Research Center for Leadership in Action
NYU Wagner

GRANTMAKERS FOR EFFECTIVE ORGANIZATIONS

Community Clinics Initiative
Networking for Community Health

A Case Study from

The Power of Learning:

How Learning Communities Amplify the Work of Nonprofits and Grantmakers

This case study is excerpted from the internal research report, "The Power of Learning: How Learning Communities Amplify the Work of Nonprofits and Grantmakers," commissioned by Grantmakers for Effective Organizations and produced by the Research Center for Leadership in Action at NYU Wagner in 2012.

To request a copy of the full report or for more information, please contact:
Leonor Alfonso at alfonso@geofunders.org

Introduction

Grantmakers for Effective Organizations (GEO) is currently undertaking a multi-year initiative, Scaling What Works, to support the success of the Social Innovation Fund and "to expand the number of grantmakers and public sector funders across the country that are prepared to broaden the impact of high-performing nonprofits." As part of this effort, GEO is interested in gaining a deeper understanding of "learning communities," especially how grantmakers can employ them to support collective learning among their grantees.

GEO selected the Research Center for Leadership in Action (RCLA) at New York University's Robert F. Wagner Graduate School of Public Service to conduct a study on learning communities (LCs). The study addresses questions about different types of LCs, their design elements, the common challenges they face and their role in helping scale effective practices as well how they define success and common elements of success in facilitating learning to change practice.

About Grantmakers for Effective Organizations

Understanding that grantmakers are successful only to the extent that their grantees achieve meaningful results, GEO promotes strategies and practices that contribute to grantee success. In 1997, a handful of visionary leaders saw a need for a place where grantmakers committed to improving organizational effectiveness could convene to share knowledge and best practices, and inspire their colleagues to act. Today, GEO is a powerful coalition of more than 2,700 individual members representing 360 grantmaking organizations committed to building strong and effective nonprofit organizations. GEO helps grantmakers improve practices in areas which, through years of work in philanthropy, have been identified by innovators in the field as critical to nonprofit success.

About the Research Center for Leadership in Action at NYU Wagner

RCLA is a research center founded at NYU Wagner in 2003 with support from the Ford Foundation. As the hub for leadership research and practice at NYU, RCLA faculty teaches courses at the undergraduate, masters and executive masters levels. In addition, RCLA works across the diverse domains of public service to build knowledge and capacity for leadership that transforms society. The Center's greatest asset is its unique ability to partner with leaders to create collaborative learning environments, translate ideas into action and build knowledge from the ground up. As a result, RCLA contributes breakthrough ideas to the worlds of scholarship and practice. The Center does this work with the conviction that today's pressing social problems require moving beyond the traditional image of a heroic leader to facilitating leadership in which people work across sectors and boundaries to find common solutions.

How to read the case study

RCLA conducted six case studies, half of which we refer to as "funder-grantee LCs" and half of which were "peer LCs." In the former, the LC was a supplementary activity to a grantmaking program. In three cases, participants who received grants from the LC organizer were required to participate in the LC as part of their grant agreement. Both the grantmaker and the grantees participated in the LC. In peer LCs, participants were not grantees of any one program and did not share a relationship with any one funder. This does not mean that there was no funding sponsor. However, the sponsor did not participate in the LC as a learner. Participants in peer LCs shared a common profession or field of practice, challenge or opportunity. The distribution of the case study LCs along these two categories was as follows:

Funder-grantee LCs	Peer LCs
▪ Community Clinics Initiative-Networking for Community Health (CCI-NCH) ▪ Schools of the Future Community of Learners (SOTF-COL) ▪ Wallace Foundation Professional Learning Communities (WF-PLC)	▪ Embedded Funders Learning Community (EFLC) ▪ Council of Michigan Foundations Participatory Action Learning Network (CMF-PALN) ▪ Eureka-Boston

Each case starts with a discussion of how the learning community was instigated and how it has emerged to fulfill its purpose. Then, each case is described through a three-part framework proposed by Snyder and de Souza Briggs[1] that builds on earlier work by Etienne Wenger. Snyder and de Souza Briggs find that learning communities have three key features: community – who belongs to the group; domain – the common issues or problems that members wrestle with; and practice – what members do as they learn together and what it is about their learning that is embedded in practice. Put simply, the three features are about who does the learning, what the learning is about and how the learning happens. Each case is discussed through each of these three features, which in reality are intermingled but separated here for analytic purposes.

