Strengthening The Capacity of Immigrant Community-Based Organizations:

Findings from An Evaluation of The New York Immigration Coalition Health Collaborative

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Executive Summary

The number and diversity of foreign-born in the United States has significantly expanded in recent years. The U.S. is now home to 33.5 million immigrants, representing close to 12% of the total population. Approximately 3 million foreign-born live in New York City, including 1.2 million who arrived within the last 10 years. Community-based organizations (CBOs) are key institutions within many immigrant communities, often providing a variety of supportive services that ease the transition into a new land. With training, skills and support, CBOs can provide educational, navigational, and advocacy services that facilitate improved access to health care for immigrants. The New York Immigration Coalition's (NYIC) *"Strengthening the Capacity of Immigrant Organizations to Link Uninsured Immigrants to Health Care and Insurance,"* sought to provide such training, skills, and support to diverse immigrant-focused CBOs.

In June 2008, the New York State Health Foundation (NYSHealth) provided funding to The New York Academy of Medicine (NYAM) to conduct a one-year evaluation of the Strengthening Capacity initiative. The evaluation utilized a mixed method approach to gather comprehensive data from multiple sources. Specific objectives of the evaluation were: **1)** identification of processes and activities utilized in project implementation, as well as factors affecting implementation; **2)** assessment of outcomes, including improved capacity among participating CBOs, increased outreach to immigrant communities, expansion in direct services to clients, and increased enrollment in health insurance; **3)** appraisal of project design, including an examination of the relative value of participation for CBOs with variable capacity and prior experience; **4)** assessment of project sustainability, including diffusion of information within the participating CBOs; and **5)** documentation of lessons learned. The evaluation aimed to provide specific knowledge regarding program impact and more general knowledge regarding the effectiveness of a particular model of training and outreach for health education, advocacy and systems level change.

Data for the evaluation came primarily from qualitative interviews conducted with directors and health advocates from all CBOs participating in the Health Collaborative, the two legal services partners, 16 clients, and directors and staff of three comparison CBOs. Interviews were also conducted with directors and staff of three comparison CBOs. Evaluation team members observed monthly meetings, trainings, Advocacy Days, and other Collaborative activities and gathered, organized, and reviewed a body of project documents provided by NYIC. Findings from the evaluation include:

- The education, training and leadership provided by the Collaborative facilitate effective direct service and advocacy activities across immigrant communities and organizations. Concerns and problems identified in the evaluation focused on structural details and processes, and should not obscure the overall positive assessment of the project.
- The multiethnic nature of the Collaborative was a strong and seemingly unique element of the model. In bringing together CBOs serving diverse immigrant communities, members were exposed to a wide range of challenges, learned to recognize commonalities and differences across populations and communities, and served as an information and referral network for one another.

- The diversity in individual and organizational capacity—although it had its drawbacks—was also seen as a strength. Members from across CBOs worked together and helped one another, especially when a new member joined. However, the Collaborative may be strengthened and resources better utilized if NYIC begins to formalize the differential roles that the CBOs take—or could take—within the project, including responsibility for specialized training consistent with their individual expertise.
- Participating CBOs were required to provide direct service to individuals, conduct community-level workshops and educational events, and to participate in advocacy events with the media and government officials. This combination of responsibilities not only reflects a high volume of work, but also utilizes differing skill sets and personal capabilities. Advocates seemed most comfortable with the direct service component of their work and several expressed fear regarding the outreach and advocacy requirements. However, seemingly all met the project expectations and appreciated the opportunity to expand their skills and their responsibilities—within their organizations and within their communities.
- CBO staff recommended increased involvement of their directors. Noted benefits of increased director-level involvement included more effective advocacy; general sharing of ideas and information; increased—and more equal—involvement of CBOs in the decision-making process and the development of the Collaborative's annual agenda; and greater levels of commitment on the part of CBOs. Increased involvement of directors would also provide them with more information on the responsibilities and accomplishments of participating staff members, which may result in increased organizational support for the work being done.
- Sustainability of NYIC and CBO program activities are currently contingent on continued outside funding and the protection of staff time that outside funding implies. In addition, within a given CBO, sustainability is often tied to staff retention, with turnover resulting in reduction or breaks in services and activities. A greater emphasis on diffusion of the skills and information gained through participation in the Collaborative—to CBO directors and staff—would likely contribute to sustainability. In addition, sustainability can be promoted by including fundraising and other general organizational training in collaborative activities. Finally, as recognized by NYIC, the likelihood of sustainability is an important consideration in the selection of CBOs.
- The significant accomplishments of the Collaborative and the *Strengthening Capacity* Project were only partially attributable to the design and structure of the program. Project successes cannot, and should not, be divorced from the significant skills, dedication, and compassion of staff from the NYIC, the legal partners, and the participating CBOs.

