TOOL BANK

The goal of this section is to begin to build a bank of assessment and planning tools that can be used by Well Being Trust staff, grantees, or other health system programs to enhance their approach to learning. Each tool details who the resource is designed for as well as why and how to use it.

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Implementation Readiness Checklist Overview

Who should use the Implementation Readiness Checklist: The Implementation Readiness Checklist is designed for Well Being Trust staff to use as a guide to assess the implementation readiness of their grantees' funded programs or initiatives.

Why use the Implementation Readiness Checklist: Grantees face challenges that can delay implementation. Well Being Trust staff and leadership have a wealth of expertise and a growing knowledge of grantee implementation that could be leveraged to ensure teams have the foundation, expertise and support for a successful program launch. By using this checklist, Well Being Trust staff can identify some of these challenges prior to funding or program launch and take steps to reduce or mitigate obstacles.

How to use the Implementation Readiness Checklist: Well Being Trust staff may consider using this checklist to inform their review of grantee applications or guide phone conversations prior to grantees launching their programs.

IMPLEMENTATION READINESS CHECKLIST

Motivation: The grantee partners have a shared understanding of the proposed program and a recognition that it is valuable to the community they serve.

- ☐ **Team has chosen a program or services that are compatible with existing organizational values and capacity.** The program leadership, stakeholders, and organizational members are more likely to support and buy in to a program if its potential outcomes are both feasible to achieve and align with their values.
- ☐ **Program goals are anchored to the prioritized needs of their community.** The program has a plan to assess their community's needs or has already completed this assessment. The program has clearly identified its target population (i.e., who they intend to serve) and aligned the program with this population's needs.
- ☐ **Program has developed a unified program vision/agenda.** Program partners have a history of collaborating on this issue. If partnerships are new, the program has a plan to build trust and collectively define a vision for change that includes a common understanding of the problem and a joint approach to solving the problem through agreed-upon actions.

General Capacity: The organizational members involved in the grantee's program have a shared resolve to implement the program or initiative

- ☐ **Program has appointed a centralized program leader or backbone organization to drive the work.** An independent, dedicated staff has been identified to provide support for the development and manage the implementation of the program, including coordinating across partner organizations or departments.
- ☐ **Program has the physical space needed to deliver services.** The physical resources required to deliver services have been allocated by the health system or partner organizations.

Program-specific Capacity: The grantee has the ability, resources, and support required to implement their proposed program

- ☐ **Program is utilizing evidence-based models in their program design.** The models selected have evidence to support their effectiveness. The program has a plan to adapt the models to suit the unique sociocultural, legislative, or geographic conditions of the program.

- ☐ **Program has secured licenses or certifications needed to deliver services.** Programs clearly understand any licensing requirements and have begun the paperwork and application process. Programs that face delays may consider engaging external stakeholders (hospital government relations departments, local governmental officials) to resolve hurdles around licensure.

- ☐ **Program has hired appropriate staff who have the expertise needed to launch services.** The program has selected staff with the background or expertise to provide program services. Programs facing challenges hiring staff may consider successful strategies employed by past grantees:

    - Consider networking among existing providers to identify appropriate staff.
    - Consider contracting with a community-based organization or specialty organization that could staff the role.
    - Consider telemedicine or remote approaches, when appropriate, which may increase the geographic area from which candidates can be recruited.
    - Consider whether there are retired individuals who may be willing to train a junior staff member until they are qualified for the role.

- ☐ **Program has identified referral pathways, established referral and eligibility criteria, and conducted outreach to referral partners.** The program has a plan to establish clear referral guidelines, protocols, and workflows with referral partnerships (e.g., local community organizations, health systems, or providers). Early misalignment in who is an appropriate program referral or confusing protocols can limit future referrals from strategic partners.

- ☐ **Program has a plan for continuous learning that allows them to monitor their success.** The program has identified measures to understand who the program served, the quality of the program delivered, and the effectiveness of the program at changing outcomes. The program has identified how this data will be collected, determined how frequently it will be collected, and established performance targets. Program leaders have a plan to regularly review this data with partners and staff to understand improvements that may be needed.

- ☐ **Program has piloted service delivery prior to scaling up**. Program has a plan to start with a small number of participants or referral partners, allowing them to refine operations or workflows and manage demand prior to scaling up.

- ☐ **Program has planned for sustainability.** Program leadership understands how services will be delivered after Well Being Trust funding is completed, including having a plan to secure any government contracts needed for reimbursement.

