



CASE Study

EARLY CHILDHOOD COUNCILS *Effective Planning Processes for Health Systems Integration*

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» ABSTRACT

The Colorado Trust launched its Early Childhood Council Health Integration grant strategy in 2008. Through this effort, the Early Childhood Councils developed strategies to better integrate health practitioners and health care services into their work, along with their already-established focus on early care and education, and family supports. The goal of this grant strategy was to support sustainable efforts by the Councils to change the way local resources were coordinated, reduce service duplication, increase access to health care services and contribute to improved health outcomes for children (ages 0-12 years) across the state. To realize this goal, The Colorado Trust provided the Councils with grant support and technical assistance to engage in the development of plans to achieve integrated childhood development systems in their communities.

This case study discusses the successes, challenges and lessons learned from the Early Childhood Council Health Integration planning grant process. Using qualitative data collected through focus groups and key informant interviews, the report details how the planning process was structured, what worked and didn't work as the Councils developed their systems-building plans, and provides recommendations for funders to consider when conducting a systems-building planning process. Key themes include:

- Grantees learned about systems change and developed plans to achieve such change. The planning process provided Councils

with the time, resources and guidance necessary to learn about and develop well-thought-out plans to build connections and develop the infrastructure to help support and sustain programs for children and families across multiple systems.

- Community-level data is essential in fostering collaboration and planning. Even as it was difficult to access key data for certain populations or geographic regions, many Councils were able to use local data as a tool to coalesce new partnerships and develop a shared vision for change.
- Integrating new partners into an established system requires planning. For many Councils, the planning process timeframe was essential in conducting outreach to local health partners, especially with regard to developing a shared vision and common language.
- Funders need to require and support systemic change. It was important that The Colorado Trust explicitly required grantees to engage in activities that supported effective implementation of high-quality programs and connections across systems as opposed to solely focusing the funding on individual programs.

While this work was new to most of the Councils, they reported that having a funder willing to support systems-building was a welcome change that better enabled them to tackle a complex scope of work and to address unanticipated challenges.

Early Childhood Councils (Councils) were introduced in Colorado in 1997 to help coordinate local health, mental health and education services for young children within communities, and to better connect families to these resources.¹ Colorado has 30 Councils operating in 55 counties across the state (see Figure 1).

The Colorado Trust provided grant support to the Councils to help them develop community-based strategies designed to better integrate health practitioners and health care services into local early childhood development systems as a means to improve health outcomes for children (ages 0-12 years) across the state. A grantmaking foundation, The Colorado Trust is committed to achieving access to health for all Coloradans. In 2008, the state of Colorado finalized its Early Childhood Colorado framework (www.earlychildhoodcolorado.org) as a means to help ensure that Colorado’s young children and their families are valued, healthy and thriving. The framework includes specific identified access, quality and equity outcomes related to early learning; family support and parent education; social, emotional and mental health; and health systems. The outcomes identified in the state’s framework include:

- Increased access to preventive oral and medical care
- Increased number of children covered by consistent health insurance
- Increased number of children with a medical home
- Increased number of children who are fully immunized
- Increased percentage of primary care physicians and dentists who accept patients with Medicaid and Child Health Plan Plus (CHP+) coverage
- Increased percentage of women giving birth who receive timely, appropriate prenatal care.

According to the authorizing state legislation, HB07-1062, Councils are to “improve and sustain the availability, accessibility, capacity and quality of early childhood services for children and families throughout the state.” Per statute, each Council has a broad membership representing early learning, family support, health and mental health partners. Despite this charge, the initial work of most Councils focused primarily on strengthening early learning systems such as child care and preschool, and not on health.

Based on the guiding framework developed by the state and the early work of the Councils, The Colorado Trust committed \$5 million in grant support over a five year period (2008-2013) to integrate health and mental health into local early childhood systems.

