# of social service agency partnerships made** • **# of payer partnerships made** • **# of publications from the program**	• Social needs screening tool piloted and finalized • Increase in healthy behaviors • Improvement in medication adherence and BP and lipid control • Decrease smoking rates • **Collaborations with key social service resources** • **Discussions with at least one payer on collaboration**	• Improved access to cardiovascular specialty care for Camden residents • Decrease in ED and hospital utilization • **Developed and shared best practices on social needs screening and collaboration across health, payer, and social service sectors**	• Decrease in cardiovascular (CV) morbidity and mortality • Social needs screenings and referrals uniformly integrated across health system • **Health system becomes national leader on social needs screening, multi-sector collaboration, and improving access to CV specialty care**

ASSUMPTIONS:

- Patients who have a higher number of social needs have worse health outcomes
- Addressing social needs will improve health outcomes

TEMPLATE
LOGIC MODEL

VISION:

Inputs	Outputs		Outcomes		
	Activity	Participation	Short-Term	Medium-Term	Long-Term

ASSUMPTIONS:

MODULE 3

Explore the System

Identify and prioritize potential partners for sustainability

INTRODUCTION
EXPLORING THE SYSTEM

Systems mapping is a method for considering the actors and factors influencing your project so you can identify new points of leverage to deepen and expand your work.

It can be particularly useful following an update of the vision and logic model, as those may have expanded the types of actors that will be relevant for sustaining your work. This exercise may also prompt you to refine your vision or logic model.

This module will provide insights about your context, partners, and impact:

Context

- **Understand the larger environment** around your work and the problem you are working to solve
- Illuminate the factors affecting your **target population**

Partners

- Provide a digestible representation of **the communities, sectors, and organizations** relevant to your project
- Highlight other actors **working towards common goals**
- Identify actors with the power to advance your work who **have not yet been engaged**

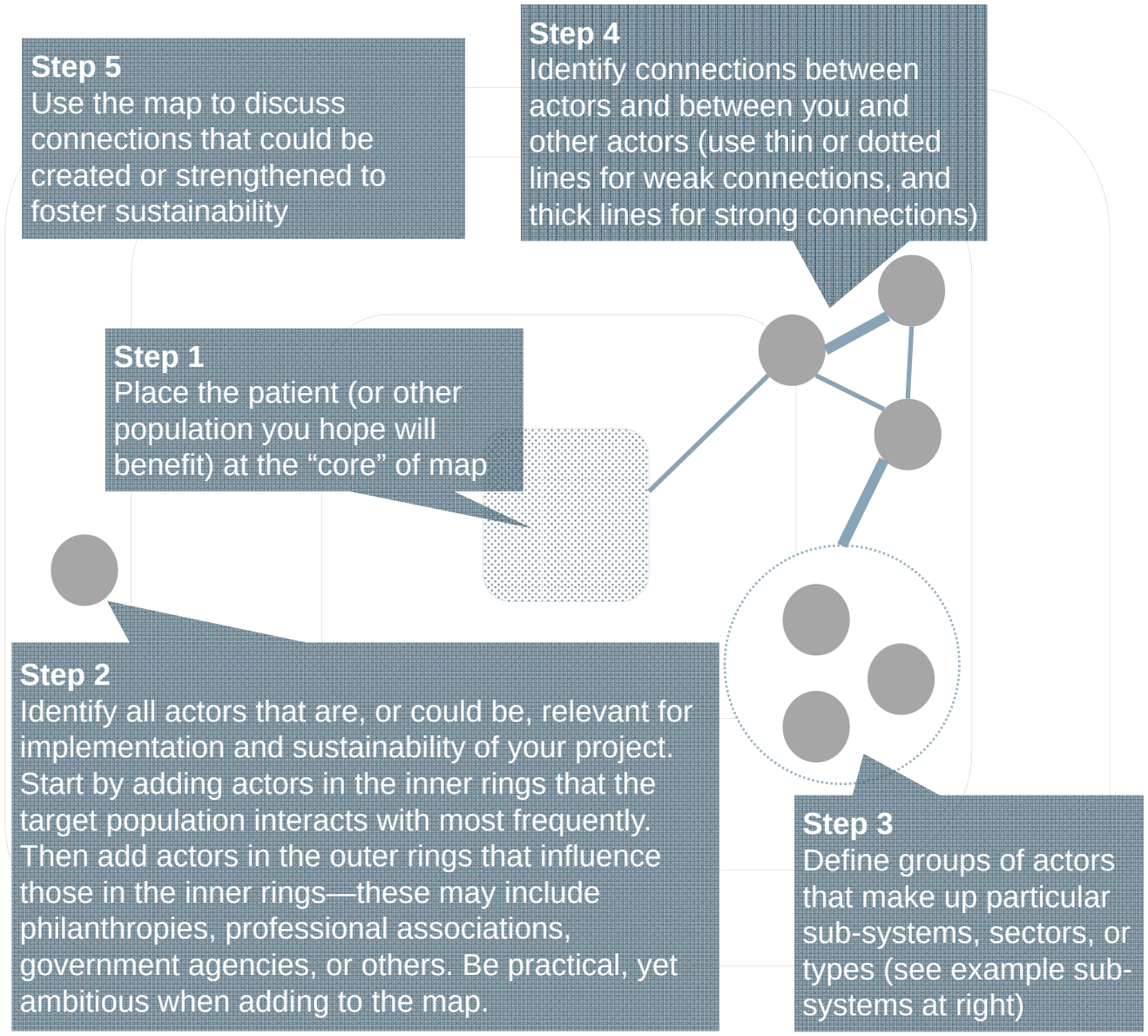
Impact

- Recognize **blocks or gaps in the system** that could limit the effectiveness of your work
- **Identify new opportunities** for sustainability and prioritize among potential partnerships

Q: When should I create a systems map?

A: Systems mapping can be done at any point in a project, but it is most effective to create a map once you have identified your target population and problem you aim to solve and/or vision for impact. Your map can be revisited and updated at any point in your work.