Adapted from Capacity Building Center for States. (2018). *Change and implementation in practice: Readiness.* Washington, DC: Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services. Retrieved from https://library.childwelfare.gov/cwig/ws/library/docs/capacity/Blob/121863.pdf?r=1&rpp=10&upp=0&w=+NATIVE(%27recno=121863%27)&m=1

Measurement Framework Tool Overview

Who should use the Measurement Framework Tool: The Measurement Framework Tool is for program leaders and staff as they are planning and developing their program.

Why use the Measurement Framework Tool: Developing a measurement framework can help you determine how to assess progress toward achieving outcomes, improve your program, and answer the questions that are meaningful to you.

How to use the Measurement Framework Tool: Once you have identified your outputs, outcomes and quality metrics, you can list each of these on the measurement framework in the first column. After you have listed each one, you can make a clear plan for assessing progress. This involves moving across the rows of the measurement framework from left to right to identify measures of change, data collection methods, data sources and data collection frequency for each outcome.

Key components of the Measurement Framework:

- **Outputs** are direct products of activities and may include number of individuals served or number of services to be delivered by the program.
- **Outcomes** are the immediate, intermediate and long-term changes or benefits you are trying to achieve. They could be patient outcomes, provider outcomes, clinical outcomes, or financial outcomes.
- **Targets:** Set a benchmark for your program to understand if the program has been successful or where improvement is needed. How many individuals do you intend to serve? How many services do you intend to deliver? What level of improvement do you expect among participants? This benchmark can change over time.
- **Measures** can be either numbers (quantitative values) or stories (qualitative) that can be used to assess whether progress was made.
- **Data collection methods** are the strategies for collecting data. This could include quantitative methods, such as conducting surveys or analyzing existing data, or qualitative methods, such as conducting interviews.
- **Data sources** are the locations from which (e.g., national database, program survey), or people from whom, (e.g., program participants), you will obtain data.
- **Data collection frequency** is how often you plan to collect data.

Considerations for developing a Measurement Framework:

- **Involve key stakeholders:** Develop your measurement framework in partnership with the individuals involved in the program's implementation. This includes those who will be collecting or synthesizing the data (e.g. program staff, health system analyst) and those who will be using the information (e.g. managers, health systems leadership). This will provide another opportunity to incorporate feedback from individuals with diverse perspectives.
- **Be realistic and creative:** Think through what kind of information you have access to when you identify measures. When programs' measures depend on data from outside organizations or other departments, it's often difficult to get access. Be creative about ways to collect similar measures.
- **Understand your capacity:** Be sure you have the needed resources (human power, skills, time, etc.) to collect and analyze data to measure the outcomes identified. If necessary, consider how you can acquire additional resources, personnel or training to do so.

- **Avoid reinventing the wheel:** Your program is innovative but it is likely that others have wrestled with how to assess similar programs' progress. Investigate how similar programs have learned about themselves and get help accessing validated assessment tools you can adapt.
- **Create a living document:** Your Measurement Framework is a tool for planning before launching your program, but should be regularly modified based on changes in your goals, activities, targets, organization's capacity or information gained from the data you are collecting. The goal is to be able to continuously learn about your own program and you get the most out of this data when you adapt your plan to program needs.

Measurement Framework Tool

Output/Outcome and Target	Measure	Data Collection Methods	Data Sources	Frequency of Data Collection
Specific outputs or changes you expect	How will you assess progress?	How will data be collected?	Where will data be obtained from?	How often will data be collected?
Reach – How do I know if I reached those who need this innovation?				
Number of individuals served Target:				
Estimated number of individuals in target population				
Effectiveness – How do I know if my innovation is working in the short term? How do I know if my innovation is working in the long term?				
Implementation – How do I know if the innovation is being delivered properly?				