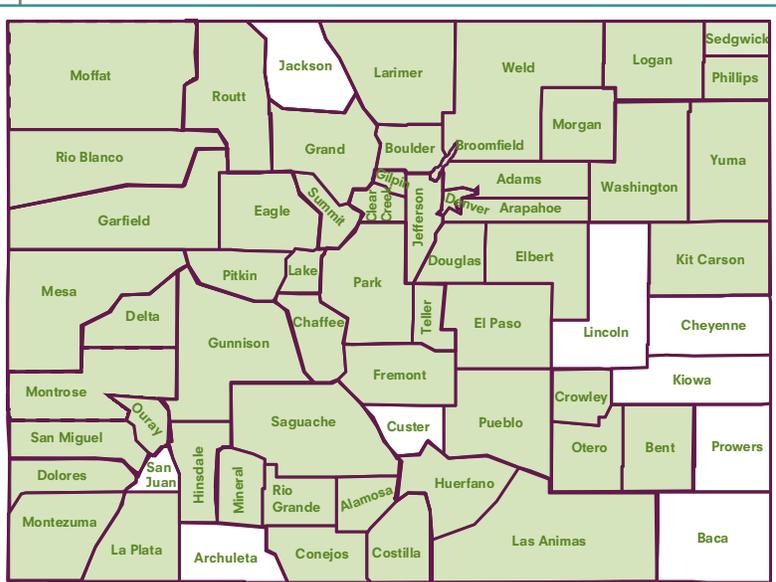


FIGURE 1: *Early Childhood Councils statewide map provided by the Colorado Department of Education.*

To increase the likelihood of success with their health integration strategies, The Colorado Trust required that all Councils interested in receiving grant support first engage in a planning process.

Accordingly, the Councils began connecting with their local health providers, helping to establish common ground, sharing data and maximizing limited resources to better serve children in their communities. This support included funding for an evaluation of this health integration strategy to help inform The Colorado Trust, the state and others interested in developing similar cross-systems building strategies.

To increase the likelihood of success with their health integration strategies, The Colorado Trust required that all Councils interested in receiving grant support first engage in a planning process. The Trust awarded six-month planning grants to 26 Councils, with grants ranging from \$5,000 to \$7,500. This support gave Councils the ability to hire outside facilitators for meetings, provide luncheons, cover travel costs for participants and fund support staff (i.e., a grant writer or team leader), as each deemed appropriate, with the caveat that planning grants were not to be used to fund the attendance of health partners at meetings. An additional two-to-three months were allowed for 14 of the Councils to revise their proposed implementation plans based on feedback from The Colorado Trust.

This process enabled Councils to learn more about systems-building and to develop a health integration strategy tailored to each of their communities. The Councils based their strategies on a systems-building framework, which outlined five primary domains²:

- **CONTEXT:** Changing the political environment that surrounds the system and affects its success
- **COMPONENTS:** Establishing high-performing and quality programs
- **CONNECTIONS:** Creating strong and effective links across the system
- **INFRASTRUCTURE:** Developing the supports the system needs to function effectively and with quality
- **SCALE:** Ensuring the system is comprehensive and works for all children.

The purpose of the Early Childhood Health Integration implementation grant was to focus specifically on three areas of the framework: Components, Connections and Infrastructure.

Each Council conducted a community assessment, engaged health partners and selected the specific Early Childhood Colorado framework health outcomes they intended to address.

In addition to the technical assistance Councils were already receiving from the Colorado Department of Human Services (CDHS) and the Colorado Department of Education (CDE), The Colorado Trust provided support for technical assistance through the Colorado Department of Public Health and Environment (CDPHE) to specifically aid the Councils with health integration and coordination among all services. This technical assistance included help with data needs, information about programs and grant writing. Councils were also encouraged to attend relevant seminars, webinars and meetings hosted by CDPHE.

At the end of the planning process, each Council submitted an implementation grant proposal to The Colorado Trust for consideration. The proposals outlined how each Council planned to implement high-performing and quality programs to impact key health outcomes (Components); how they engaged health partners in the planning process and would continue to do so in the implementation phase (Connections); and how they intended to build the infrastructure of each Council to support and sustain these Components and Connections (Infrastructure). Twenty Councils were ultimately awarded implementation grants by The Colorado Trust.

This report details successes, challenges and recommendations for funders regarding both the general design and process of the planning grant phase and the impact of the planning process on implementation of health integration plans according to a sample of participants involved in the planning process.