Introduction

The number and diversity of foreign-born in the United States has significantly expanded in recent years.[1] According to the U.S. Census Bureau's Current Population Survey, the U.S. is now home to 33.5 million immigrants, representing close to 12% of the total population.[2] Approximately 3 million foreign-born live in New York City, including 1.2 million that arrived within the last 10 years. At the time of the 2000 census, 45% of the New York City population was born outside the U.S., with immigrants and their children accounting for nearly two-thirds of the City's population.[3;4] Twenty-two percent of the population of New York State is foreign-born and 2.35 million State residents are limited English proficient (LEP).[5] Compared to U.S.-born residents, immigrants and their families have limited access to health care services. Inadequate English language skills;[6;7] low incomes;[8] poor access to public and employer-sponsored health insurance;[1;9-11] and differing knowledge,[12;13] attitudes, and concerns regarding health and health care[14-16] serve to promote disparate use of needed health care services contributing to delayed care[17] and poor health outcomes.[18;19]

Community-based organizations (CBOs) are key institutions within many immigrant communities, often providing a variety of supportive services that ease the transition into a new land, connect immigrants with their compatriots, and provide concrete services and training needed for education, financial security, housing and other vital services.[20;21] With training, skills and support, CBOs can provide educational, navigational, and advocacy services that facilitate improved access to health care for individual clients and for immigrants overall.[13] The New York Immigration Coalition's (NYIC) *"Strengthening the Capacity of Immigrant Organizations to Link Uninsured Immigrants to Health Care and Insurance,"* sought to provide such training, skills, and support to diverse immigrant communities in and around New York City utilizing a collaborative approach to education and skills development.

Strengthening the Capacity of Immigrant Organizations: Founded in 1987, NYIC (www.thenyic.org) is a nonprofit policy and advocacy organization with more than 200 member groups in New York State, including nonprofit health and human services agencies; religious and academic institutions; labor unions; and community, legal, social, and economic justice organizations. NYIC programs and services focus on policy analysis, protection and promotion of immigrant rights, improving access to services, resolving problems with public agencies, and mobilization of members for effective advocacy. The *Strengthening Capacity* project was implemented through the agency's Health Collaborative, which has been ongoing since 2001. The Health Collaborative provides education, training, and technical assistance to health advocates from member CBOs who, in turn, assist immigrant New Yorkers and their families to access health care and insurance coverage and advocate for improved health care services for immigrants at the City and the State level. CBOs receive funding from NYIC to compensate for a commitment of staff time and are expected to meet a number of deliverables and participate in all project activities, as described below. The Strengthening Capacity project was funded by the New York State Health Foundation (NYSHealth) from January to December 2008.

Introduction *(continued)*

Evaluation Overview: In June 2008, NYSHealth provided funding to The New York Academy of Medicine (NYAM) to conduct a one-year evaluation of the *Strengthening Capacity* initiative. The evaluation utilized a mixed method approach to gather comprehensive data from multiple sources. Specific objectives of the evaluation were: **1)** identification of processes and activities utilized in project implementation, as well as factors affecting implementation; **2)** assessment of outcomes, including improved capacity among participating CBOs, increased outreach to immigrant communities, expansion in direct services to clients, and increased enrollment in health insurance; **3)** appraisal of project design, including an examination of the relative value of participation for CBOs with variable capacity and prior experience; **4)** assessment of project sustainability, including diffusion of information within the participating CBOs; and **5)** documentation of lessons learned. The evaluation aimed to provide specific knowledge regarding program impact and more general knowledge regarding the effectiveness of a particular model of training and outreach for health education, advocacy, and systems level change.

Data for the evaluation came primarily from qualitative interviews conducted with directors and health advocates from all CBOs participating in the Health Collaborative; the two legal services partners; and directors and staff of three comparison CBOs: *Association of Senegalese in America, Arab American Family Support Center, and Jewish Community House of Bensonhurst*. We also conducted 16 interviews with community members who sought and received health access services from four of the Collaborative CBOs: *North Fork Spanish Apostolate, RACCOON, Filipino American Human Services (FAHSI), and the South Asian Council for Social Services (SACSS).* The interviews were translated (when necessary) and transcribed, coded, and then analyzed using an NVivo database developed specifically for this project.

Evaluation team members also collected primary data throughout the year by attending monthly meetings, trainings, Advocacy Days, and other Collaborative activities. Evaluation team members observed, took notes, and collected educational and advocacy materials distributed during these activities. Throughout the evaluation period, we also gathered, organized, and reviewed the body of project documents provided by NYIC. These documents included educational and advocacy materials provided to members of the Collaborative, as well as reports submitted to NYIC by Collaborative members and reports submitted by NYIC to NYSHealth. The reports included counts of the number of individuals that received direct client assistance from the CBOs, the number of community workshops held by CBOs, and the number of community members attending those workshops.

Finally, the evaluation team had two formal discussions with NYIC staff members on the status of the Health Collaborative, the *Strengthening Capacity* project, and the ongoing evaluation. The first took place at the start of the evaluation and provided us with the background information we needed to finalize our evaluation plan. The second, which took place at the evaluation midpoint, provided an opportunity to discuss preliminary evaluation findings with NYIC staff members, so the findings could be utilized for quality improvement purposes on a timely basis.

PROGRAM DESCRIPTION: THE NEW YORK IMMIGRATION COALITION HEALTH COLLABORATIVE

The Health Collaborative represents a partnership between the NYIC (in the lead role), immigrant-focused CBOs, and *pro bono* legal service providers focused on improving access to health care and health insurance for individual immigrant clients and immigrant populations overall. The Collaborative addresses access issues at the ground level by educating health advocates regarding options for affordable and accessible care—as well as processes for their navigation—that may be utilized by CBO clients and other community members. At the systems level, the Collaborative promotes policy changes that would facilitate improved access for all immigrants. Varying slightly from year to year, in 2008, the Collaborative included two legal services organizations and nine CBOs (see **Figure 1**), representing the Latino, South Asian, Russian, Balkan, Korean, Haitian, and Filipino communities, spreading from Eastern Long Island to Nassau County, Brooklyn, Queens, Manhattan, the Bronx and Staten Island.