Example Measurement Framework Tool

Output/Outcome and Target	Measure	Data Collection Methods	Data Sources	Frequency of Data Collection
Specific outputs or changes you expect	How will you assess progress?	How will data be collected?	Where will data be obtained from?	How often will data be collected?
Reach – How do I know if I reached those who need this innovation?				
Number of patients enrolled in therapy program Target: 1,000 patients/year	Number of patients who complete an initial assessment with a therapist	EHR	EHR	Data will be pulled by system analyst monthly
Estimated number of individuals in target population	Number of patients age 65+ in patient panel multiplied by estimate of depression in seniors	EHR; review of literature	EHR; review of literature	Data will be pulled by system analyst quarterly
Effectiveness – How do I know if my innovation is working in the short term? How do I know if my innovation is working in the long term?				
Improved patient depression scores Target: 23%	Percent of patients with clinically significant improvement in depression 12 weeks after enrollment in therapy	PHQ-9 administered by therapist	EHR	At each visit; data will be pulled my system analyst monthly
Improved patient anxiety scores Target: 25%	Percent of patients with clinically significant improvement in anxiety 12 weeks after enrollment in therapy	GAD-7 administered by therapist	EHR	At each visit; data will be pulled my system analyst monthly
Improved provider perception of resources to address mental health needs Target: 30%	Change in percentage of providers who "agree" or "strongly agree" that they have adequate mental health resources in their clinic	Survey	Providers in primary care practices launching the new therapy program	Before launching the new therapy program; 12m after launching the new therapy program
Implementation – How do I know if the innovation is being delivered properly?				
Program capacity Target: 30 visits/week/therapist	Number of therapy visits conducted per week	EHR	EHR	Data will be pulled by system analyst monthly
Patient completion of therapy program Target: 80%	Average length of time in therapy program Percent of patients completing at least 10 sessions of therapy Reason for disenrollment	EHR	EHR	Data will be pulled by system analyst monthly
Patient satisfaction Target: 85%	Percent patients that would recommend care at this clinic.	Survey	Patients	After each visit

Adapted from W.K. Kellogg Foundation. (2017). *The Step-by-Step Guide to Evaluation: How to Become Savvy Evaluation Consumers.* Retrieved from https://www.wkkf.org/resource-directory/resources/2017/11/the-step-by-step-guide-to-evaluation--how-to-become-savvy-evaluation-consumers.

Reach Assessment Tool Overview

Who should use the Reach Assessment Tool: The Reach Assessment Tool is for program leaders and staff to use during planning, implementation and evaluation of their program.

Why use the Reach Assessment Tool: Reach measures the extent to which a program was delivered to the identified target population and reasons why or why not. Reach helps answer the question "Did I reach those who need this innovation?"

Reach is an important metric for measuring the impact of population health strategies. It can provide an approach for thinking about and communicating the spread of programs and the need for these services by:

- Providing a measurable way to assess the extent to which programs reached their target populations.
- Informing refinements to the program design and outreach efforts to more effectively reach the populations and communities that the program intends to serve.

How to use the Reach Assessment Tool: Follow the prompts in steps 1-5 as they guide teams through assessing reach.

REACH ASSESSMENT TOOL

Step ❶: Define who your program intends to serve.

Who your program intends to serve is often referred to as your "target population". As you complete this step, consider the following:

- **Engage stakeholders.** Defining your target population creates an opportunity for health systems, funders and payors to begin a dialogue with program teams about what they want to accomplish together, who a program is targeted to (and why) and how a program will reach, in a highly inclusive way, that target population.
- **Consider starting narrowly.** Your target population can shift over time. Some programs initially launch services with a more focused target population in order to pilot the program, refine operations, and demonstrate effectiveness before scaling up. Think about:
  - Any focus based on payor type? E.g. Medicare or Medicaid beneficiaries.
  - Any focus based on geography or referral organization? E.g. referrals from a specific organization or hospital.
  - Any focus based on acuity? E.g. patients screening positive for severe or moderate depression.
  - Any focus on specific sub-populations? E.g. seniors, minority, or houseless patients.
- **Plan your outreach efforts.** Think through how you are going to connect to and engage this population. Develop screenings or other ways of systematically identifying the population and any sub-populations you intend to serve in a highly inclusive way. Clearly define and communicate any eligibility criteria to referral partners.

❶: Our program's target population is: _____

Example ❶: The Collaborative Care Program's target population is: Adult primary care patients in six clinics across two counties who screen positive for depression, with an initial focus on Medicare beneficiaries before expanding the program to all patients.

Step ❷: Estimate the size of your target population.

As you complete this step, consider the following:

- **Estimating your target population is challenging.** If this step seems difficult, that is because it is. This is a step where many newly launched and established programs struggle.
- **Approximate.** Calculating the estimated size of your target population is still valuable for program planning, refinement, and communicating impact, even if it is an approximation. Some programs estimate a high and low range of their target population size based on different assumptions.
- **Use a mix of program data and publically available data.** Depending on your program, there are often publically available data sources that can help you estimate the size of your target population, even if they are not from your county or state. Here are some sources to explore: Peer-reviewed literature, California Health Foundation's Health Care Almanac or California's Office of Statewide Health Planning and Development's Emergency Department Data.
- **Set a target reach goal:** Based on the size of the target population, set a benchmark or target percent that you intend for your program to serve.