» **METHODOLOGY**

Qualitative interview and focus group feedback were obtained from key informants representing Councils who participated in the planning phase (whether or not they were awarded an implementation grant), from CDE and CDHS staff who oversaw the Council system, from CDPHE technical assistance staff working with the Councils at the time of the planning phase and from staff of The Colorado Trust who were responsible for the coordination of the planning phase. Twenty-six individual interviews and three focus groups were conducted with a total of 50 participants. Eleven councils were represented by interview and focus group participants, including Arapahoe, Boulder, Chaffee, Denver, El Paso, La Plata, Larimer and Mesa counties, as well as the ECHO & Family Center Council in Fremont County and multicounty councils such as Triad (Jefferson, Clear Creek and Gilpin counties) and the Rural Resort Region Northeast Division

(Summit and Grand). The roles of the representatives from the Councils that participated in the interviews and focus groups were: Council coordinator (11), health partner (8), health integration coordinator (4), executive director (4), director (3), Council member (3), board member (2) and other (8). Interviews were also conducted with representatives of CDPHE (2), CDHS (2), CDE (1), The Colorado Trust (1) and the Colorado Children's Healthcare Access Program, a statewide health partner that assisted those Councils interested in addressing the outcome related to "increased access to a medical home approach to care."

The interview and focus group protocols were conducted with an exploratory, open-ended design. Challenges and lessons learned were solicited around key issues such as the collaborative process, identifying and recruiting health partners, prioritizing health outcomes within the implementation plan, utilizing data and technical assistance in the planning process, working with a new funder (The Colorado Trust) and the logistics of the planning process. This report summarizes themes and findings from the key informant interviews and focus groups.

» FINDINGS

Design of the Planning Process

The Colorado Trust required that each Council engage local health partners during their planning process. Health partners were specifically defined as: "local health system partners (e.g., hospitals, public health departments, local American Academy of Pediatrics chapters, local dental societies, WIC (Women, Infants and Children), community health centers, rural health clinics, school-based health centers and staff from local health care practices) and health professionals (e.g., nurses, pediatricians, family physicians and other primary care providers, dentists, dental hygienists, clinical social workers, psychologists, psychiatrists and other mental health providers)."³ In addition to engaging local health partners, each Council conducted a community assessment to identify specific local health needs.

As well, The Colorado Trust provided each Council with:

- A comprehensive planning guide that defined systems building
- A list of seven required, pre-identified health outcomes from the Early Childhood Colorado framework, from which each Council could choose one or more health outcome as a focus of their implementation grant

- Technical assistance available in both planning and implementation phases, provided through CDPHE
- Community-level data to facilitate data-driven identification of health outcomes in each council, also provided by CDPHE.

The planning phase was reported by many of the Councils, as well as the state representatives interviewed, as beneficial, if not critical, to the success of developing their integration plans. Feedback regarding the clarity of what was expected by the foundation from the Councils during the planning process was somewhat mixed; however, most respondents agreed that the step-by-step planning guide helped them to navigate through the process.

Having pre-identified health outcomes from the Early Childhood Colorado framework from which to choose was also cited as helpful. Many Council representatives reported they wished they could focus on more than a few outcomes, but the planning guide and technical assistance provider encouraged them to prioritize, and in the long run this focus was determined to be helpful.

Councils viewed the planning process as similar to a strategic planning process, which many had already been doing as part of their broader early childhood efforts. After the planning process, a few Councils reportedly revised their strategic plans to reflect the work they were doing with The Colorado Trust during the implementation phase of the health integration grants.

While the size and contents of the comprehensive guide was reportedly daunting to some Councils, it was generally well received. Several Councils noted that the guide served as a useful ongoing reference and resource guide.

The concept of health integration was especially challenging for some Councils. Several people noted that additional information or technical assistance about this concept and how to systematically integrate health into the work of the Councils would have been useful. As well, the concept of systems building was new to many of the Councils. In particular, new Councils and new members of more established Councils found the literature provided in the guide on systems building to be helpful because it described this process in concrete and understandable terms.

» THE COLORADO TRUST'S GRANTEE PLANNING GUIDE

Several of the key components contained within The Colorado Trust's guide to help the Councils with their planning processes included:

BACKGROUND INFORMATION: *Why The Colorado Trust funded the Councils, the foundation's objectives, funding details, information about the technical assistance available to each Council and an outline of the process to be undertaken by each Council.*

IMPLEMENTATION GRANT APPLICATION: *Outlined all requirements for the grant application.*

HEALTH INTEGRATION PLAN TEMPLATE: *A required document to be completed after the community assessment and that included information about the state's Early Childhood Colorado framework.*

GRANTEE DIRECTORY: *A compendium of Colorado Trust-funded grantees whom they could call for information and collaboration.*

HEALTH DISPARITIES AMONG COLORADO CHILDREN: *A listing of various health disparities as they occur by gender, race and ethnicity, education level, disability or geographic location. Also included were literature on culture and how a lack of awareness about cultural differences affects the care that children and families receive, as well as literature on addressing racial disparities.*

READINGS: *Literature on health integration and how to build systems that described key concepts, issues, challenges and case examples.*

» TECHNICAL ASSISTANCE PROCESS

Several aspects of the technical assistance provided by CDPHE were cited as helpful. For example, webinars provided useful information about different programs and initiatives. The technical assistance providers were also able to help Councils utilize existing state and local data, and show them how to find additional data. For Councils having difficulty selecting outcomes, technical assistance providers helped them narrow their focus and discussed how each Council's outcomes would fit within their goals and budget.