FIGURE 1: Health Collaborative Member Organizations

ORGANIZATION	ETHNIC/NATIONAL COMMUNITY	GEOGRAPHIC COMMUNITY SERVED
Make the Road New York	Latino/a	Brooklyn, Queens, Staten Island
CARECEN–Central American Refugee Center	Latino/a	Nassau County, Long Island
North Fork Spanish Apostolate	Latino/a	Suffolk County, Long Island
Korean Community Services	Korean	Brooklyn, Queens, Manhattan, Staten Island, and New Jersey
RACCOON–Reconciliation and Culture Cooperative Network	Balkan	Bronx, Northern Manhattan, Queens
South Asian Council for Social Services	South Asian	Flushing, Queens
Haitian Americans United for Progress	Haitian	Jamaica, Queens
Filipino American Human Services, Inc.	Filipino	Jamaica, Queens
Shorefront YM/YWHA	Russian/Eastern European	Brighton Beach/ South Brooklyn
New York Lawyers for the Public Interest	Not applicable	
Urban Justice Center	Not Applicable	

The Collaborative model incorporated a number of structured activities and expectations, including:

Collaborative meetings: Monthly half-day meetings that rotated among partner sites, offered Collaborative members educational, skills-building and networking opportunities. More specifically, monthly meetings included:

- An educational component, which was commonly presented in a didactic format and responded to questions or issues raised by health advocates in prior meetings or individual consultations.
- Announcements of advocacy and education activities being held by Collaborative members or the NYIC.
- Preparation for advocacy days, including role-play with mock elected officials.

> "I love [the monthly meetings] because we can give advice. Because if I've been here longer I probably know more, so I'm glad to share my experiences and advice. At the same time, if I don't know how to solve a problem I know I have peers [at the meeting] I can count on." **—LANA KHRAPUNSKAYA, SHOREFRONT Y)**

> "Case sharing is very important for me as a case manager. We discuss different current health issues, a little bit of advocacy. Also, we get to know different health State agencies and independent agencies that help us with our work."
>
> **—MARIJA SAJKAS, RACCOON**

- Case sharing, where health advocates discussed client cases and difficult situations they had encountered since the previous meeting. Advocates solicited advice, connections, and referrals from the NYIC staff, other Collaborative members, the legal service partners, and others in attendance. Case sharing was considered a particularly valuable and engaging portion of the meetings because of its interactive format and relevance to the health advocates' daily work. It was recommended that this portion of the meetings be lengthened to give the CBOs a more active role.

Annual four-day intensive training: The four-day training (held over the course of four weeks) included information and skill-building sessions, which incorporated new and familiar material. Training exercises taught the health advocates how to use the information provided in educational workshops. Advocates were also given the opportunity to role-play interviews with mock reporters and view their interviews on screen. Group critiques offered opportunities for suggestions on substance and presentation style.

> "All the skills they teach have been really helpful. Like, with the media. Before press conferences, they work with us about how to do a press conference, the skills you need. I've always been very shy, but the Collaborative has taught me confidence." —KATHY MOMPEROUSSE, HAUP

Similar to the format of the monthly meetings, guest speakers with expertise on specific issues were brought in to conduct special sessions during the four-day training. Presentations were followed by group discussions during which health advocates had a chance to apply the material provided to concrete cases they had encountered. Copies of useful documents were provided to each CBO on a USB flash drive—an ecological and labor saving innovation introduced this year, which was considered a significant improvement over the three or four inch binders provided previously.

Legislative Advocacy Days: Advocacy days, including rallies and small group meetings with elected and other officials, as well as their representatives, were held in New York City and

> "At the beginning I didn't feel so comfortable talking to the media, but now I do and we had a party here last month and I spoke to two members of the media. So I set up an appointment with them and I will be talking to them soon...I felt that doing the presentations helped me a lot in dealing with the media. When I do the presentations I feel like I am doing "the real thing." In September it was Legislators Day and I talked to the legislator with Maysoun [from NYIC] about hospitals and about financial assistance. Going to Albany also gave me the confidence to talk to the media." —MIRNA CORTES-OBERS, CARECEN

Albany. The rallies, organized by the NYIC and the participating CBOs, included advocates and hundreds of community members. Small group meetings with elected and other officials provided opportunities for Health Advocates, community members, and NYIC staff to discuss and advocate around priority issues, including language access in health care settings. Health advocates and community members offered testimonials based on their own experiences, effectively illustrating immigrant-related barriers to care and their real-life implications.

In preparation for legislative advocacy activities, health advocates were trained using a variety of methods. Policy and educational updates provided over the course of the year served as background information on the legislative issues to be addressed, as well as an understanding of the political process and the role of advocacy within it. Role-plays with health advocates

approaching mock politicians provided opportunities to practice the initial approach, to develop effective policy arguments, to use poignant cases that leave a strong impression, and to request support for particular legislation. Health advocates, in turn, provided training to community members who would be joining them at the rallies and legislative meetings.