EXERCISE
SYSTEMS MAPPING (1/2)



Sub-systems relevant for health

Health Care Systems and Providers (e.g., community clinics, private practice)	**Public and Private Payers** (e.g., Medicare, state Medicaid agencies, private insurers)
Private Sector (e.g., employers, pharmacies, grocery stores, tech companies)	**Community Infrastructure** (e.g., transportation, housing, parks, schools)
Government (e.g., city councils, health departments, county, state & federal agencies)	**Community Organizations** (e.g., faith-based orgs, task forces & coalitions, service providers)

EXERCISE
SYSTEMS MAPPING (2/2)

Recommended Discussion Questions

- Overall, what do you see? What did the systems mapping activity reveal about the **context** in which you are working and the **sustainability pathways** you hope to pursue?

- What opportunities did your map illuminate to **make progress towards your sustainability vision and strategy**?

    - Are there **additional actors working to achieve a shared goal** that you could partner with to **deepen implementation** of your project? *[Note: They may be closer to the center of your map]*

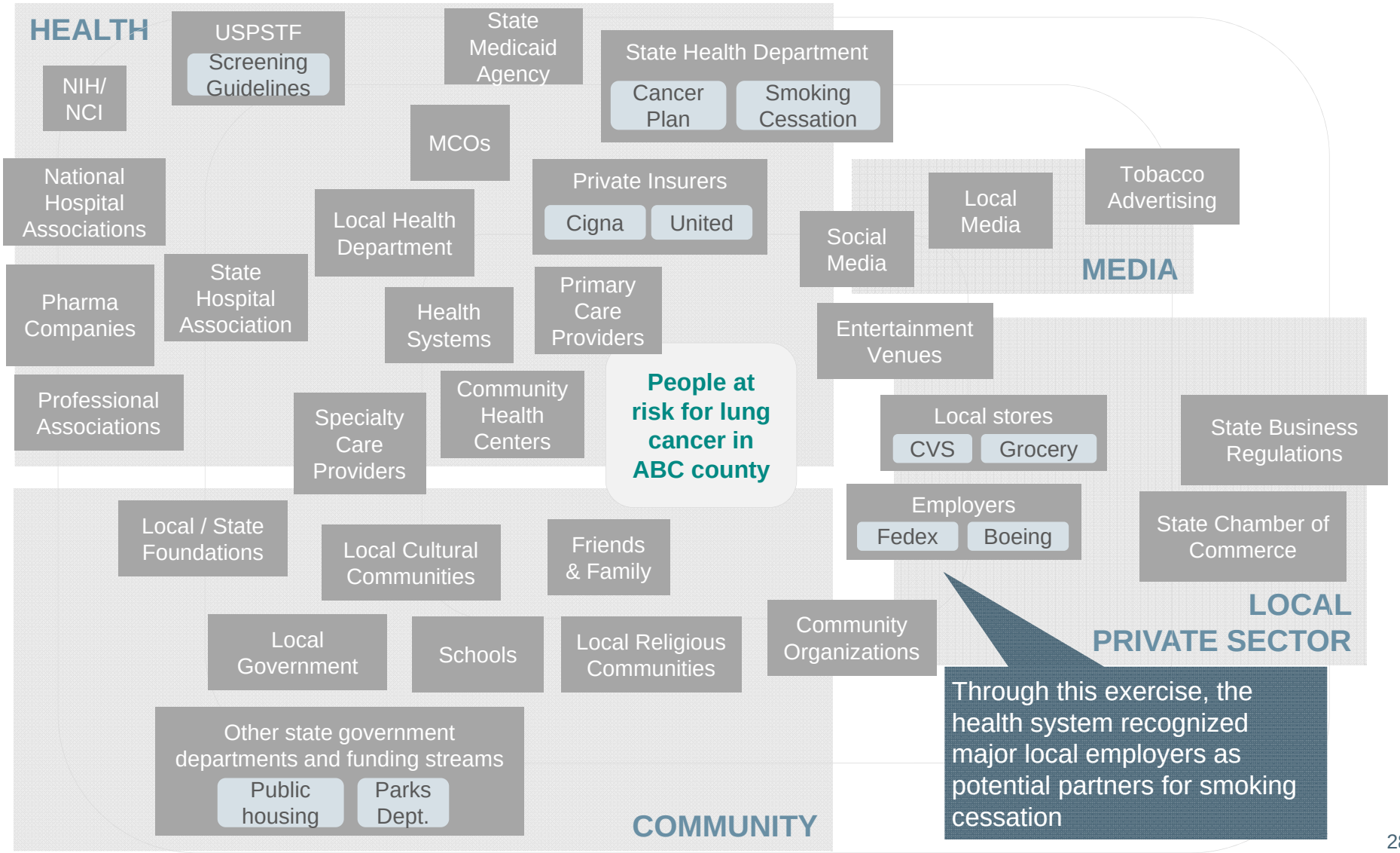
    - Are there **additional actors you can engage early on to build relationships and support** for **sustaining** your work over the long term? *[Note: They may be closer to the outside of your map]*

    - Are there **opportunities for disseminating your work** to broader audiences that you may not currently be pursuing (e.g., public meetings, professional associations, other related organizations)?