One limitation Council members mentioned was the staff turnover among technical assistance providers. This reportedly made it difficult for Councils to access technical assistance in a consistent and timely manner. This turnover may also have led to a perceived lack of communication

between The Colorado Trust and the technical assistance providers, leaving Councils sometimes unsure as to how the technical assistance was being coordinated. Finally, while the technical assistance was regarded as helpful overall, some Councils reported that it may have been more useful for newer Councils than for more established Councils, as the newer Councils were just beginning the process of systems building.

» WORKING WITH A NEW FUNDER

For some Councils, The Colorado Trust was reportedly an initially intimidating partner since many had never worked directly with the foundation before. At the same time, The Colorado Trust's well-established reputation also worked to the benefit of many Councils, helping them to recruit new members and to secure additional involvement from health partners.

The timeframe allowed by The Colorado Trust was a welcome change to the Councils, providing them with an adequate amount of time to determine their priorities and the ability to align their project goals with the needs of their community.

Once the Councils began to work with The Colorado Trust, many reported finding the foundation to be approachable and knowledgeable. For some Councils, the flexibility and freedom provided by The Colorado Trust also fostered a sense that the foundation was confident they could direct the planning process themselves and identify their own goals. This was especially important since few of the Councils had previously received grant support for a planning process.

Almost every Council interviewed said the most valuable thing they spent their grant funds on was staff time, whether to hire an outside facilitator or to fund an increased number of hours for an existing Council member. Further, having the resources to support a planning phase allowed Councils to build relationships with their new health partners and fully vet their health integration priorities before submitting their implementation application to The Colorado Trust. Many of the interviewees reported that the planning phase would not likely have been as useful without the variety of resources (e.g., individual technical assistance, planning guide) made available by The Colorado Trust. Council representatives also pointed out that too often funders ask grantees to develop their plan in three to four weeks with a prescribed programmatic focus. The six-plus month timeframe allowed by The Colorado Trust was a welcome change to the Councils, providing them with an adequate amount of time to determine their priorities and the ability to align their project goals with the needs of their community.

» A FOCUS ON SYSTEMS

Interviewees reported that grant applications from various funders more often required Councils to submit program-oriented rather than systems-building proposals; having a funder interested in supporting systems building was a welcomed change. Several Councils also noted that, if awarded an implementation grant, the component of multiple-year funding that could be carried over from year to year was essential to engaging in effective systems building. Accordingly, the long-term commitment and flexibility provided to the Councils by The Colorado Trust better allowed them to tackle a complex scope of work and to address unanticipated challenges.

» FLEXIBILITY AND FEEDBACK

Interviewees also pointed to the usefulness of being allowed to discuss their plans with The Colorado Trust as they were being developed during the planning phase, rather than simply being subjected to a pass-fail system with the foundation accepting or denying their proposals. The assistance The Colorado Trust offered via its own staff, as well as the technical assistance providers from the state, helped Councils to feel supported. As noted earlier, by the end of the six month planning period, some Councils were asked by The Colorado Trust to revise and re-submit their implementation grant applications, offering them a three-month extension in which to complete this additional work. These Councils generally regarded this extension as helpful and as a sign that The Colorado Trust was willing to be flexible in the overall process to be certain the Councils were on track with the requirements of the implementation grant. One additional recommendation provided by Councils was that The Colorado Trust could have given more robust feedback to those Councils that did not receive implementation grants at the end of the planning phase.