Community Outreach and Education: Health advocates supported by the Collaborative were responsible for conducting community workshops (10 per year) and media activities. According to reports submitted to NYIC, Collaborative CBOs organized a total of 25 community workshops per quarter with a combined attendance averaging near to 650 people. Workshops were held in churches, schools and other community institutions and addressed topics that included health care service options, public vs. private insurance, Medicaid, and access to health care for children.

Direct Client Services:[1] From the perspective of the CBOs, the majority of the work with the Collaborative focused on assisting community members to access and navigate the health care system. Primarily (though not exclusively), health advocates provided assistance related to:

- utilization of public health insurance programs, including information regarding insurance eligibility and insurance benefits, documentation needed for application forms, referrals to facilitated enrollers, provision of interpretation services, and follow-up with enrollment and recertification problems;

> "Marisa [the health advocate] helps seniors get the benefits they need. Once I went to Hillside to get my medications for rheumatoid arthritis. My Medicaid was expired, so I called Marisa and asked her what I should do. She showed me how to fill out the forms I needed, and within one month I had my new Medicaid card. Marisa gives me advice on what to do and how to fill out forms. Medicaid doesn't cover enough of the treatment for rheumatoid arthritis, and Fidelis has a problem where they don't necessarily refund all the upfront costs. Marisa helped me work through that and get money back." **—ANGELA, CBO CLIENT**[1]

Evaluation Findings: Process, Outcomes And Lessons Learned

As noted above, the evaluation of the Health Collaborative's *Strengthening Capacity* Project included a number of specific process and outcome objectives, including appraisal of project design and assessment of sustainability. The evaluation aimed to provide specific knowledge regarding program impact and more general knowledge regarding the effectiveness of a particular model of training and outreach for health education, advocacy, and system-level change. In reporting on evaluation aims and objectives we focus on the most salient findings, including those with the greatest utility to organizations and individuals seeking to implement, fund, or join programs similar to that described here. We assume there will be those primarily interested in content, specifically, how to reach immigrant communities and other populations with limited access to health insurance and health care. Others may be primarily interested in structure, including the development, implementation, sustainability, and impact of collaborations. Both issues are highly relevant to public health research and practice: the former due to the size, diversity and increasing dispersal of the immigrant population, and the latter due to a sustained interest in collaborations among communities, providers, and funders.

Finally, we assume that some readers will simply be interested in an assessment of Collaborative's work and the extent to which it effectively promotes improved access to health care for New York's immigrant populations. Findings regarding this final point are integrated throughout the report and embedded in many of the staff and client quotations. Still, it should be noted that the evaluation confirmed that the education, training, and leadership provided by the Collaborative facilitated effective direct service and advocacy activities across immigrant communities and organizations. Concerns and problems identified in the evaluation were centered on structural details and processes, and should not obscure the overall positive assessment of the project.

FINDING #1:

A MODEL TO ENHANCE ORGANIZATIONAL CAPACITY AND HEALTH CARE ACCESS WITHIN IMMIGRATION COMMUNITIES

As a capacity-building project, the NYIC Coalition aims to effect change at the level of the **1**) individual staff member; **2**) participating organization; and **3**) community served. In the sections below, we address each of these three levels independently.

Development of Skills at the Individual Level: Despite the fact that their involvement with the NYIC Collaborative represents just a portion of their jobs, all health advocates interviewed as part of the evaluation described notable improvements in knowledge and skills as a result of their participation. In addition to the training and education provided directly through the Collaborative, personal growth resulted from linkages to other valuable resources, including networking opportunities and connections to other NYIC initiatives. One of the health advocates, for example, won the 2008–2009 Immigrant Advocacy Fellowship Program offered by the NYIC, which "helps

> "So, the educational piece is very helpful. Secondly, the trainings are great because I have grown as a person and I have seen others grow too. Every person in the Collaborative has grown as a health advocate. I can see people are growing. Self-confidence is growing in all of us, and this is important in advocacy, because if we respect ourselves as immigrants, this helps us do our advocacy work better. I was given the chance to speak with elected officials, and I am not sure I could do this if we weren't part of the Collaborative. I used to be embarrassed and shy because of the language, but then I started talking. The Collaborative allowed me to talk to people I couldn't have spoken to otherwise." **—LANA KHRAPUNSKAYA, SHOREFRONT Y**

leaders working with immigrant communities to develop insights, strategies and skills needed to increase immigrant participation in the civic and political life of New York." The director of the same organization was selected to be part of "Leading Change," an executive seminar series organized by the NYIC and funded by the Annie E. Casey Foundation.

Organizational Change: At the organizational level, a sustained impact is less obvious, likely reflecting the fact that just a single employee participates in the Collaborative at most organizations. However, as long as the employee is retained and the services are funded, CBO capacity is enhanced. This was particularly the case for organizations that had previously lacked a health focus. That said, there were several examples of organizational impact worth noting.

- At two of the CBOs, staff were charged with developing Coalitions on their own, completely separate from the NYIC project. Both utilized the Collaborative model in their efforts.
- One CBO with strong advocacy emphasis in areas outside of health was able to expand these efforts to become effective in health as well. At this organization, higher-level staff had involvement in the Collaborative, thus facilitating organizational change.
- CBOs noted that membership in the Collaborative commanded respect and could be leveraged within funding requests.

Additional information regarding organizational change is included in "Finding #3: Sustaining CBO Capacity."