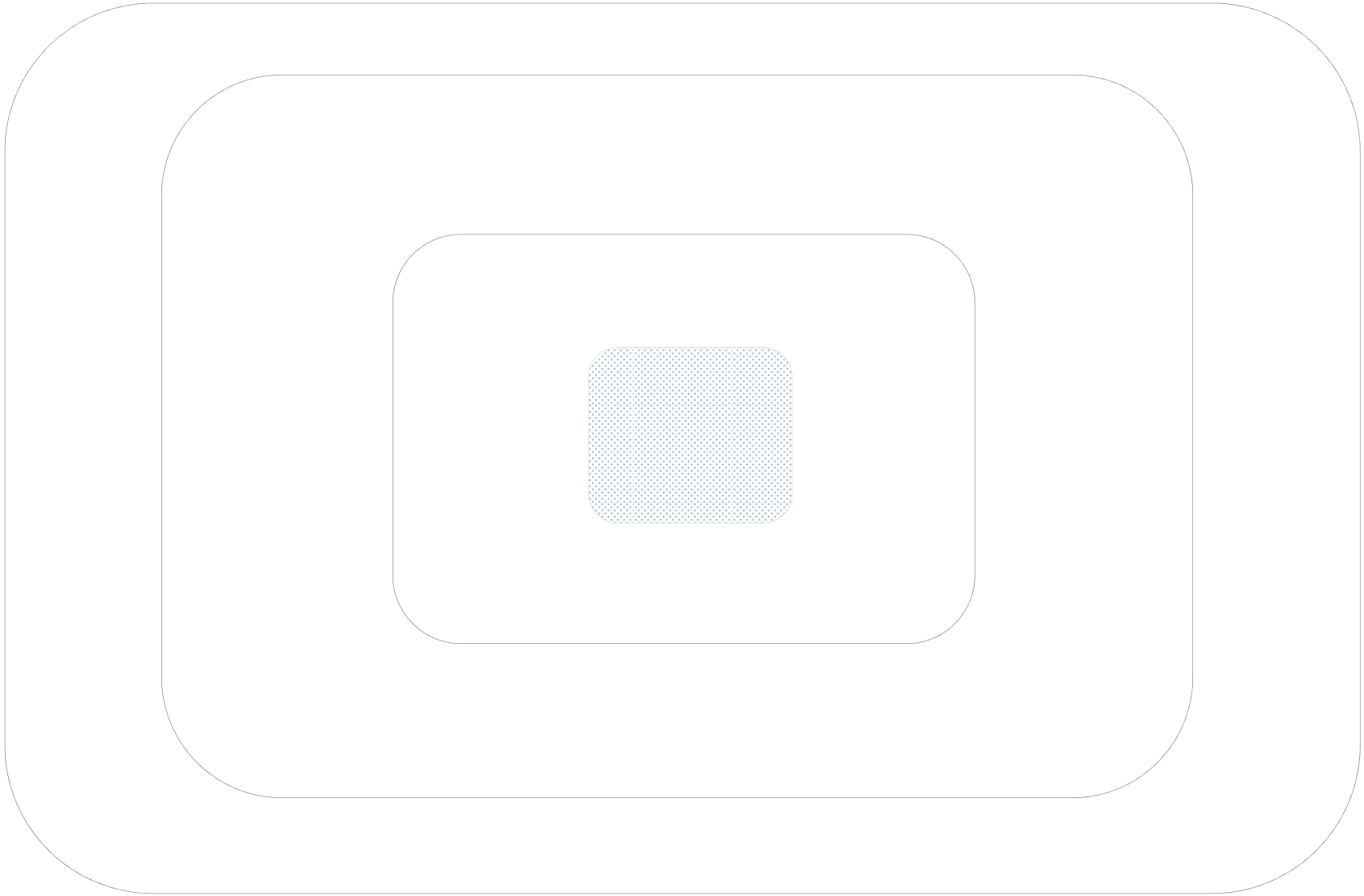
    - To what extent do the opportunities you identified have a **time dimension**? Which opportunities **are best pursued in the short-, medium-, or long-term**? Are there any that it might be helpful to pursue **sooner than you originally thought**?

EXAMPLE
SYSTEMS MAP

Example: Maryland health system working to improve lung cancer screening and linkage to care



TEMPLATE
SYSTEMS MAP



MODULE 4
Plan Partner Engagement

Develop an action plan to engage high-priority sustainability partners

INTRODUCTION
PLANNING FOR PARTNER ENGAGEMENT

While partnerships require flexibility, a clear plan can support effective partnership-building efforts that advance your sustainability goals.

A partner action plan defines the "who," "what," "how," and "why" of partner engagement. It is a tool to help you prioritize potential partners, identify shared goals, and coordinate your team's work to engage partners.

This module will help you to:

- **Clearly define shared goals** around which you can engage potential partners
- **Surface questions** to ask potential partners to understand their potential interest in your work
- **Define the roles** you hope potential partners will play in your work
- Provide your team with **concrete ideas for engaging partners** and building relationships over time
- Provide the team with a **shared plan that you can revisit periodically to track progress and maintain momentum** while you are in the midst of day-to-day implementation

Q: We're already building a number of partnerships. Why do we need a partner action plan?

A: This provides a great opportunity to clarify the intentions behind partnerships, prioritize your time and attention on highest-priority partnerships, and identify ways of gaining traction. If you have updated your logic model and/or created a systems map, you have likely developed new ideas for working with others to achieve sustainability. A partner action plan provides a chance to step back and connect those ideas to a set of activities for making them a reality.

INTRODUCTION
PARTNER ROLES

Partners can play a wide variety of roles in either deepening the implementation of your project or working with you to scale, expand, or replicate the project.

As you consider partners' roles, it is important to consider each partners' unique interests, priorities, networks, and capabilities.

Deepen implementation	Scale, expand, or replicate the project
• **Help establish deeper connections** with your target community • Provide a **service your target population needs**, but your organization cannot provide	• Change **institutional policies and practices to** create supportive conditions for the program • Advise on **materials** (e.g., reports, training materials) so they fit with institutional priorities
• **Share guidance** on your project's strategies, metrics, and progress • **Coordinate data collection** to demonstrate the impact of your work (e.g., on health outcomes, patient satisfaction, cost efficiency) in ways that also advance their goals	• **Fund** future stages of your work • Assist with **identifying new avenues** for securing resources • Partner to **jointly apply** for funding
• Align efforts across organizations to create a **mutually reinforcing approach** to achieving ambitious health equity goals that would be difficult for each organization to achieve alone	• Provide opportunities for **relevant stakeholders to learn from your work** (e.g., trainings) • **Leverage their influence** to encourage behavior change among relevant practitioners

INTRODUCTION
PARTNERSHIP LEVELS

In addition to identifying partner roles, it is also helpful to consider the depth at which to work with partners at various stages of the project to keep them engaged and motivate action.

Below are four levels of partnership that you could employ across partners.