❷: Our program's estimated target population size is:_____

Description of how ❷ is estimated: _____

Example ❷: The Collaborative Care Program's estimated target population size is: Initially, between 7,918 and 13,857 patients when the program is focused on Medicare beneficiaries.

Example description of how ❷ is estimated: The Collaborative Care Program leaders asked the health system for the number of adult patients who had at least one visit in the past 12 months from the six clinics, which was 329,935 patients. Program leaders knew that on average, 30% of the patients in these clinics are Medicare beneficiaries. They did not know how many of their patients would screen positive for depression, so they reviewed the peer-reviewed literature to estimate this. They found an article that estimated 12-month prevalence of depression among adults in primary care setting between 8%-14%.

Calculation: Total number of adult primary care patients in the six clinics who have had at least one visit in the previous 12 months (n=329,935) multiplied by proportion of Medicare beneficiaries (30%) multiplied by estimated 12-month prevalence of depression among adults in primary care setting (8%-14%).

Step ❸: Track how many individuals your program serves.

As you complete this step, consider the following:

- **Define "served".** Clearly articulate what it means to be served by the program. This will be specific to your program design, but could mean program participants that attended a training, those that enrolled, were admitted, or screened.
- **Design easy to use tracking.** Before the program launches, identify where this data will come from, how it will be updated, and who will be responsible. Some programs use simple excel spreadsheets. Avoid using word documents, as this will make aggregation over time challenging.
- **Track unique participants.** Depending on your program, participants could be "served" multiple times (e.g., admitted multiple times to a residential detox facility). Develop tracking systems that are able to identify the number of unique individuals served, as this will make your reach estimates more accurate.
- **Collect participant demographics.** Depending on the focus of your target population, you may consider collecting participant demographic information (e.g. race, ethnicity, gender, disability status, housing status, etc.). Unless these demographics are collected, your program will not have the information needed to identify and understand how to close gaps where disparities appear.
- **Set a timeframe.** Consider a time period that makes sense for your program and align it with your target population estimate, e.g. participants served over a 12 month period.

❸: Our program served _____ individuals over _____ time period.

Description of how ❸ is defined: _____

Example ❸: The Collaborative Care Program served 1,276 patients over a 12-month time period.

Example description of how ❸ is defined: The Collaborative Care Program defined a patient as "served" or "participated" when the patient enrolled in the Collaborative Care Program and attended at least one session with a therapist. This data will be extracted monthly from the Electronic Health Record.

Step ❹: Estimate program reach.

Reach is calculated as the number of individuals served by the program divided by the estimated target population, or $\frac{❸}{❷}$

❹: Our program reached _____ of the population the program intended to serve.

Calculation of ❹: _____ =_____.

Example ❹: The Collaborative Care Program reached between 9-16% of the population the program intended to serve.

Example calculation of ❹: $\frac{\text{1,276 patients}}{\text{Between 7,918 and 13,857 patients}} = \text{9-16\%}$

Step ❺: Reflect and iterate.

Estimating reach is a conversation starter, not a box to check. As you complete this step, consider the following:

- Refine your reach goal: Did your program meet its target reach goal? Adjust and refine your reach goal over the longer term.
- Examine who your program is not reaching: Are there disparities in who your program has reached (e.g. by race, ethnicity, gender, etc.)? What methods will you use to engage underserved populations? How can you build relationships with your community to improve your reach to these populations?
- Reflect on program design: Programs make intentional or unintentional decisions when structuring programs or launching services that both limit and facilitate their reach. Relationship building with referral partners or physical proximity to referral partners can improve reach, while staffing shortages and limits on the types of payors or patients served by the program can limit reach. Describe any planned changes to program design or outreach efforts. How will these changes improve reach efforts?
- Iteratively measure reach: Assessing reach over time can foster ongoing discussions about how your program will be implemented to connect with the population to foster inclusivity and help clarify how these decisions affect patient or community access to your programs.

Adapted from Balasubramanian, B. A., Fernald, D., Dickinson, L. M., *et al*. J. (2015). REACH of interventions integrating primary care and behavioral health. *The Journal of the American Board of Family Medicine*, 28(Supplement 1), S73-S85.