A box titled "What Success Looked Like" offers a glimpse into how success was defined for each LC and what it looked like. When LC organizers did not have measures of success, we discern them through the LC's articulated purpose and goals. While three of the LCs were part of larger grant programs with monitoring and evaluation systems in place, we attempt to delineate outcomes of the LC itself from outcomes of the grant program and highlight the former. We include anecdotes of success that may have been intended or unintended outcomes and that exemplify the value generated by the LC when learning was at its best. A subsequent section

[1] William M. Snyder and Xavier de Souza Briggs (2005). *Communities of Practice: A new tool for government managers.* Collaboration Series. IBM Center for the Business of Government.

teases out elements particular to each case that amplified the LC's success. Some of these may not be directly transferrable to another LC, or may not resonate with the experience of another group. However, they contributed to the success of each case. The last section of each case includes advice for designing and carrying out LCs provided by those interviewed or inferred by the researchers from each case.

Community Clinics Initiative – Networking for Community Health

The Community Clinics Initiative (CCI) is a $113 million collaborative effort between the California Endowment and the Tides Foundation. CCI was established in 1999 to support community health centers and clinics through major grants, technical assistance and knowledge sharing, with the ultimate objective of improving health outcomes in underserved communities in California. Through over a decade of iterative learning, CCI has provided funding and support in five focus areas: information technology, technology-enabled quality improvements, clinic leadership, major capital investments, and strategic investments in collaborative IT for community clinic networks and their members. In 2008, CCI launched the Networking for Community Health (NCH) program to support and strengthen California community clinics' networking efforts, encouraging them to "go beyond their own four walls" in tackling health issues. A learning community was at the core of this effort.

The Emergence of Networking for Community Health (NCH)

In 2008, CCI wanted to explore how clinics' connections with other community organizations could propel the development of "centers for community health." CCI envisioned these centers as taking a population-based approach to care that would account for physical, mental, social and environmental determinants of health; offer coordinated or integrated services; and empower community residents to advocate for the health of their communities.[2]

Purpose: The aim has been to support and strengthen California community clinics' networking and knowledge-sharing efforts.

Community: California community clinics and regional clinic networks that have formed allies in the healthcare safety net and with community-based partners or agencies have participated. In the second cohort of 2010, there were 32 grantee clinics.

Domain: Participants have discussed their progress and challenges working on grant projects, and raised larger lessons for the field on issues of importance such as the role of youth and health promoters.

Practice: Grantees have come together in one-day convenings two to three times a year and have participated in monthly Webinars, site visits and an online platform to discuss common issues and challenges and to lift learning for the field.

This new funding focus was the product of a series of gatherings with a diverse set of community clinic leaders and others involved in movement building with low-income populations. Building on clinics' expertise in providing clinical care and their longstanding connections to the communities they serve, the NCH program supported clinics in partnering with other organizations (e.g., community-based organizations, schools, neighborhood associations) to tap into external expertise and resources, build and strengthen connections with local residents, and empower the community to take action for community health. Grantees worked on varied projects, such

[2] BTW, 2011. *Executive Summary: Building Capacity to Promote Community Health. The Experience to Date of the Community Clinics Initiative's Networking for Community Health Program*.

as promoting healthy behaviors, improving access to coordinated services, enhancing quality of care and supporting community advocates for health.