Levels of partner engagement

	Inform	Consult	Involve	Co-Lead
How	**Alert potential partners** about the existence, progress, and successes of your program	Request **guidance from partners** on project goals, strategies, processes, and/or metrics	Work with partners on **mutually reinforcing activities**	Bring partners into your work as joint **decision-makers**
What *(Illustrative)*	• Share **publications** or project briefs • Include in **mailing lists** for regular project updates	• Meet regularly to **discuss project progress** and **gather partner feedback**	• **Coordinate data collection** to meet a need of both partners • **Collaboratively facilitate** meetings with a population of shared interest	• Invite partners to a project's **Steering Committee** • Establish a **formal agreement** to co-lead an effort
Why	**Increase awareness** of your work	**Add experienced insight** to your work and **build buy-in**	**Achieve greater** progress towards objectives by deepening implementation and expanding buy-in among key stakeholders	Embed **additional perspectives** into all aspects of your project and build ownership for the work among partners

Source: Adapted from Tamarack Institute Community Engagement Continuum

EXERCISE
DEVELOP A PARTNER ACTION PLAN

Consider your sustainability goals and the actors that would be most important for moving them forward (these actors may currently be central to your work, or more peripheral).

For the partners that seem most important to achieving your goals, fill out the table below with your team.

Potential Partners	Shared Goal that will Prompt Engagement	Current Relationship	Desired Level of Engagement and Specific Ask		
			Year One	Year Two	Year Three

1. Specify why this partnership makes sense for both your and your partner's work (e.g., "both working to reduce asthma disparities in New England")

2. Indicate your current relationship with the partner (e.g., "no relationship," "met once at conference," "meet monthly")

3. Identify your ideal level and type of engagement with the partner at different stages of your grant (e.g., "Inform – send them our brief," "Involve – invite to join Steering Committee")

EXAMPLE
PARTNER ACTION PLAN

Example: Collaboration between a university cancer center, local cancer registry, and nonprofit research center on a patient navigation program for Asian Americans in Northern California

Potential Partners	Shared Goals	Current Relationship	Desired Level of Engagement and Specific Asks		
			Year One	Year Two	Year Three
Shanti	Cancer navigation	Member of Patient Advisory Committee, collaborator on other projects	Inform; Consult on navigation	Inform; Consult: Involve in web portal development	Involve; Co-lead to disseminate and test web portal
Eureka	Leveraging technology for health care	Technology partner for web portal development	Involve in web portal development	Involve in web portal development/ maintenance	Involve; Explore potential to co-lead
California Pacific Medical Center	Patient care in San Francisco	Collaborator on other projects	Inform; Explore potential for partnership	Inform; Consult for feedback on web portal	Involve in dissemination of web portal
San Francisco Cancer Initiative	Reduce the burden of cancer in San Francisco	Collaborator on other projects	Inform	Inform; Consult for feedback on web portal	Involve in dissemination of web portal
Curesoft	Leveraging technology for navigation	Member of Patient Advisory Committee	Inform and consult (via Patient Advisory Committee)	Inform and consult (via Patient Advisory Committee)	Involve in dissemination of web portal; additional projects

TEMPLATE
PARTNER ACTION PLAN

Potential Partners	Shared Goals	Current Relationship	Desired Level of Engagement and Specific Asks		
			Year One	Year Two	Year Three

MODULE 5

Craft a Data-Driven Pitch

Develop compelling messages and use evidence to attract partners

INTRODUCTION
CRAFTING A DATA-DRIVEN PITCH

Crafting an effective pitch involves speaking to partners' unique interests and priorities.

Identifying key elements of your story early on provides time to plan for, collect, and use relevant data from a variety of sources to establish narratives that partners find influential.

This module will help you to:

- **Engage multiple partners** across a variety of sectors in ways that are **uniquely relevant to them**
- **Refine your evaluation plan** in light of your sustainability goals
- Identify **additional sources of data beyond your project's M&E** that will help provide a holistic view of your project's progress and impact

Q: What data can I use to engage potential partners if my project has just started?

A: Every project has valuable data, even projects that have not yet started! If you are early in your work, you can use data to highlight the needs your project is meeting, estimate the health impacts you anticipate having, compare your anticipated impact with that of other, similar efforts, and relate your goals to particular partners' priorities (e.g., health equity, systems transformation, quality and satisfaction, cost effectiveness). See page 42 for more ideas.

INTRODUCTION
ELEMENTS OF A STRONG PITCH

There are three steps to constructing a data-driven pitch.

DEFINE YOUR VALUE PROPOSITION

Consider the motivations of potential partners based on their contexts (e.g., industry, geographies of interest, past work) and identify the key ways your project addresses their priorities

CRAFT A COMPELLING NARRATIVE

Craft a series of messages that will be compelling and motivating to specific high-priority partners