Community-Level Outcomes: Although quantitative documentation of increases in insurance coverage or linkages to providers was not available, through interviews with staff and clients, we noted a number of ways in which the participating CBOs facilitated improved access. In the words of CBO clients:

> **My Medicaid lapsed last month, and I wasn't able to renew it. I went five times to the HRA office, and I had to bring Marisa to help, because it was difficult to get them to look at my documents.** ***—Laura, CBO client***

> **I also started having asthma allergies about three to four years ago, so that's when Marisa suggested I apply for Medicaid. So, I went to Elmhurst to apply for Medicaid. Before Marisa told me to get covered, I was not covered. She told me where to go. I was so shy; I didn't want to bother anyone. I've always been like this. I never wanted to ask for help.** ***—Natalia, CBO client***

> **Yes, [the CBO] helped me get the HHC insurance. With it, I pay only $15 per visit. I didn't know that I could apply and get health insurance until I met with [the CBO] people. For that, I am very grateful to them. I don't have many health problems now, but you never know when you can get sick. Before I had the insurance, I went to a doctor to do annual checkup and got billed for $1,000. I couldn't pay for it, so [the CBO] negotiated with the doctor's office to withdraw the claim. They succeeded after many phone calls back and forth on my behalf.** ***—Nevenka, CBO client***

> **I lived for years without health insurance. Then, in April of this year I applied for Medicare, but was initially turned down. I contacted people at [the CBO] and they helped me with the paperwork. They also made some calls, and finally I was approved. I have a lot of health problems and absolutely must have health insurance. A few years back, I was diagnosed with the ovarian cancer and underwent an emergency hysterectomy. Medical bills started coming in and wouldn't stop until [the CBO] people made calls to the hospital. I didn't have insurance at the time of the surgery.** ***—Jovana, CBO client***

She continued:

> **Yes, whenever I needed help. I can call, and they will help with scheduling, translating for me, explaining how the hospital system works, whatever is necessary. After my hysterectomy, I was harassed for a long time by a hospital to pay $20,000 for the surgery. It was thanks to the [the CBO] members who put many, many calls to the hospital administration that they finally stopped calling me.**

In addition, as noted above, health advocates successfully disseminated information on health care access through their communities. According to data submitted to the NYIC, health advocates conducted approximately 25 trainings per grant quarter, reaching an estimated 650 people.

FINDING #2:

COLLABORATIVE STRUCTURE: FINDING AN APPROPRIATE MIX

In 2008, nine CBOs were part of the NYIC Collaborative, representing a mix of national and ethnic communities and multiple New York City metropolitan neighborhoods. CBOs were also diverse with respect to experience, scope, and available resources. Some of the organizations had significant capacity for outreach and advocacy, as well as the ability to provide a relatively high volume of diverse client services; others were much smaller and more limited in the services they offered. Although the difference between CBOs was in some ways problematic (as discussed below), the NYIC and CBO staff have in large part utilized the diversity as an asset, and virtually all of those interviewed for the evaluation agreed that diversity added—rather than limited—value. The more experienced CBOs provide advice and practical supports that even NYIC staff (who do not see clients) could not offer. This advisory role was seen in a positive light by the experienced advocates, as it provided them with opportunities to build their educational and training capacity and to "give back."

> "What I love about Collaborative is that we are a very diverse group. It helps a lot. Because the way Collaborative is structured is the way New York is structured, in a way. For me as an advocate, when working with people from only our small parts of the world, you tend to stay close to people from that part of the world and forget that you are part of a larger picture and living in a larger community with people with a different culture, different language, different issues. When discussing how to deal with advocacy issues you'll see an interesting polarization. Someone from Latin America will say, "we should put a disclaimer about this up at the front." Then someone from like Russia, or us, will say, "No, no, no—if you put the disclaimer up front, our people will think it is some scheme going on and they will not take the flyer seriously." For me the Collaborative is important to be able to communicate to my clients, for instance, with that flyer, I can say to them: "Don't be paranoid. Most people in New York will appreciate this. I know that because we're from the Communist background we don't like it, but now we're part of this bigger city." **—MARIJA SAJKAS, RACCOON**

Consistent with the variability in internal capacity is variability in access to outside resources. For example, Haitian-Americans United for Progress and Shorefront Y belong to the Greater Brooklyn Health Coalition; Make the Road, Korean Community Services, Haitian-Americans United for Progress, and the South Asian Council for Social Services belong to the New York City Managed Care Consumer Assistance Program (MCCAP). Through these organizations, CBOs are getting both new and duplicative information. The unique contribution of NYIC, however, is—not surprisingly—the immigrant perspective. The value placed on NYIC meetings and activities is reflected in near perfect attendance rates by Collaborative members.