» ENGAGING HEALTH PARTNERS

The planning phase brought new health partners (e.g., hospitals, public health departments, local American Academy of Pediatrics chapters, local dental societies, WIC (Women, Infants and Children), community health centers, rural health clinics, school-based health centers, staff from local health care practices) and health professionals (e.g., nurses, pediatricians, family physicians and other primary care providers, dentists, dental hygienists, clinical social workers, psychologists, psychiatrists and other mental health providers) to the table reportedly because:

1. Both the Councils and the health partners were trying to reach the same target population
2. The process allowed Councils to focus on doing something concrete with their health partners
3. The opportunity for the Councils to receive grant funding for implementation provided motivation for health partners to participate in the process and meant that action could be taken on their collective ideas
4. The involvement and support of The Colorado Trust helped to increase credibility for some Councils
5. The planning process gave Councils the opportunity to raise awareness about Early Childhood Councils in their communities.

As well, health partners identified additional reasons for becoming involved with the Councils during the planning phase, including:

1. Being asked by a Council member or other health partner to participate
2. The Councils made it clear to the health partners that their expertise was needed
3. The possibility that the health partners could gain additional exposure in their communities
4. The work of the Councils fit in with their own missions as health professionals.

Perhaps most importantly, Council members reported that new health partners added new, unique and valuable representation to their work. It was also noted by a few Councils that individual

health partners were more likely to participate if their organization supported their participation. Finally, community awareness about the importance of the Councils also seemed to contribute to the likelihood that additional partners would participate.

Councils stated that the planning phase allowed them to be intentional about their partnerships. It was reported that grant applications often required already-established partnerships related to the mission of the funder instead of the applicant, and these partnerships may have been difficult for the Councils to develop in a short timeframe. They noted that a letter of support was sent from CDPHE to each Council as a tool to engage their local public health departments and encourage them to work with the Councils. Reportedly, Councils found this to be a useful means to begin building relationships with health partners.

Almost all of the Councils interviewed felt that enough time was allocated for the planning process and a shorter timeframe would not have allowed them to adequately engage their members in the process, particularly new members, such as the health partners. Still, there were some initial challenges with getting the right partners to the table. For example, some Councils reported that, though project outcomes were often selected in partnership with their initial health partners, the community assessment suggested a need to engage additional health partners, which required further time and effort. Some Councils reported that the health partners who came in mid-process may have been more skeptical of the data presented because they had not been involved in the initial data collection process or in helping to identify the outcomes.

Some health partners identified other logistical and process-oriented challenges they encountered during both the planning and implementation phases. For example, organizing health partners and Council members for meetings was an ongoing challenge, particularly given busy schedules and the volunteer nature of participation. A few of the health partners also cited the changing economic climate as making it challenging for them to stay engaged because of the time commitment required. Finally, many health partners felt that it might be difficult for them to fully participate throughout the implementation phase because the grant required that they be actively involved, which may have been hindered by the challenges to engagement cited above.

» BUILDING COLLABORATION

Learning a New Language

Representatives of multiple Councils reported that learning the terms and acronyms used by physical, mental and dental health to be difficult. The same words (such as “provider”) might mean different things to Council members, for example, than to health partners. On the other hand, many of the health partners reported they did not experience the same degree of a professional “language barrier,” though they did note that they were engaged for their health expertise and were often asked or expected to explain health terms and acronyms. This focus on health terms during the planning process may account for the reported learning curve Council members experienced. In retrospect, some Council members stated they could have benefitted from additional assistance in learning the “language of health” to help make conversations with their new health partners more productive. However, the benefit to Council members of having to learn a new language, as well as teach their own language to their health partners, was that the process forced Councils to deepen their knowledge of health issues and be better able to explain these concepts to the broader community.

Sustaining Involvement

Several health partners mentioned that key aspects to sustaining their involvement in the Council included:

1. Their employer or organization allowing them to contribute their time to the Council
2. That Councils effectively use their time to focus on health issues
3. That Councils keep everyone who participated in the planning process updated through email or other forms of communication so that even health partners who do not participate regularly in the implementation of the project can stay involved.

Health partners also reported that the planning process seemed collaborative and that the process was respectful even when there was disagreement among Council members. Because of this, many health partners were encouraged to attend other Council or community-based events, and reportedly these activities have helped to create a professional network among health partners and Council members alike.

Benefits of Peer Networking

For some Councils, ongoing peer communication operated as an important natural support network to share ideas and discuss key challenges and opportunities. For example, this informal support network surfaced key barriers, such as the geographical distance between Councils across the state and between more rural Councils and funders. As a result, an important benefit of the awareness of neighboring Council activities was that it reportedly helped contribute to a more seamless network for families and community members utilizing the local early childhood system, especially for those families who live within the territory of one Council but utilize services in the territory of another. This shared knowledge helped the Councils to better refer parents to neighboring counties and more easily access the services they needed. In addition to the peer network, the technical assistance provider also gathered and shared information among the Councils about the activities of various Councils.