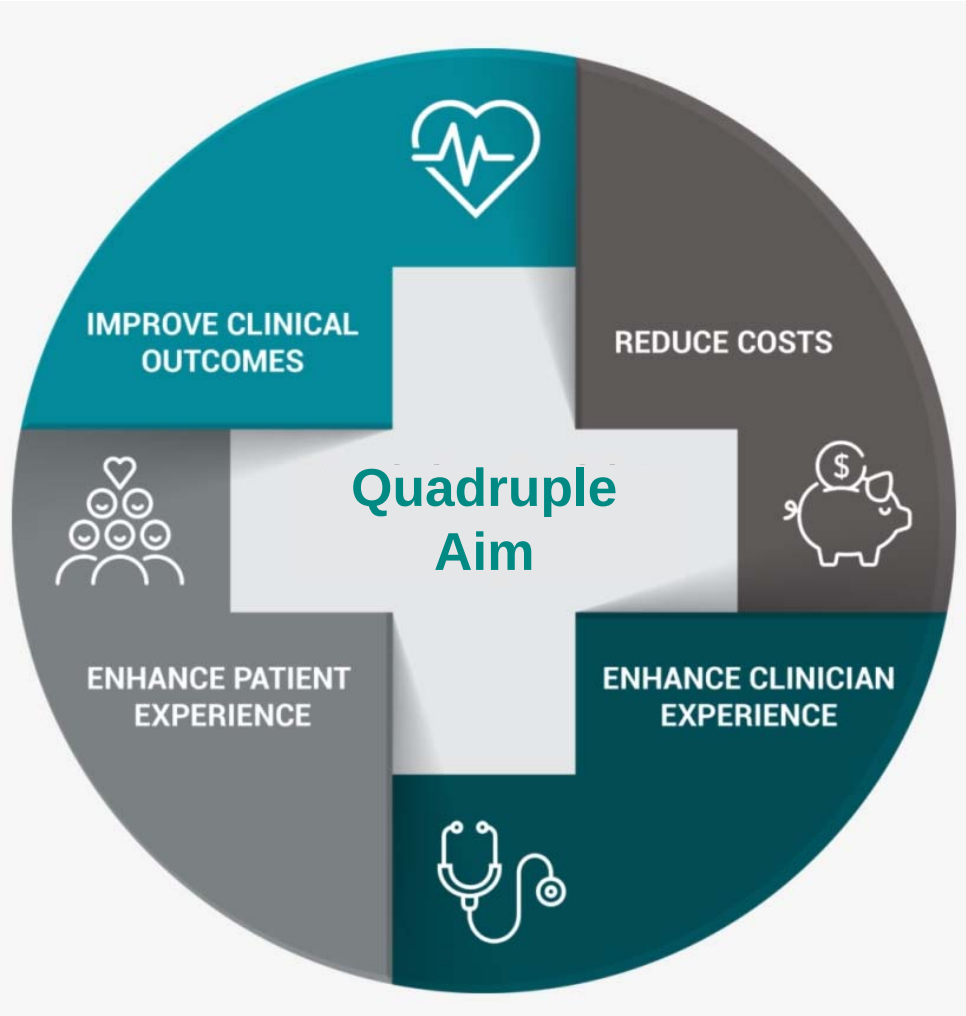
IDENTIFY AND GATHER SUPPORTING DATA

Determine the data needed (from multiple sources) to support your key messages, and develop a plan for gathering it, including data sources, necessary resources, and timeline

See the ***Appendix* for resources** on identifying the **motivations and data interests of common types of partners**: health care, government, philanthropy, and payer organizations.

INTRODUCTION
DEFINE YOUR VALUE PROPOSITION

The "Quadruple Aim" of Health Care



- The Quadruple Aim framework is commonly used by health systems, policymakers, and payers
- It highlights four common aims of health care programs *(note: the original framework did not include the clinician experience element)*
- Aligning the value proposition of your program to this framework will help you make the case for your work with key sustainability partners
- The case for sustaining or replicating your program will be strengthened if you can develop and share evidence across multiple elements
- For financial calculations, a time horizon of 1–3 years is reasonable

Source: Adapted from the Institute for Healthcare Improvement's Triple Aim Framework. See detailed guide for additional information.

INTRODUCTION
CRAFT A COMPELLING NARRATIVE

A compelling narrative about your program addresses the need for and impact of your work, as well as your resource/partnership aspirations—from your audiences' perspective.

Below is a sample outline for partner engagement materials to share this narrative.

1. **Introduction to the program and its impact *(common for all audiences)***
   a. Health problem the program is addressing, and the current implications of the problem for patients, and at the local, state, and/or federal levels (e.g., number of people affected, costs to the system, economic implications)
   b. Drivers of the problem (e.g., financing, complexities with navigating the system, effect of social needs on access to care)
   c. Anticipated scale or depth of the benefit to patients if this problem were addressed
   d. How the program addresses these health problems
   e. Components/key features of the program

2. **Early results of the program *(tailored to value proposition for each audience)*** *These could include:*
   a. Improvements related to the Quadruple Aim (e.g., health outcomes and equity, health care quality, cost-effectiveness, operational effectiveness, patient satisfaction/retention, provider satisfaction/retention, provider use of time, revenue)
   b. Improvements to community-level coordination and/or mobilization of community resources
   c. Benefits to the local, state, or federal health system (e.g., quality, cost-effectiveness, reach)

3. **Vision for sustainability (i.e., aspirations for deeper implementation, scaling, or replication)**
   a. Additional problems program stakeholders seek to address (e.g., application of the program to the needs of additional populations, other health problems, or other parts of the health system)
   b. Why this program model is a good fit for addressing these problems
   c. Anticipated scale/impact of benefits if this additional problem were addressed *(tailored to each audience)*

4. **What is needed to reach vision for sustainability *(tailored to each audience)***
   a. A specific need/ask, or a "menu" of needs/asks, that illustrate how the potential partner can engage in or support your work

INTRODUCTION
EARLY IMPLEMENTATION DATA SOURCES

If you are early in your project, you likely will not have progress or outcomes data to use. However, you can draw on a number of other types of data to speak to the need for your program and its anticipated benefits.

Types of Data	*Potential Data Sources*
• **Local** demographic and health data (e.g., on disease incidence, rates of smoking) illustrating need for the program	• National Minority Quality Forum Indices with zip code level data on health inequities • Reports or data from **local health departments** • **Data** from private payers • Health systems' Community Health Needs Assessments
• Evidence of **impact of addressing health problems** (e.g., on health outcomes, cost, productivity) in ways that illustrate the potential impact of your work	• **Academic studies** based in your target geographical area, or relevant to your target population
• Case studies and data from **similar programs** or interventions that illustrate the outcomes you hope to achieve	• **Evaluations** from similar efforts
• Qualitative data sharing **stories or perspectives from individual** patients that show the need for the program in real life	• **Interviews and focus groups** with intended beneficiaries
• **Data from the partner** to illustrate potential implications for them (e.g., cost data)	• **Claims or payments data** from local government departments or private payers

INTRODUCTION
LATER IMPLEMENTATION DATA SOURCES

If you have been implementing for a while, you can complement project progress or outcomes data with additional data illustrating the systems impact and potential future benefits of the program, particularly if sustained and/or scaled.

Types of Data	*Potential Sources of data*
• **Program data on the progress, reach, and health impacts** of the project, from your monitoring and evaluation efforts	• **Service provision data** from internal databases • **Clinical outcomes data** from internal databases • **Results of surveys, interviews, focus groups**, and other evaluation methods
• **Calculations of financial return-on-investment** tailored to partner audiences (e.g., health systems, payers, gov't agencies)	• **Data from health systems, payers, or government agencies** to support return-on-investment calculations
• Qualitative data sharing **stories or perspectives from individuals** that illustrate the impact of your work on the patient experience and potentially on patients' lives	• **Interviews and focus groups** with participating patients and/or providers
• Comments on the value of the program **from the perspective of other actors whose views are important to the partner** (e.g., views of staff physicians for an audience of health systems leadership)	• **Letters of support** from project stakeholders • **Interviews** with project partners

EXERCISE
BUILD A DATA PLAN

Focusing on your partnership aspirations, consider the motivations of potential partners and the types of messages and supporting data they would find most compelling. Fill out the table below with your team.