From an evaluation perspective, the range of capacity and access to outside resources is more problematic. Although the inclusion of high capacity organizations does undoubtedly add value to the meetings, provide support to new members, and strengthen advocacy efforts, if these organizations do not need the training and education available, resources are not being utilized in a way that is most effective. Although requiring more experienced organizations to "graduate" from the Collaborative would be an error, a "one size fits all" approach is similarly inappropriate. It would benefit the Collaborative to consider the capacity and needs of the different CBOs and more formally recognize the roles that the different organizations play or can play. Resource commitments to member CBOs can remain equal—so as to promote a sense of egalitarianism and to avoid administrative challenges—but the expectations should be tailored to optimize overall program outcomes. Having more experienced CBOs mentor new organizations or

> "I sent a Pakistani who lives in Coney Island to the Shorefront Y—they have a great amount of experience. They've identified a Pakistani who speaks Hindi, Urdu, and Punjabi in the community who can interpret. Also, there are South Asian taxi drivers on Staten Island that I refer to Make the Road, which has an office there." **—AYAZ AHMED, SACSS**

conduct educational sessions represents a better use of their time (and program dollars) than attendance at familiar trainings. For example, within the Collaborative there are agencies with specialized knowledge around community organizing, domestic violence, and services for older adults. Providing these agencies with opportunities to develop and deliver training sessions would benefit all members of the Collaborative and provide opportunities for leadership that build capacity and reinforce a sense of commitment.

A separate issue with respect to variable capacity among CBOs relates to variable power in steering the Collaborative. Although recognized by a small number of individuals we interviewed, it was not seen as particularly problematic. Also considered generally unproblematic, was the geographic and ethnic diversity of member CBOs. This diversity was seen as an asset by Collaborative members, providing them with exposure to challenges faced by communities across

> "Well, most of [my clients] are Hispanic immigrants, mostly low income. They usually work in places that don't give them health insurance, for example house cleaning and babysitting jobs. So, many of them don't have health insurance and it is very expensive for them to seek health care services, they are reluctant to use health care services...one big problem is that hospitals fail to tell patients about the availability of financial assistance. People have difficulties paying bills. This person in particular received a letter for a claim about money she owed. So, I had to negotiate for my client with the hospital and as soon as I said the word "law" [referring to the possibility of going to a lawyer], that's when the person at the hospital got scared and told me to come in and that they would take care of it. And when I talked to the client a few months afterwards, she told me that she had managed to get Medicaid!" **—MIRNA CORTES-OBERS, CARECEN**

the New York City area, cross-cultural differences and similarities, and a diverse network for referrals. In working together to address health care access issues in multiple immigrant groups, the CBOs are able to move beyond their own ethnic or national group to address immigrant health care overall. That said, CBOs outside New York City faced particular challenges in that many of the City-based institutions and systems are unavailable outside the five boroughs. Although NYIC staff and legal partners made proactive efforts to address the concerns of organizations outside the City, comparable information was not always available.

The significant role of the two legal partners, the Urban Justice Center and New York Lawyers for the Public Interest (NYLPI), should also be noted as part of the appropriate Collaborative mix. The legal service partners offered educational services to the group overall, as well as pro bono advice and representation on individual cases. Multiple Collaborative members commended their work with accolades including "extremely helpful" and "wonderful."

Finally, the "appropriate mix" question also suggests a consideration of appropriate roles within the mix. Although the issue of CBO roles relative to one another was discussed above, there is an additional question regarding the role of NYIC relative to the participating CBOs. NYIC staff were seen as highly skilled, knowledgeable and responsive to requests for information and to the practical concerns of the CBOs. CBO recommendations regarding implementation procedures were also utilized. For example, on the recommendation of a health advocate, monthly meetings were rotated between CBO offices during 2008 rather than being held at NYIC. Similarly, in 2009, for the first time experienced health advocates were able to opt out of a portion of the four-day training.

> "It has been very helpful because we can call [NYIC] at any time, and they call us once in a while to check up on us. They are very prepared."
>
> —SUDHA ACHARYA, SACSS

> "Yes, yes, they are always available. Jenny called me about an event and also she offered that we practice together. [NYIC doesn't] just throw you into things, they help you." —MIRNA CORTES-OBERS, CARECEN

However, at the macro level, the Collaborative was seen as less democratic and the majority of CBOs had little opportunity for direct input in major decisions, particularly with respect to the advocacy agenda. Minimal CBO input in the decision making process was considered to be reflected in, and reinforced by, lack of involvement at the director level. Seen as problematic by some participating CBOs, the disconnect from directors also has implications for sustainability, as described below.

FINDING #3:

SUSTAINING CBO CAPACITY

The NYIC Health Collaborative, as it is currently designed, requires continued funding to sustain the full range of project activities. Supplementary funding was, in fact, secured for the year that followed the NYSHealth grant, allowing the Collaborative to continue with its work.

Given the high need and limited funds available to many immigrant-focused CBOs, funding of their work in a way that facilitates expanded capacity is likely an efficient use of grant monies. None of the Collaborative CBOs felt they had independent access to the range and volume of information regularly provided by NYIC; most lacked resources for the development of advocacy efforts as well. Given changing regulations and changing populations, the Collaborative meets an ongoing need. Questions regarding level and allocation of funds to best support the work (given limited resources), however, remain open. Embedded in these questions are considerations regarding: **1)** allocation of funds to individual CBOs, recognizing the differential

> "It would be impossible to do this work without the Collaborative. It's a very effective use of the money; we couldn't have set the project up for an equivalent amount of money. It only works because Mirna can go into this already set up and have the expertise of all the other groups and the staff." —PAT YOUNG, CARECEN

returns on investment associated with CBO capacity, as well as the need for fairness and transparency; and **2)** allocation of funds in support of different program activities. As noted in the previous section, we suggest that funding levels stay equal across member CBOs, but that expectations better reflect the time commitment and capacity of individual organizations, as well as the need in specific target communities. With respect to specific program activities, including direct client service, education, and advocacy, each was valued by the Collaborative members interviewed. Furthermore, the melding of activities was considered to add value beyond what each activity would have accomplished on its own. As expressed by the Advocates themselves:

> "Everything is always changing. We will constantly need the Collaborative and other coalitions. As new immigrant populations come in, there are new problems. First it was language issues with providers, then it was language issues at hospitals, now it's figuring out billing processes. No one knows what's next." **—KATHY MOMPEROUSSE, HAUP**

> **In my role as an advocate, my experience with community members was crucial. It is a very powerful tool to know their stories and use them [with policymakers].** ***—Marija Sajkas, RACCOON***

> **It makes sense and I think it's advantageous: if they're service based to develop their advocacy skills, and if they're just doing advocacy to look into doing more services. They can then have a more well rounded approach to the things that are affecting immigrant communities.** ***—Theo Oshiro, Make the Road New York***

Although from an outside perspective, it might seem efficient for limited funding to go directly to client services, Collaborative members made a convincing case that: **1)** systemic change will not occur without advocacy; and **2)** systemic change is ultimately more efficient than service to individuals. Collaborative members also acknowledged that funding for direct service is more readily available than funding for advocacy work. As noted above, the direct service experience Collaborative members bring to their advocacy work makes it particularly effective.

Funding allocated to member organizations in health-related coalition members, in general, is highly variable ranging from zero to nominal amounts (generally tied to meeting attendance), to more significant amounts (as is the case with the NYIC Collaborative) that fund project activities in addition to meetings. The sustainability of collaboratives is also highly variable, with funding representing just one of several contributing factors. Among NYIC Collaborative organizations, there were differing responses to our inquiry regarding meeting attendance in the absence of funds. Although several felt they would continue to attend, others—including

those from resource poor CBOs—felt continued attendance would be difficult or impossible. And, without regular in-person contact the work of each CBO would reportedly be diminished. As noted previously, contact has facilitated a number of benefits including information exchange, collaboration on project activities, and inter-agency referrals. Inter-agency support is also apparent in the practical advice advocates provide to one another. At one meeting, a health advocate described a client with a $60,000 debt at Stony Brook Medical Center. A health advocate from another CBO offered the contact information for an individual in Stony Brook's financial aid office that could help to negotiate the client's bill. Although some contacts and some level of assistance would certainly be maintained without scheduled interaction, regular meetings help reinforce relationships that in turn facilitate improved advocacy and client services.

In addition to sustainability at the Collaborative level, there is the issue of sustainability of CBO services and activities. All of the health advocates interviewed for the project reported acquisition of significant knowledge and skills related to health care access, advocacy, and public education. This knowledge and these skills will likely be retained and will facilitate sustained improvements in programs and services. For example:

Now I know who to call at particular hospitals and who to call at the Collaborative...I have learned how to negotiate with hospitals to reduce bills for uninsured clients...I know where to send clients who are terminally ill, where to send the undocumented clients...Previously, I hadn't known about HHC options.*—Ayaz Ahmed, SACSS*

I quickly learned about the media and lobbying from the Collaborative. When I started ... my experience was with casework. The Collaborative became a way for me to learn about health advocacy. For press events, [NYIC] provided one-on-one training...I knew I would be required to do media work but, initially I found it frightening, so the trainings were very helpful.*—Theo Oshiro, MTRNY*

I learned community organizing and public speaking skills...I used these skills in my MSW program, more I think than I even use the skills from my MSW in my work with the Collaborative. I have grown professionally and learned a lot. The work I've done with the Collaborative is a big reason I went into community organizing. ***—Kathy Momperousse, HAUP***

Because they provided all the materials on immigration rights and fair hearing and they taught us how to work with all the health care issues, it helps us help the community. I know what I'm doing now because I was trained. ***—Lana Khrapunskaya, Shorefront Y***

As in the examples above, advocates invariably spoke of skills gained in ways that imply sustainability. However, Collaborative funds are still required to protect staff time for direct services, education, and advocacy. Interviewees were consistent in predicting a reduction in direct services and educational and advocacy activities if grant funds were unavailable. In fact, the relatively limited funds provided through the Collaborative (paying for 10 or fewer hours per week of work) were a common concern not just on the part of the CBOs (advocates and directors alike), but also from the perspective of the NYIC staff members. The financial challenges were felt most profoundly among the smaller CBOs, whose only source of funding for health related work came from the NYIC.

Outreach and lobbying were particularly challenging with limited resources. Directors from two small CBOs suggested that a larger grant would have allowed them to hire a part time person specifically for these activities. For CBOs with sources of health-related funding other than the Collaborative grant, funds from NYIC provided a stronger base of support for an existing position and allowed them to focus their resources on specific activities, including outreach, that wouldn't have been possible otherwise. They agreed that the grant size was insufficient for a stand-alone program, but in combination with other funds, resulted in stronger programming and more services.

Diffusion of information from the health advocate participating in the Collaborative to other CBO staff would likely contribute to sustainability, so this was an ongoing concern throughout the evaluation. We noted some variability, reflecting individual personality and initiative (both from the perspective of the Health Advocate and from the perspective of other staff), as well as organizational size and structure. For example, there was relatively little opportunity for diffusion if the Health Advocate was the only person within a CBO working on health related issues. In contrast, among CBOs that sent multiple staff to Collaborative meetings (either jointly or sequentially) diffusion—as well as enhanced sustainability of project activities—was built into the program structure. Overall, the diffusion of information within CBOs would likely be enhanced by greater involvement of director-level staff, particularly in light of significant turnover within some organizations.