Implementation Costs Assessment Tool Overview

Who should use the Implementation Costs Assessment Tool: The Implementation Costs Assessment Tool is designed for program leaders during implementation of a new program in either the clinical or community setting.

Why use the Implementation Costs Assessment Tool: Cost and other resources required are often primary considerations in whether a potential program or policy will be adopted or implemented and is an important element in determining value. Understanding costs from the perspective of the clinic or community organization implementing a program can help organizations or health systems plan for the resources required to scale up or spread the program in the future.

How to use the Implementation Costs Assessment Tool: This tool can be used prospectively and iteratively during program delivery, and preparation for communicating program impact. It is designed as a pragmatic guide for understanding and estimating time and economic costs, not as a rigorous or costly economic evaluation.

Participants are encouraged to fill out the cost templates relevant to them and select the costs within each template that apply to the program or policy being implemented. If the program is being implemented at multiple sites, each site should complete an implementation costs assessment. These templates are designed to be filled out by participants with minimal instructions and can be completed in interview format, or used as a template for tracking cost data over time.

IMPLEMENTATION COSTS ASSESSMENT TOOL: CLINIC, WORKSITE, OR LOCAL COMMUNITY GROUP PERSPECTIVE

This template estimates costs to the clinic, worksite or local community group beyond the time costs of staff implementation.

This cost data collection template is designed to estimate the resources associated with the implementation of a given program. It is meant to be edited and adapted to enable you to best capture time and resources relevant to your program. Your best guess is sufficient here. If helpful, you can also use a combination of observation of activities, interviews with staff and financial records of the organization to approximate costs.

Worksite, clinic, and local community group	Approximate Costs
Number of new employees hired (program-specific)	
Average cost of hiring a new employee (if available from Human Resources)	$
Training costs (cost of training program and/or staff time to deliver training, travel)	$
Costs of program related equipment (only include what is not already used for current role) –e.g. computers, tablets, phones, hardware	$
Software, licenses (only include what is not already used for current role)	$
Travel expenses (specific to the implementation process) Note: Exclude trainee time costs if included in staff time above	$
Cost of materials specific to the program (e.g. marketing materials, rental equipment, use of space that is not already available [e.g. renting space outside the clinic or office location; do not include overhead or indirect costs])	$
Total Costs	$

IMPLEMENTATION COSTS ASSESSMENT TOOL: CLINICIAN OR PROGRAM DELIVERY STAFF PERSPECTIVE

The cost data collection template on the following page is designed to estimate the resources associated with the implementation of a given program. It is meant to be edited and adapted to enable you to best capture time and resources relevant to your program.

The program staff member in each location who has the best knowledge of the program in your setting should provide the information requested in the template.

- In some cases, different persons may need to complete different sections.
- The program staff member collecting the data should primarily rely on their knowledge and understanding of the program in their location to fill in the estimates below.
- Do not worry about having to be precise: Your best estimate is sufficient.
- If helpful, you can also use a combination of observation of activities, interviews with staff and records of your organization to approximate costs.
- For each job title, add the total number of hours per person per week. Next, multiply the number of hours per week by the number of implementation staff. To quantify staffing costs, multiply this figure by the average hourly rate for each job title.

Clinician or Program Delivery Staff							
Staff Time: List all hours per week							
Job Title **(Customize to fit the staff makeup of your program)**	**Physician**	**Medical Assistant**	**Front office staff**	**Billing/ coding**	**Care Manager (Health educator; patient navigator)**	**Behavioral Health Provider**	**Other roles (please specify)**
Number of staff who deliver the program with each job title							
Average hourly rate (including benefits)	$	$	$	$	$	$	$
Time spent attending meetings (include implementation team meetings, development, staff meetings related to implementation, other relevant activities)							
Training and supervisions related to program (or other phases - planning, follow-up)							
Recruitment (including patient/ client screening and recruitment)							
Assessment (including all enrollment data collection and entry)							
Program Implementation - Time for notes, charting, preparation for meetings - Patient/client training - Coordination of services (pharmacy, labs, etc.), - Program delivery documentation or quality control - Other activities directly related to program delivery							
Total hours per week (number of hours per week multiplied by the number of implementation staff)							
Staffing costs (multiply total hours per week figure by the average hourly rate for each job title)	$	$	$	$	$	$	$

Total costs per week $ _____

Adapted from Jones Rhodes, W.C., Ritzwoller, D.P., Glasgow, R.E. (2018). Stakeholder perspectives on costs and resource expenditures: tools for addressing economic issues most relevant to patients, providers, and clinics. *Translational Behavioral Medicine*, Volume 8, Issue 5, Pages 675–682.