Potential Partner	Motivations of Partner	Compelling Data for Partner	Data Sources	Plan and Timeline for Accessing Data
	Specify why this partnership makes sense for your partners' work* (e.g., "both working to reduce asthma disparities in New England") **If you have created a partner action plan, you may copy the responses from that sheet here*	**Describe what types of data speak to this partner** (e.g., "quantitative analysis of cost savings," "evidence of need")	**Identify where you might gain access to this data and note new data will need to be collected** (e.g., "Research from local state departments")	**Briefly describe your plan and timing for gathering and sharing data with the partner** (e.g., "Conduct cost savings estimation of project and meet with State Health Department by 3rd month of grant")

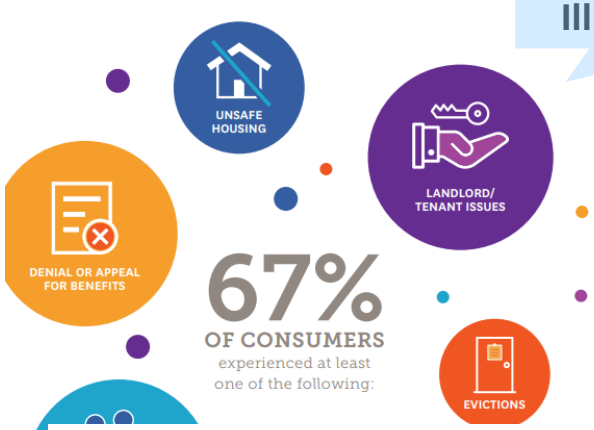
Recommended Discussion Questions

1. What **additional information** do we need in order to understand the motivations of our potential partners?
2. If we have access to the data that our current or potential partners would find compelling, what is our **plan for synthesizing and sharing this data** with the partner?
3. If we do not currently have data we want, what **steps can we take** to create or access this data?

EXAMPLE
AN EFFECTIVE MULTI-FACETED DATA PITCH

Example: The National Center for Medical-Legal Partnerships uses different types of data to articulate its value proposition to different audiences

Illustrating the need



Noting impacts and benefits for providers

Clinicians have a positive view MLP services.

In our 2016 survey of medical-legal partnership programs across the country, we asked health care organizations to tell us how often clinicians at their hospital or health center anecdotally reported the following benefits of MLP services:

- 86% reported improved health outcomes for patients;
- 64% reported improved patient compliance with medical treatment; and
- 38% reported improved ability to perform "at the top of their license."

Highlighting quotes from credible experts

> *"Providing legal assistance where clients get their healthcare can improve their lives in both worlds. People don't think of legal and medical problems as related, but actually resolving one can help the other."*
>
> **Jack Tsai, PhD**
> DIRECTOR, YALE DIVISION OF MENTAL HEALTH SERVICES AND TREATMENT OUTCOMES RESEARCH

Studies show that when legal expertise and services are used to address social needs:

Providing evidence of cost savings and patient impacts

People with chronic illnesses are admitted to the hospital less frequently.
Studies showed that legal assistance targeted at improving housing conditions improved the health of asthma patients (*Journal of Asthma* and *Journal of Healt... the Poor and Underserved*), and another study showed medical-legal partnership's positive impact on the health of sickle cell patients (*Pediatrics*).

Less money is spent on health care services for the people who would otherw... frequently go to the hospital, and use of preventative health care increases.
A study showed that MLP services reduce health care spending on high-need, high-cost patients (*Health Affairs*), and a randomized control trial found families of healthy newborns increased use of preventive health care after MLP services (*Pediatrics*).

Clinical services are more frequently reimbursed by public and private payers.
Medical-legal partnerships have been shown to save patients health care costs and recover cash benefits (*Journal of Health Care for the Poor and Underserved* and *Journal of Palliative Medicine*).

EXAMPLE
DATA PLAN

Example: A Philadelphia health system that is engaging a learning community dedicated to reducing lung cancer stigma and other barriers to care, and to increasing lung cancer prevention and control, especially among the city's most vulnerable residents

Vision	Serve Philadelphia's uninsured and underinsured populations by providing greater access to LDCT (low dose computerized tomography) screening

Potential Partner	Motivations of Partner	Compelling Data for Partner	Data Sources	Plan and Timeline for Accessing Data
Center for Urban Health	To improve the **health and well-being** of Philadelphia's residents	• Report on the increase in survivorship when early screening is undertaken • Results from New Jersey effort to provide greater access to LDCT screening	• Health academic journals • Reports from the American Lung Association	• Begin compiling evidence in week 1, month 1 of the project • Develop key takeaways to share with potential partners by week 2, month 2
Independence Blue Cross (IBC)	Serve the **health insurance needs** of Philadelphia and southeastern Philadelphia	• Research on decreased insurance costs when lung cancer screening is readily available • Projections on savings for IBC	• Team financial analysis • Reports from the National Cancer Institute	• Begin compiling research week 1, month 1, complete by week 1, month 2 • Begin financial projections week 1, month 2, finish projections by week 4, month 3

TEMPLATE
DATA PLAN

Potential Partner	Motivations of Partner	Compelling Data for Partner	Data Sources	Plan and Timeline for Accessing Data

Additional Resources

- ***Other sustainability resources***
- ***Context for understanding the motivations and interests of potential partners***

ADDITIONAL RESOURCES

Below is a collection of additional resources and tools on a variety of topics that you may find valuable for pursuing sustainability.