NCH was preceded by a decade-long trajectory of fluid program design committed to maintaining community clinics as vital partners in building healthier communities, particularly in rural and inner-city areas. CCI's logic model was based on supporting community clinics to counter unfavorable forces such as reduced funding, higher levels of chronic disease and more uninsured patients. It started in 1999 as a one-time grantmaking program with a focus on preparing clinics' information systems for the new millennium (Y2K). From this initial set of grants, CCI grew into what is now a $113 million initiative that has supported 92 percent of California's 180 community clinics, as well as 16 networks of clinics. Three percent of CCI's budget goes to the learning community, which includes engaging in applied research.

To help clinics emerge as centers for community health through the NCH program, CCI provided both monetary and non-monetary support. Clinics received two-year grants, averaging $180,000, to develop partnerships with other organizations and launch their community health project. Throughout the projects, CCI convened clinic grantees and partners for peer-learning community meetings. They also continually assessed and addressed grantees' needs for external assistance by offering different types of technical assistance (e.g., network management, media advocacy, youth leadership training, data tracking, evaluation) and providing small, supplemental grants for unanticipated project needs (e.g., conference fees, group facilitators, transportation costs for community members). CCI made it a priority to infuse knowledge into the initiative and lift learning both to inform next steps and share knowledge with the field as a whole.

Community – who does the learning

As a prerequisite to grant funding, participating clinics formed or continued partnerships with other organizations to further their project goals. Clinics worked with a variety of organizations, including allies in the healthcare safety net (e.g., other clinics, public hospitals) and community-based partners (e.g., community organizing agencies, school districts). While clinics usually served as the experts in providing clinical care, partners brought complementary strengths, including access to community groups and other project resources. Many grantees built their network with uncommon partners to address community health issues. For example, Planned Parenthood Mar Monte formed a collaborative with farm workers, labor organizations and agricultural businesses – partners that often have opposing priorities – to hold discussions and create an action plan to address pesticide-related illnesses among farm workers. In another example, LifeLong Medical Care engaged in a project with a community-based organization and a private healthcare provider to increase access to care.

The first cohort to receive funding was made up of 26 grantees. The second cohort was selected in 2010, with 75 percent of Cohort 1 receiving additional grants. Currently there are 32 grantees in the NCH program addressing a spectrum of issues in their communities. Almost half of the projects indicated that community empowerment is a central issue in their grant. Other

commonly addressed issues included poor health outcomes among community residents and food insecurity. On average, clinics partnered with six organizations on strategies such as providing health education and advocacy support, creating venues of healthy food access, and coordinating or streamlining agency services.

Although the community of peers from grantee clinics was slow to gel, or perhaps did not gel all that much according to some accounts, formal evaluations of the program point to the collective identity of the grantees as a field. According to Sarah Frankfurth, CCI program officer, it was not the priority of the learning community to help grantees spur further collaborations together – each grantee was already in a network of partners, a challenge in its own right. Rather, the purpose of the learning community was to build the grantees' connections to act as resources to each other, to learn from each other's projects and to "help them be as successful as they could be in their projects." Collaborative work between clinics and other likely and unlikely partners who could move the needle on health outcomes was new territory for the field, so it was important to create the space to process that experience.

Looking at the internal operations of the learning community, only the annual conference-style convenings were mandatory. For all the other smaller in-person convenings and Webinars, grantees had the freedom to choose whether to attend and who to nominate for participating. While this freedom to participate or not did not contribute to group bonding due to the infrequency of interaction, it contributed in other ways. Herrmann Spetzler, chief executive officer of Open Door Community Health Centers reflected, "Yes, I always knew people at my level, but I did not necessarily know people at the level that was practical to get things done. The community allows us to take a top-tier-front-desk-and-everyone-in-between strategy and bring them together horizontally." Herrmann and other directors have put together teams to attend different convenings depending on what is being discussed and to maximize the potential for applying the learning.