Councils noted that the ability to participate in meetings by phone or webinar was cited as helpful, particularly if they were located outside of the metro-Denver area. Yet, while inter-Council collaboration was explicitly encouraged during the implementation phase, Councils noted that they would have appreciated a more formal opportunity to collaborate during the planning phase.

Outside Facilitator

Councils who hired an outside facilitator to assist with the planning phase felt that having this additional consultant was invaluable. Because there was someone viewed as a neutral but knowledgeable outsider, Council coordinators were able to simply participate in the discussion as a member of the Council, rather than also having to facilitate the discussion. Facilitators also helped to move the process along in a timely fashion, kept Council members focused on their goals and explained the requirements of the grant application.

Use of Data

The requirement by The Colorado Trust that Councils and their health partners use data on the specific health needs of their community during the planning phase opened up a number of options for the Councils. The technical assistance provider, CDPHE, gave each Council a flash drive with customized data, such as demographics and county-specific information for each identified

Early Childhood Colorado health outcome using U.S. Census data, maternal and child health data, data on the number of safety net providers and the number of eligible but not enrolled children in a county. Council members unfamiliar with their local data stated they were surprised to learn what data were and were not available to help with decisionmaking. In particular, it was difficult to find data specifically for children under five and even more challenging to find data for children under three. This was especially true in more rural communities in which accurate birth or health records may not always be available. This lack of available data in certain areas provoked a series of questions about where additional data could be found, who collects the data and what data are reliable, and it drew attention to the fact that there are a lot of data that simply are not collected.

To address this data gap, Councils conducted original data collection via community assessments to better understand local needs, such as rates of uninsurance, existing mental health, oral health or primary care services and barriers to health access. After doing so, many Councils indicated an increased recognition of the value of data as a way of assessing community needs and interacting with health partners in a way they had not previously done. Most of the Councils interviewed reported that conducting the

community assessment led them to identify an Early Childhood Colorado health outcome they originally had not considered. In addition, since many of the health partners engaged in the planning process served a key role in conducting the community assessment, this process also contributed to the further integration of health partners into the Councils.

Data collection also allowed for further engagement of Council representatives and health partners with the community, thereby raising community awareness about the Council. It was reported that use of data helped to reduce disagreement among Council members about which health outcomes to focus their attention on. Data served as an objective measure of existing health needs within the community, resulting in a consensus when making the decision to address certain outcomes. Many of the Councils reported that although they started out thinking they were going to address a specific community health need; they often ended up with a refocused goal of impacting a specific health outcome. Data also served as a way of transcending the language barriers between health partners and Council members, such that any challenges they were experiencing in understanding acronyms and definitions were reportedly minimized when they focused on data.

» CONCLUSIONS

During the planning phase, Councils developed a plan to engage in systems-building work that would impact Components, Connections and Infrastructure in order to implement effective and high-quality programs, build connections between systems and develop the infrastructure to help support and sustain programs for children and families across multiple systems. Overall, this planning phase was reported as beneficial in helping Councils engage health partners, participate in systems-building activities, identify community needs, identify opportunities for data collection to help meet community needs and to develop a sustainable plan for implementation. Many Councils reported that the activities they engaged in not only helped them to develop the implementation plan, but also to begin the systems-building work that would help with implementation of the plan.

Based on qualitative interviews and focus group feedback from 50 Council representatives, health partners and other state funders, the following section provides a summary of both the challenges and successes during the planning phase. Recommendations for individuals, organizations and/or funders seeking to replicate a similar planning phase process to support systems-building activities are also provided.

Challenges

- Getting formal commitments from Council partners
- Learning to speak the same language as health partners
- Getting all necessary Council members and health partners to the table at the same time
- Obtaining the necessary expertise based on a specific health outcome focus
- Council members and health partners may not always receive support from their organizations to participate in unpaid activities through the Council

continued

Conclusions, *continued*

- Staff turnover of technical assistance provider
- Narrowing the scope of work to a few health outcomes because Councils wanted to address all of the identified needs in the community
- Lack of data at the local level for children ages 0-5, especially in more rural areas
- Moving from a program-based perspective to systems-building thinking
- A lack of awareness in the community about the function and importance of Councils
- Navigating the health system; for smaller communities there may not be enough providers, and for larger communities they may feel intimidated by the larger health providers
- Some Councils reported the need to have a better understanding of what activities were already going on in the community
- Councils did not always understand the different expectations of The Colorado Trust, the technical assistance provider and other state-based funders.