Logic model development	**W.K. Kellogg Foundation Logic Model Development Guide** www.wkkf.org/resource-directory/resource/2006/02/wk-kellogg-foundation-logic-model-development-guide
Sustainable financing models	**Beyond the Grant: A Sustainable Financing Workbook, by ReThink Health** https://www.rethinkhealth.org/financingworkbook/
Philanthropic funding	**Foundation Center –** *"Offers data sources, publications and trainings focused on the philanthropic sector"* fconline.foundationcenter.org/
	Foundation Stats data.foundationcenter.org
	Foundation Maps maps.foundationcenter.org
Government funding	**Grantspace: Where can I find information about government grants?** grantspace.org/resources/knowledge-base/government-grants/
Community health data	**Community Commons –** *"We provide public access to thousands of meaningful data layers that allow mapping and reporting capabilities so you can thoroughly explore community health."* www.communitycommons.org
Communications	**Cause Communications: Communications Toolkit** www.causecommunications.org/communications-toolkit
Community Engagement and Equity	**Tools to Engage: Resources for Nonprofits, Compiled by the Building Movement Project – "***An interactive, multi-level search portal that connects people and organizations looking to align the values and principles of their work to the best tools, research, and resources from across the social sector."* tools2engage.org/
Monitoring and evaluation	**W.K. Kellogg Foundation Evaluation Handbook –** *"A new step-by-step Guide to Evaluation released in November 2017 for grantees, nonprofits and community leaders…"* www.wkkf.org/resource-directory/resource/2010/w-k-kellogg-foundation-evaluation-handbook

REFERENCE

ADDITIONAL INFORMATION ON PARTNERS

To support you in partner action planning and crafting a data-driven pitch, the following slides pages contain information on the motivations and data interests of common types of partners: health care systems, government agencies, philanthropy, and payer organizations.

Health Care Systems

Government Agencies

Philanthropies

Payers

HEALTH CARE SYSTEMS
PARTNER TYPES

System administrators are in an important position to **change institutional policies and practices** in ways that can catalyze and scale your work. Aligning your work to priorities identified in a Community Health Needs Assessment and to the Quadruple Aim will be compelling for this audience.

Community benefit departments have **great potential for partnerships** as they have an imperative to invest in the community and can provide **grant funding.** Aligning your work to priorities in the Community Health Needs Assessment will be critical to gaining their support.

Dignity Health

Dignity Health is a large health system with over 39 hospitals in Western states

- Dignity Health hosts the Coordinated Community Network Initiative (CCNI), which electronically links health care providers to organizations that provide community services
- Dignity Health began piloting CCNI in Nevada in 2016. Starting in 2017, Dignity Health began replicating the initiative in 17 additional sites
- Among the sites operating CCNI, 4,200+ referrals have been made to 240 programs
- They aim to scale the program to all 34 of its hospitals by 2020, and to continue to improve the platform to enable better outcomes tracking

KAISER PERMANENTE

Kaiser Permanente is a leading health care system that provides both insurance and care. Its Community Health program aims to:

- *Ensure health access* by providing individuals served by Kaiser Permanente or safety-net partners with integrated clinical and social services
- *Improve conditions for health and equity* by engaging members, communities, KP's workforce, and all of the organization's assets
- *Advance the future of community health* by innovating with technology and social solutions

Community Health plans to provide more than $23M in grants in 2018

Note: Integrated health systems such as Kaiser Permanente, are particularly interested in health equity innovations

HEALTH CARE SYSTEMS
MOTIVATIONS

PRIMARY MOTIVATION	System Admin.	Comm. Benefit	RELEVANT DATA
Improve health outcomes for patients and the surrounding communities	X	X	• Data-driven assessment of underlying **drivers of health inequity** • Quantitative assessment of **health and cost impacts of SDOH** • Comparison of target group health **outcomes and health care costs relative to population**
Reduce non-reimbursed expenses	X		• Assessment of **current non-reimbursed expenses** and ability of program to reduce them (e.g., reduce hospital readmissions for uninsured patients)
Increase number of patients entering system for screening, diagnosis, and care	X		• Assessment of number of insured patients that are **not accessing required health care** • Assessment of number of patients **receiving late diagnosis that could have been prevented** with earlier outreach
Elevate reputation of health system	X	X	• Ability to **publish results, share program nationally and/or with specific relevant audiences** or conferences
Meet community benefit requirements		X	• Assessment of opportunities to **help health system conduct community needs assessment** and/or meet community benefit obligations
Aid provider operations and satisfaction	X		• Evidence that interventions are optimizing processes in ways that **save providers' time or effort** • Data that interventions increase **provider job satisfaction**

GOVERNMENT
PARTNER TYPES

Government partners can connect your program to **communities of interest**, provide **robust data** to support stages of your work, and/or open **access to significant sources of funding**

There are three main levels of government to consider

Local/Municipal (e.g., local health departments)

- Tend to focus on county-, city-, or neighborhood-level issues
- Not likely to provide direct grant funding, but can partner directly on services and facilitate access to specific communities or community-specific data
- Respond well to efforts that align with or leverage their existing work

State Government (e.g., state health departments)

- Focus on issues relevant to states' specific social and policy context
- May provide direct funding and are well-positioned to scale successful efforts
- Have interest in efforts that can reduce or contain state costs while responding to an issue of constituent interest

Federal (e.g., NIH/NCI, CDC, HRSA, CMMI)

- Often focus on cutting-edge programs that can advance a field and/or issue
- Different agencies have different specializations – some focus on research, others on scaling programs to improve population health
- Can supply significant funding for efforts and incentives to support scaling

GOVERNMENT
MOTIVATIONS

PRIMARY MOTIVATION	Local	State	Federal	RELEVANT DATA
Improve health care and public health processes and public outcomes	X	X	X	• Quantitative assessment of **health and cost impacts of SDOH** • Deep **understanding of patient processes** and barriers to care • **Narratives** that reflect the benefit of an intervention to constituents
Address health disparities and promote health equity	X	X	X	• **Milestones data** that demonstrates **concrete progress** within timelines that are responsive to political shifts (e.g., election cycles) • **Data-driven assessment** of underlying drivers of health inequity
Contain or reduce costs	X	X	X	• Thorough cost analysis to **pinpoint specific savings** • Detailed description of how an intervention **reduces downstream patient costs**
Encourage public-private partnerships with corporate and/or philanthropic actors		X		• **Strong potential partnerships or current partnerships** with a diverse range of entities • **Demonstrated history** of public-private partnership
Respond to issues of constituent interest	X	X		• **Evidence of public interest** in a program's goals and/or outcomes • Clear **relationship to a government focus** and/or area of interest • **Narratives** that reflect the benefit of an intervention to constituents