Partnership Assessment Tool Overview

Who should use the Partnership Assessment Tool: The Partnership Assessment Tool is for leaders, partners, and staff involved in multi-sector collaborative initiatives.

Why use the Partnership Assessment Tool: The Partnership Assessment Tool can be used to assess the functioning of a partnership or coalition over time. Results from the tool can be used to highlight successes, document progress, and identify areas of improvement in how partners work together.

How to use the Partnership Assessment Tool: Leaders, partners, and staff involved in the partnership or coalition should independently answer the questions. The partnership can consider collecting data anonymously. This assessment tool can be modified for use by specific partnerships – adding, modifying, and removing questions as it makes sense. Using the tool at multiple time points allows a partnership to track changes over time in its collaborative effectiveness. Results should be aggregated and used to facilitate a conversation among partners about what is working well in the collaborative partnership, and areas in which improvements can be made.

PARTNERSHIP ASSESSMENT TOOL

You are receiving this survey because you are a member of [Initiative]. The purpose of the survey is to understand the strengths of the collaborative effort and to identify opportunities for improvement. Your honest feedback is appreciated. Your responses will not be attached to your e-mail address, your name, or your organization.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
Common Goals Partners have a clear understanding of what [Initiative] is trying to get done.						
1. [Initiative] has clearly stated its goals.						
2. Partners understand [Initiative]'s goals.						

If you responded "disagree" or "strongly disagree" to any of the above, please explain.

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
Membership and Engagement The right partners have been engaged and have created an environment where participation is encouraged.						
3. [Initiative] has recruited diverse people and organizations into the partnership.						
4. The right people and organizations are represented to ensure success.						
5. [Initiative] has fostered respect, trust, inclusiveness, and openness in the partnership.						
6. The level of participation in meetings from partners is appropriate.						
7. Partners communicate well with each other.						
If you responded "disagree" or "strongly disagree" to any of the above, please explain.						

Clarity of Roles & Responsibilities Roles and responsibilities of partners are clear.						
8. Partners understand their roles and responsibilities.						
9. Partners actively plan and implement activities for which they are responsible.						
If you responded "disagree" or "strongly disagree" to any of the above, please explain.						

Shared Decision-Making Power Partners understand and support how decisions are made.						
10. I feel ownership in the process used to identify and prioritize the work done by [initiative].						
11. I support the decisions that have been made by [Initiative].						
If you responded "disagree" or "strongly disagree" to any of the above, please explain.						

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
Administration & Management [Initiative] has the processes in place to effectively manage and support our activities.						
12. [Initiative] has mechanisms to make decisions, e.g., voting.						
13. [Initiative] effectively coordinates communication among partners.						
14. [Initiative] organizes regular, structured meetings.						
15. [Initiative] appropriately resolves conflict.						
16. [Initiative] allocates resources fairly.						
17. [Initiative] evaluates the progress and impact of its programs.						
18. [Initiative] effectively applies for and manages grants and funds.						
If you responded "disagree" or "strongly disagree" to any of the above, please explain.						

Synergy We are working in a way that will build a strong and effective network.						
19. [Initiative] identifies new and creative ways to solve problems.						
20. [Initiative] includes the views and priorities of the people affected by [Initiative]'s work.						
21. [Initiative]'s activities respond to the needs and problems of the community.						
22. [Initiative] implements strategies that are likely to work in the community.						
23. [Initiative] carries out comprehensive activities that connect multiple services, programs, or systems.						
24. [Initiative] supports meaningful collaboration among members from different backgrounds.						
25. [Initiative] obtains support from individuals and community organizations that can either block [Initiative]'s plans or help move them forward.						
If you responded "disagree" or "strongly disagree" to any of the above, please explain.						