While peer bonding through the learning community was less of a priority for NCH, it was always a priority to build community clinics as a driving force in the healthcare field. Indeed, CCI succeeded in building a stronger field identity among clinics through shaping important policy debates, such as the one around clinical measurement standards, and supporting a more unified and prominent role for clinics in the national and state healthcare system and policy debates. This was achieved more through long-term intensive grantmaking in clinic and network capacity than through the learning community per se. CCI also helped position clinic leaders to play key roles in conversations and decisions about the future of healthcare. As one stakeholder noted, "Community clinics are a whole separate segment of the provider community that has not been high on the radar. Everybody knows about health maintenance organizations and county hospitals, but there is this whole other segment that is overlooked. CCI has elevated awareness of the community clinic movement at the legislative level and within physician organizations."[3]

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[3] BTW, 2008. *Cultivating Leadership through Social Change Initiatives: Broadening Our View and Support of Nonprofit Leaders.*

Domain – what the learning is about

The domain of the learning community centered on the grantees' experience of working collaboratively to improve health outcomes. Two or three times a year, three participants from each funded project came together for a day-long convening. There was usually a two-part agenda. For the first half of the day expert speakers were invited to speak on issues such as media and communications and engaging the community. The second half consisted of peer-led sharing on common issues selected by CCI staff based on grant reports and evaluation data from previous learning community meetings. Part of the day was also reserved for the invited experts to provide rapid technical assistance to small groups of participants. Participants self-selected the group they wanted to join. Past topics included creating and maintaining successful partnerships, data collection and analysis, community awareness, and advocacy. Webinars offered frequently throughout the year tended to be user-generated and addressed topics such as establishing community gardens and working with local hospitals. As a result of these Webinars, some grantees continued to communicate to learn from each other's experience.

Insights from the learning community and researchers about how to make partnerships work:

- Set expectations and create a work plan that can be revisited throughout the course of the project.
- Assess each potential partner's capacity.
- Be clear about decision-making processes and ensure that each core partner has a voice at the table.
- Distribute funds to match the expectations and efforts of each partner organization.
- Recognize when the network needs external assistance; however, ensure that it contributes to greater network capacity.
- Clearly communicate with partners throughout the project.
- Remember that networks are dynamic, not static.

Source: BTW, 2011. *Building Capacity to Promote Community Health: The Experience to Date of the Community Clinics Initiative's Networking for Community Health Program.*

At the beginning of CCI, very little research existed about the community clinics field. As a result, CCI commissioned research to create a growing body of knowledge about community clinics. The insights emerging from the grantees in the learning community, together with findings from more systematic research, resulted in a set of issue briefs on themes such as managing transformative change, engaging community youth for healthier communities and the role of health promoters.

Clinics and their partners also received a variety of resources and tools to assist them with their projects. For example, to help form and manage their network partnerships, clinics received a book that provides guidance for launching networks, *Networks that Work*, and an assessment tool, The Network Health Scorecard. Clinics and partners also received guides and exercises related to media advocacy.

Practice – how the learning happens

Whereas in other cases in this series the learning community shifted from expert-led to peer-led, the opposite occurred in the NCH. This was considered a positive change from the participants' perspective. Bob Moore, chief medical officer of Partnership Health Plan of California, commented, "The experts were great. They had a lot of fresh new material. In the clinic world we talk about a lot of ideas with peers at the same level, but it's also good to have people outside your usual circle." Bob and other grantees mentioned that they probably learned more from the experts than from their counterparts at other clinics, perhaps because of the specific and cutting-edge kind of expertise required for healthcare work. The convening three-part design incorporating expert input, participant sharing, and expert-provided technical assistance in small groups seemed to work for participants.

The flexible and quasi-voluntary nature of participation contributed to the value of the learning community in the participants' view. Projects had the flexibility of delegating up to three participants for the bi-annual convenings, and the option of sending people to the smaller convenings in between. This flexibility in choosing who to attend was especially powerful for smaller clinics and those in rural areas, as well as for certain types of clinic staff members (e.g., financial and operations personnel) who may lack peers within their organization and rarely have opportunities to share ideas with others in similar positions. Once participants attended, they also had the freedom to choose which sessions to take part in. From Herrmann Spetzler's perspective, this has been helpful since "some of the learning community events are less applicable to CEOs and some are more. We put together different teams depending on what they (at the event) are talking about, and we have done a good job at bringing together the different teams. Over the years, we have also gotten better at taking the morsels that we get from the event, chewing on them for a while and then deciding which ones to swallow and which to spit out."