Summary of Lessons Learned

The evaluation of the NYIC Collaborative aimed to provide specific knowledge regarding program impact and more general knowledge regarding the effectiveness of a particular partnership model for training and outreach focused on health education, advocacy, and system-level change. In reporting on our findings we focused on those with the greatest utility to organizations and individuals seeking to implement, fund, or join programs similar to that described here—including those primarily interested in content (how to reach immigrant communities and other populations with limited access to health insurance and health care), and those interested in structure (the development, implementation, sustainability, and impact of collaborations). These findings are summarized below:

An Important Initiative for New York Immigrant Communities: The education, training, and leadership provided by the Collaborative facilitated effective direct service and advocacy activities across immigrant communities and organizations. Concerns and problems identified in the evaluation were centered on structural details and processes, and should not obscure the overall positive assessment of the project.

Strength in (and Challenges of) Diversity: The multiethnic nature of the Collaborative was a strong and seemingly unique element of the model. In bringing together CBOs serving diverse immigrant communities, members were exposed to a wide range of challenges, learned to recognize commonalities and differences across populations and communities, and served as an information and referral network for one another. The Collaborative thus becomes a microcosm of the New York immigrant population, and the CBOs end up serving not only their communities, but also the broader immigrant population of New York. Most of the interviewees were highly appreciative of the multiethnic aspect of the Collaborative. In addition to ethnic diversity, the diversity in individual and organizational capacity—although it had its drawbacks—was also seen as a strength. Members from across CBOs worked together and helped one another, especially when a new member joined. As suggested earlier in the report, however, the Collaborative may be strengthened and resources better utilized if NYIC begins to formalize the differential roles

> "There are people who see their roles as service providers or see their role as advocates. I think one of the values of the Collaborative is that it gives people a taste of what the other would be like...In their organization, they might not have any other avenue to get this information or these skills from. In the worst cases it doesn't work. They still have this knowledge that maybe they don't put into their work every day. In the best cases it really finds advocates that just needed that source of knowledge and training." —THEO OSHIRO, MAKE THE ROAD NEW YORK

that the CBOs take—or could take—within the project, including responsibility for specialized training consistent with their individual expertise.

Combining Direct Service, Community Education and Advocacy: Participating CBOs were required to provide direct service to individuals, community-level workshops and educational events, and to participate in advocacy events with the media and government officials. This combination of responsibilities not only reflects a high volume of work, but also utilizes differing skill sets and personal capabilities. As evaluators, we were concerned that expectations were too high and that effectiveness would be limited by a mismatch in personnel. These concerns were partially, but not entirely borne out. Advocates did seem most comfortable with the direct service component of their work, and several expressed fear regarding the outreach and advocacy requirements. However, seemingly all met the project expectations and appreciated the opportunity to expand their skills and responsibilities within their organizations and communities. In addition, advocates welcomed the opportunity to contribute to systemic change. Based on our observation, even relatively new advocates were perceived to be effective in their meetings with public officials. As discussed below, the extent to which involvement of CBO directors would result in increased impact was a concern expressed by several project participants.

Need for Collaboration at Multiple Levels: Although the Collaborative was described in very positive terms, several of the individuals interviewed expressed discontent with the lack of involvement of CBO directors. Noted benefits of increased director-level involvement included more effective advocacy; general sharing of ideas and information; increased, and more equal, involvement of CBOs in the decision-making process and the development of the Collaborative's annual agenda; and greater levels of commitment on the part of CBOs. Increased involvement of directors would also provide them with more information on the responsibilities and accomplishments of participating staff members, which may result in increased organizational support for the work being done. Greater director-level communication was one of the preliminary recommendations we made to NYIC, and in fact, a directors' meeting followed the recommendation. Most CBO directors participated in the meeting, suggesting a desire for initiating this channel of communication. That said, director-level involvement should not require a time commitment that would result in a redistribution of grant funds from the advocate to the director. Semi-annual meetings would likely be sufficient.

Sustaining Improved Capacity: Sustainability of NYIC and CBO program activities are currently contingent on continued outside funding and the protection of staff time that outside funding implies. In addition, within a given CBO, sustainability is often tied to staff retention, with turnover resulting in reduction or breaks in services and activities. A greater emphasis on diffusion of the skills and information gained through participation in the Collaborative—to CBO Directors and staff—would likely contribute to sustainability and might be included as a grant requirement (e.g., two internal staff trainings per year). In addition, sustainability can be promoted by including fundraising and other general organizational training into Collaborative activities. Finally, as recognized by NYIC, sustainability is an important consideration in the selection of CBOs.

For example, there was relatively little opportunity for diffusion if only one person within a CBO worked on health related issues. Consistent with the recommendation above, the diffusion of information within CBOs would likely be enhanced by greater involvement of director-level staff, particularly in light of significant turnover within some organizations.

Staff Quality and Responsiveness: Although not specifically stated in previous sections, the significant accomplishments of the Collaborative and the *Strengthening Capacity* Project were only partially attributable to the design and structure of the program. Project successes cannot, and should not, be divorced from the significant skills, dedication, and compassion of staff from the NYIC, the legal partners, and the participating CBOs.

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