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	N/A
Mutual Benefit and Drawbacks There is value to my organization as a result of my participation in [Initiative].						
26. Participating in [Initiative] enhances my ability to address an important issue.						
27. Participating in [Initiative] increases utilization of my expertise or services.						
28. Participating in [Initiative] provides me useful knowledge about services, programs, or people in the community.						
29. Participating in [Initiative] enhances my ability to affect public policy.						
30. Participating in [Initiative] allows me to have a greater impact than I could have on my own.						
31. Participating in [Initiative] allows me to develop valuable relationships.						
32. Participating in [Initiative] enhances my ability to meet the needs of my patients/clients.						
33. Other benefits, please describe.						
34. Participating in [Initiative] diverts time and resources away from other priorities or obligations.						
35. My organization has insufficient influence in partnership activities.						
36. Participating in [Initiative] results in conflicts between my organization's work and the partnership's work.						
37. Other drawbacks, please describe.						
38. The benefits of participating in [Initiative] exceed the drawbacks.						
39. Is there anything else you would like to add?						

Adapted from

- Center for the Advancement of Collaborative Strategies in Health. (2002). Partnership Self-Assessment Tool Questionnaire. Retrieved from https://www.nccmt.ca/knowledge-repositories/search/10
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- Butterfoss, FD. (1998). Coalition Effectiveness Inventory (CEI). Norfolk, VA: Eastern Virginia Medical School. Retrieved from http://coalitionswork.com/wp-content/uploads/coalition_effectiveness_inventory.pdf

Program Sustainment Assessment Tool Overview

Who should use the Program Sustainment Assessment Tool: The Program Sustainment Assessment Tool is designed for Well Being Trust staff to understand the extent to which piloted programs and services continue to be sustained after Well Being Trust funding ends. The assessment is intended to be completed by grantee teams 6-12 months after the project period is over. The assessment can also be used during program implementation to monitor a program's progress towards sustainment.

Why use the Program Sustainment Assessment Tool: This tool was designed to assess programs of different types and with different foci, enabling comparisons across both clinical and community settings. Understanding which of the Well Being Trust programs continued to deliver services and/or maintained financial solvency in the longer-term would better position Well Being Trust to advocate for the scale and spread of promising models. Understanding which programs were unable to maintain funding or continue to deliver services could support Well Being Trust in advocating for needed changes to federal and state funding streams.

How to use the Program Sustainment Assessment Tool: Well Being Trust staff may consider implementing the assessment using an online survey, or via a brief phone conversations with a contact at the grantee organization.

PROGRAM SUSTAINMENT ASSESSMENT TOOL

The following questions are designed to better understand the sustainability of your Well Being Trust-funded program. Please respond to the following statements relating to [insert name of program] using a scale ranging from 1 = to a little or no extent to 5 = to a great extent.

If this program no longer exists or no longer provides services, please answer N/A to all items. If you feel specific statements are not relevant to your program (e.g., community partnerships section), answer N/A.

	To a little or no extent		To a moderate extent		To a great extent	N/A
Program Sustainment	**1**	**2**	**3**	**4**	**5**	**N/A**
1. The program continues to operate as described in the original application for funding.						
2. The program continues to deliver services to its intended population.						
Funding and financial support						
3. The program has sustained funding.						
4. The program is financially solvent.						
5. A portion of program operating costs are covered by a health system or community benefit office.						
Coalitions, partnerships, and networks						
5. Community members are actively engaged in the development of program goals.						
6. The program is supported by a coalition/partnership/ network of community organizations.						

	To a little or no extent		To a moderate extent		To a great extent	N/A
7. Coalition/partnership/network members actively seek to expand the network of community organizations, leaders, and sources of support for this program.						
8. The coalition/partnership/network is committed to the continued operation of this program.						
9. There is a high level of networking and communication within the organizations responsible for sustaining the program.						
Infrastructure and capacity to support sustainment						
10. The program is well integrated into the operations of the organization and its partners.						
Implementation leadership						
11. The program has a formally appointed person responsible for coordinating the process of implementing and sustaining the program.						
12. The program has a process in place to sustain the program in the event this person leaves.						
Data and evidence of positive outcomes						
13. There is sufficient and timely feedback or data about the program delivery to maintain or improve quality.						
14. The program provides strong evidence of positive outcomes.						

Adapted from Palinkas, L.A., Chou, C., Spear, S.E. *et al.* (2020). Measurement of sustainment of prevention programs and initiatives: the sustainment measurement system scale. *Implementation Sci,* 15, 71.

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Well Being Trust is an impact philanthropy dedicated to advancing the mental, social, and spiritual health of the nation. Created to include participation from people and organizations across sectors and perspectives, Well Being Trust is committed to innovating and addressing the most critical mental health challenges facing America, and to transforming individual and community well-being.

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