In addition to the day-long convenings and Webinars offered through NCH, an important part of the learning community has been an online platform that is part of CCI's overall learning support strategy for the clinic field. The Community Clinic Voice (the Voice) is an online community that connects over 2,000 clinic professionals throughout California, as well as in other states. Members represent a variety of clinic staff positions, ranging from administrative staff to medical directors to IT specialists. Voice users can receive daily e-mail updates from the site and/or log on to post questions or start discussions around topics of interest. Discussions frequently revolve around financial management, clinical care issues, organizational operations, health IT and healthcare policy. CCI staff members update the site continually with news and trends in the healthcare field as well as research and tools for users to download and utilize in their clinics.

The online platform was cited by grantees as an essential tool for connecting peers in remote rural communities. Herrmann Spetzler recounted: "The clinics I direct are in a geographic area that covers the size of Connecticut and with only 80,000 people in that area. The entire area is rural – there are less than 11 people per square mile. Using technology to communicate with

each other is very important – the farthest a clinic is to another is two to three hours. Creating a virtual environment has been a god-send for us."

The Voice has a $150,000 annual budget and serves 2,000 members within the healthcare safety net.[4] The current structure provides members with a one-stop center to access news stories as well as peer-reviewed and vetted resources (e.g., standard procedures, definitions, reporting requirements), participate in discussions and connect with colleagues. Members also have the ability to self-form groups, send private messages and write or read blogs. While anyone surfing the Web can view certain pages of the Voice (e.g., home, news, jobs, calendar), only registered members are allowed to access the library, discussions and issues pages. It also enables members to set up mini-communities hosted by the site.

The Voice had the privilege of a decade-long learning curve and many adjustments and iterations. This pattern of improvement applies across CCI, which has been able to elevate the conversation beyond the day-to-day realities of clinics to focus on larger issues and opportunities in the field. Participants cited the opportunity for big-picture learning and reflection as an important element for reenergizing their vision for the field.

[4] BTW, 2010. *Online Communities as a Tool for the Nonprofit Field: A Snapshot of the Community Clinic Voice*.

What Success Looked Like in the NCH Learning Community

NCH was very much part-in-parcel with the larger CCI initiative, which over the years has made impressive impact through enhancing the capacity of community clinics. While it is challenging to disentangle the learning community accomplishments from those of the larger initiative we believe that the outcomes related to networking and field identity are more likely to result from the focus on learning that was central to NCH.

An overall evaluative report of CCI, titled *Currents of Influence: Success Factors for a Multifaceted Social Change Initiative*, points to achievements such as the creation of stronger, more integrated networks among clinics, greater attention from the philanthropic and public policy sectors, and stronger field identity and stature. Before CCI, clinics tended to work in isolation from each other with few opportunities for learning exchange except at the executive director level. The learning culture of CCI opened up avenues for exchange and collaboration. CCI did not initially intend to influence other foundations, but as the Initiative became an increasingly important information and intellectual resource for grantmakers working with community clinics, CCI enhanced the visibility and stature of community clinics among foundations.

An example will clarify the impact of learning exchange. A project that was originally focused on increasing health-related data collection about the Asian and Pacific Islander community and raising awareness about health disparities, decided to create a community garden after being exposed to other grantees with gardening projects through the learning community and seeing a critical need in their community. Then as this practice was scaled within the community, projects with a community gardening component recognized a real need to connect with others in the state doing similar work. Based on their experiences in the learning community, one project approached CCI about the possibility of hosting a statewide community gardening conference. The grantee designed a two-day conference "Growing Garden Communities." The conference, the first of its kind in the state, was a big success and was attended by NCH projects from around the state and other regional community garden associations.