What Worked

- Providing adequate time and funding to meet the requirements of the planning grant, which also allowed Councils to be more intentional in their planning; six months appeared to be an appropriate timeframe
- Empowering Councils to direct their own planning processes with the support of the funder, a comprehensive planning guide and external technical assistance
- Selecting outcomes from a pre-identified list of health outcomes helped the Councils to focus their expectations and the parameters of their work
- Bringing new partners, and in particular, health partners to the table and having the time to learn a new language with new health partners and vice-versa
- Utilizing local champions to help recruit new partners and move the process forward
- Hiring an outside facilitator allowed for more Council members to participate in a process that was more objective and focused than might have otherwise been the case
- Flexibility to ask questions of the funder, utilize technical assistance and re-submit grant applications, if necessary
- The credibility of the funder contributed to motivation and the buy-in of current members and the recruitment of new members
- Conducting an initial community assessment and using data in the planning process helped Councils to agree upon and prioritize the health needs in their communities
- Technical assistance provided support in many forms during what can be a challenging process
- The ability to carry-over unused implementation grant funds helped support the planning of the implementation phase
- The technical assistance provider and The Colorado Trust helped the Councils and their new health partners to focus on systems building (a new way of thinking) as opposed to simply taking a programmatic focus
- Allowing for the creation of natural peer support groups through reduced competition for funding and opportunities for Councils to meet regularly.

» RECOMMENDATIONS FOR FUNDERS CONDUCTING A SYSTEMS-BUILDING PLANNING PROCESS

1. Give collaborative groups adequate time, resources and guidance to thoughtfully develop their implementation plans, including identification of outcomes, who will be involved, identification of roles and what is needed to meet their implementation goals. All three of these components – time, resources and guidance – are important to a successful planning process. Without any one of these components, the final implementation plan may be incomplete and the members of the collaborative group may not have built the consensus, member commitment or community buy-in needed to implement the plan.
2. Explicitly focus grant requirements on systems-building activities that support effective implementation of high-quality programs and connections across systems as opposed to solely focusing the funding on individual programs. Moreover, reinforce these requirements by providing clear examples and providing technical assistance.
3. Be flexible with grantee inquiries (including possibly extending the application deadline), allow for the use of carryover funds during the implementation phase and recognize that this will be a learning opportunity for many organizations.
4. Provide community-level data and support enhancement of data collection at the local level that helps data-driven decisionmaking in both the planning and implementation phases.
5. Require that representatives from targeted systems (e.g., health) participate in the planning and implementation phases.
6. Encourage the development of naturally occurring peer mentoring groups among grantees. This allows them to leverage connections, learn about effective systems-building practices from their peers and partner with their neighbors if service systems cross over Council jurisdictions.
7. Help facilitate communication between grantees from different initiatives within the same community. Council members reported that it would be helpful to get connected with other funded programs in the community and possibly build a partnership between themselves and other funded programs.
8. Support the use of webinar technology and conference call-in access as an option for both regional and statewide meeting participation. This allows for greater participation of Council members both at the state level and within their own region, particularly if the Council is comprised of multiple counties and/or a large geographical region.
9. Help raise community awareness about the purpose and capacity of community collaborative entities, such as the Councils. For example, other community-based organizations or key community representatives may be more likely to partner with community collaborative entities if they receive information from multiple sources.
10. Make the business case to collaborative partners as a way to engage and sustain involvement.

Councils frequently reported that although engaging health partners was challenging at times, the positive outcome of establishing this partnership to creating new connections and building infrastructure was worth the challenge.

» ENDNOTES

¹ Colorado Department of Education. (2008.) Colorado's Early Childhood Councils. Available at: http://www.cde.state.co.us/cdeprevention/download/pdf/ec_councils_one_pager.pdf.

² Coffman, J. & Parker, S. (April, 2010.) The Colorado Trust Issue Brief: Early Childhood Systems Building from a Community Perspective. Available at: http://www.coloradotrust.org/attachments/0001/1403/EarlyChildhoodSystemBuilding_IssueBrief.pdf.

³ The Colorado Trust. (2008.) Expanding Children's Access to Health Early Childhood Health Integration, Health Integration Planning Grants, Request for Proposals.



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