PHILANTHROPIC FUNDERS
PARTNER TYPES

Philanthropic capital can be very useful in **catalyzing innovation**, demonstrating the impact of **unproven pilot programs**, and providing the **seed funding** to test and scale interventions that are not yet verifiable

There are several types of philanthropic funders:

Health-Focused Funders (e.g., National or State Private Foundations)

- Tend to be larger and focused specifically on health and health equity issues
- Grant making often focuses on proactive and cutting-edge initiatives
- Respond well to ambitious and well-researched efforts

Corporate Philanthropies (e.g., Pharmaceutical and Insurance Companies)

- Larger and focused on issues related to core areas of the business (e.g., pharmaceutical companies focus on disease-specific areas)
- Grant making may occur in regular cycle
- Respond well to projects that clearly align with their business interests

Local Funders (e.g., community foundations, local family foundations)

- Tend to be smaller and focused on place-based issues
- Grants are made in response to community challenges
- Respond well to data that demonstrates how a project or program will improve the community issue of their interest

PHILANTHROPIC FUNDERS
EXAMPLES

Health Focused Funder

Robert Wood Johnson Foundation

To **build a culture** of health and health equity for all communities, Robert Wood Johnson Foundation employs a **4-pronged action framework**:

- Making health a **shared value**
- Fostering **cross-sector collaboration** to improve well-being
- Creating **healthier, more equitable,** communities
- Strengthening **integration** of health services and systems

Corporate Philanthropy

aetna℠ FOUNDATION

Aetna Foundation **encourages healthy lifestyles** and improves health among the underserved by:

- Partnering with national and select international organizations to bring **innovative efforts** to the world
- Coordinating with national partners to use **research**, **experimentation**, and **education** to **reduce health inequities**
- Providing grants to U.S. nonprofits to support **interventions** that inspire **healthier lifestyles** across communities

Local Funder

GREATER WASHINGTON COMMUNITY FOUNDATION

The Greater Washington Community Foundation supports the **Washington area** by:

- Mobilizing local philanthropy to support **initiatives** that support a **diverse range of issues**
- Lending strategic knowledge to the area's nonprofits and donors to **create a robust community sector**
- **Convening local leaders** across an array of industries to support collaboration with a goal of **local systems change**

PHILANTHROPIC FUNDERS
MOTIVATIONS

PRIMARY MOTIVATION	Health Focused	Corporate	Local	RELEVANT DATA
Advance health equity by piloting ways to address the social determinants of health	X	X	X	• Data-driven assessment of underlying **drivers of health inequity** • Quantitative assessment of **health and cost impacts of SDOH** • Comparison of target group health **outcomes and health care costs relative to population**
Address the needs of target demographic groups or disease areas	X	X	X	• Traditional **health, quality, and demographic** indicators and outcomes • Comparison of target group health **outcomes and health care costs relative to population**
Support cross-sector collaboration	X		X	• Demonstrated instances of **collaboration** (e.g., existence of common agenda) • Map of **mutually reinforcing** activities and / or opportunity for **collaboration**
Respond to local needs			X	• Traditional **health, quality, and demographic** indicators and outcomes • Evidence of target **health priority** relative to other local needs (e.g., health impact on education outcomes)
Foster systems change	X		X	• Assessment of local policy environment and assessment of **opportunities to scale** and/or replicate program approach

PAYERS
PARTNER TYPES

Public payers can be key partners in creating **changes in clinical practice** and in driving uptake of changes by **providing infrastructure** that bridges systems of care. Start by identifying and approaching the largest Medicaid providers in your state.

Private payers can be key partners for **accessing data**, leveraging their **networks**, and **sustainably funding** program costs (e.g., making expenses reimbursable). Work in partnership with a health system and start by approaching the state health plans of major private payers.

HPP Health Partners Plans

HealthPartners Plans, a Medicaid MCO in Pennsylvania, partnered with the Metropolitan Area Neighborhood Nutrition Alliance (MANNA) to:

- **"Prescribe" food and nutrition** to medically vulnerable patients struggling with food insecurity
- Prepare and **deliver 21 frozen meals a week** to clients' homes

By delivering over 470K meals to more than 1,858 medically vulnerable members, the effort has ***decreased HbA1c scores of diabetic members by 26%*** *and* ***reduced medical costs by 27%***

Cigna

Cigna uses a distinct approach in each community, depending on the health issues particular to the region. In Memphis, TN, Cigna used GIS mapping and claims data to:

- Identify a community that had a **particularly high incidence of breast cancer**
- **Disaggregate the data** to see that African American women in that community had lower rates of screening compared to white women
- **Partner with churches and a Methodist hospital** to communicate the importance and "how-to" of screening to the community

PAYERS
PARTNER TYPES

PRIMARY MOTIVATION	Public Payers	Private Payers	RELEVANT DATA
Improve Medicaid / Medicare patient health outcomes, experience, and access to services	X		• Data-driven assessment of underlying **drivers of health inequity** • Quantitative assessment of **health and cost impacts of SDOH** • Comparison of target group health **outcomes and health care costs relative to population**
Increase member satisfaction and loyalty		X	• Evidence of program (or analogous programs) resulting in patient satisfaction and/or improved patient experience • Evidence of program (or analogous programs) resulting in provider job satisfaction, time savings, or other dimension
Reduce costs, especially related to high-cost patients	X	X	• Data-driven assessment of underlying **drivers of health inequity** • Quantitative assessment of **health and cost impacts of SDOH** • **Claims data** for high-cost patients, including services provided, cost, and location • Expected or actual **cost of program** (e.g., to estimate return on investment) • Expected or actual time to impact (e.g., to estimate likely cost savings)
Build the case for key priorities (e.g., policy change, SDOH)	X		• Assessment of **local policy environment** and assessment of opportunities to scale and/or replicate a program or approach
Demonstrate the case for SDOH pilots and improve community heath		X	• **Ability of program to be scaled / replicated** across communities in which the payer operates


FSG
REIMAGINING SOCIAL CHANGE