Amplifying Elements

The following discussion teases out elements particular to this case that amplified the learning.

Long-term, multi-pronged investment. Not many learning communities have the privilege of substantial funding and a decade-long learning curve – learning communities had been woven throughout various CCI programs before NCH. The learning community supplemented the grants by helping grantees learn from each other's work and the advice of experts, so both the

learning community and the grantmaking strategy supported each other. The long-term nature of the project and the fact that many NCH grantees were previously part of other CCI programs helped build trust and eased the inevitable tensions that occur when grantees and funder share the same learning space.

Emphasis on high visibility within the field. The convenings, the Voice and other learning community components were treated as opportunities to heighten the visibility of community clinics and to build their identity as a powerful field within the larger healthcare field. This strategy reflected CCI's overall focus on visibility for clinic leaders. Although they were previously recognized as clinical experts, medical directors are now commonly seen as crucial participants on clinic management teams: As a clinic CEO said, "CCI has brought physicians more into the mainstream of leadership in community health centers. I think there's been a recognition – and in part by pushing leadership skills – that physicians in particular have a huge role to play in the strategic direction of the community clinic." CCI also assisted individuals and organizations in stepping up their involvement and visibility in broader arenas. With partial funding from CCI, for instance, the California Primary Care Association facilitated a number of specialty task forces that gave clinicians, chief information officers and chief financial officers a platform for organizing and advocating for key healthcare issues. CCI nurtured clinics' sense of being a field by bringing them together, continually talking to them and treating them as a field, and using data to reflect on the field as a whole.

CCI's engagement in continual learning. The CCI management team itself engaged in an intensive learning process by constantly collecting, analyzing and using data and feedback about their grants, the state of the field, and where new money and energy should be invested. Additionally, CCI staff effectively modeled reflective practice for clinics. This reflective practice was done formally through the evaluation process and commissioned research and informally through meetings and discussions with practitioners, outside experts and observers of CCI. The focus on iterative learning and continuing quality improvement, amplified by the long-term nature of the work, demonstrated CCI's commitment to learning for the grantees.

Advice from CCI-NCH Learning Community

- *Allow learning from both success and failure, especially in new terrain.* Participants felt this was an essential feature of the learning community, especially since they were engaged in charting new terrain for community clinics. According to Herrmann Spetzler, "I got something out of every one of the learning experiences that I took part in, but I don't know if it is important that each experience had to end in success. Learning about mistakes is just as important as learning about successes. When there were dead ends, this provided learning, as well – outside of our domain sometimes." He went on, "Everyone is making the shift to technology. It is happening but it takes some time to transition to something new. We are all in the middle of a huge change and there are MORE opportunities to learn by failure than there are with something that has been around for a long time."

- *Craft learning agendas and convenings collaboratively.* While participants interviewed were pleased with the flexibility of learning, they had hoped for more participation in crafting convening agendas. For the most part, CCI staff offered sessions on topics that they drew out from evaluation and grant reports. Engaging participants in designing convenings can be tricky given their time limitations, but it is an important step for maximizing the potential for learning.

- *Consider coaching as a supplement.* CCI is now pondering the provision of coaching to help with the implementation of new learning gained through the learning community. In CCI coaching may be instituted as routine check-ins (i.e., monthly calls). The check-ins would provide the grantees with the opportunity to share their challenges in real time and allow CCI staff to actively support, monitor and encourage projects.

- *Provide and connect varied levels of learning.* In addition to providing varied learning and convening modes, such as the different types of convening and the online platform, participants have also found it helpful to have different levels of learning. In NCH, there is a focus on clinics' day-to-day operations and the issues they face in implementing their grant projects, on connecting these daily realities up to form a larger picture, and at a higher level of abstraction, on providing general lessons for the field. The movement between small picture, big picture and field learning helps maintain a level of pragmatism for the learning and build CCI's and the clinics' role as levers of influence in the field.