CITIZEN PARTICIPATION
IN HEALTH PLANNING
A CASE STUDY OF CHANGING DELIVERY SYSTEMS

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ABSTRACT

A community health planning initiative in three separate counties that brought together consumers, health care providers, and purchasers of health insurance is evaluated in light of the literature on citizen participation. The literature review covers seven topics: systems change, knowledge transfer, civic engagement, inclusion, community decision making, project organization, and project leadership. The paper then explores how the three communities and the funding agency dealt with these issues in their efforts to plan for an integrated health delivery system with increased community-wide coverage and access in the post-Clinton Health Plan era. The lesson learned is that a citizen-based health planning effort may require substantial technical and staff support as well as ongoing leadership training.
INTRODUCTION

Citizen participation is a process in which individuals take part in decision making in the institution, programs, and environments that affect them (Wandersman 1984). The goals of citizen participation are to improve programs, to increase their responsiveness to people's needs, and to gain community acceptance. In the United States citizen involvement in a democratic planning process seeks to restrain experts and policymakers from designing and implementing programs that do not take local opinion into account (Selznick 1949; Weinstein 1997). In particular, it assures that planning is not centrally coordinated, but rather attempts to meet real community needs. Planning efforts may be supported by public, private, or nonprofit organizations.

From the mid-1960s through early 1980s citizens were directly involved in the planning of regional health systems (Checkoway 1981) and on the governing or advisory boards of community-based health centers and services. Then, beginning in the late 1980s, major foundations such as Robert Wood Johnson, Kaiser, and Kellogg became interested in improving primary health care and delivery. The W. K. Kellogg Foundation's Comprehensive Community Health Models (CCHMs) was one of several projects funded to improve community health systems through citizen participation in a health planning process.

This paper is based on the cluster evaluation\(^1\) of the CCHMs initiative. The next section presents an overview of the CCHMs. The second section is a brief review of the literature on citizen participation in health planning.\(^2\) The third section discusses the CCHMs model for health reform relative to the reviewed literature. The paper concludes with a set of lessons learned from the CCHMs attempt at health planning in the post-Clinton Health Plan era.

EVOLUTION OF THE CCHMS

The CCHMs called for the creation of community partnerships that would bring together consumers, health care providers, and purchasers of health insurance in a planning effort aimed at increasing access to health care services in their counties. These stakeholders were expected to strengthen local control over health policy by jointly developing plans for restructuring their community's health care delivery system and ultimately improving the health status of the residents. The Kellogg Foundation identified three medium-sized counties with medically under-served groups and populations between 100,000 and 200,000. These counties, which we will call Oldtree, Linchpin, and Beehive, each had two or three hospitals, a few large businesses, a union presence, and several civic organizations. Most important, these counties had a history of voluntary community action to resolve problems. They were also communities in which activities and changes in health care delivery might be expected to be noticeable and attributable to the program.
Citizen Participation

The CCHMs initiative sought a neutral convener (see Gray 1989), that is, a community-based group that could bring together consumers, health care providers, and those who purchase health insurance without being overly identified with one set of stakeholders. Community foundations were identified as a reasonable and appropriate body to be the recipient of the grant. Representatives of the community foundations in the three counties were invited to separate meetings to explore the possibility of becoming a CCHMs community. As a result, the community foundations agreed to hold a series of public forums and private meetings on health care issues and reform in their counties. These foundations were ultimately expected to convene a representative county-wide steering committee and develop a Community Health Investment Plan (CHIP) which would describe how the community would implement its version of a Comprehensive Community Health Model.

To facilitate this process, the W.K. Kellogg Foundation provided funding for a 12- to 18-month planning phase to help the communities: (1) learn more about the nature of their health care problems and system, (2) establish priorities, and (3) propose programs that would expand access and improve the integration, coordination, and effectiveness of health services. Each community was expected to contribute funds or in-kind support for the planning phase.

The CCHMs planning phase started in the spring of 1994 and ended in the summer of 1996. The initial idea for CCHMs began several years earlier during a period of rapidly rising health care costs and the call for national health care reform. However, with the demise of the Clinton Health Plan, the Kellogg Foundation again saw a role for local rather than national or regional health planning. The CCHMs initiative had three core objectives. One was a comprehensive, integrated delivery system designed to improve the health status of residents by emphasizing preventive and primary care and linking the medical care services with human services. The second was community-wide coverage assuring that all residents will be eligible for health benefits and have access to appropriate, affordable, quality health care resources and services. The third objective was citizen participation through a broadly based and representative steering committee and set of workgroups responsible for the planning effort and in a position to oversee its implementation. As a community-intensive model, CCHMs were advanced on the premise and necessity that community stakeholders and leaders would be committed to the fundamental change of their health care system.

CITIZEN PARTICIPATION IN HEALTH PLANNING:
AN OVERVIEW

The literature on citizen participation in health planning highlights at least seven major topics. These include systems change, knowledge transfer, civic engage-
ment, inclusion, community decision making, project organization, and project leadership. This section presents a brief overview and discussion of these topics, from the most general to the more specific.

Systems Change

Shaheen and Perlstadt (1982) suggested that systems change can be the result of one of two processes. One is an inside-outward attempt at change where a person or community initiates change, on their own behalf, from within. The second process is an outside-inward effort where forces external to a community, such as the federal government or large private foundations, attempt to affect change (Arne
stein 1969; Langton 1978; Wandersman 1984). In the first scenario, the need, extent, and type of change is determined by those closest to the situation, those most directly affected by it. In the latter, the program objectives and methods do not arise out of the expressed desires of the local community, but rather are determined by the funding agency. As a result, the funding agency and the local community often do not see eye to eye and must make adjustments for the program to continue (Selznick 1949).

The literature raises the question of whether and how an externally initiated effort can successfully engage the local community. For example, many agency and program administrators are ambivalent about citizen participation (Langton 1978), or prefer to coopt the grass roots leaders (Selznick 1949). To overcome this problem, Tye (1973) proposed identifying political linkage agents who would mediate power relationships between dominant decision-making bodies and their corresponding constituents or user groups. Citizens also tend to be ambivalent about their participation and confused about their purpose on committees and boards (Bates 1983; Wandersman 1984). Wandersman (1984) also emphasized that simply mandating citizen participation does not provide the strategies, training, or motivation to develop effective participators.

According to Havelock and Havelock (1973), change agents are likely to play some combination of four roles in attempting to achieve their goal. For instance, they may serve as a catalyst to get the system moving and encourage people to develop solutions. The change agent may be a solution giver that has some set ideas about how to approach and resolve a situation. Change agents may also function as process helpers that facilitate the learning process for people involved in an initiative. Lastly, a change agent may be a resource linker that makes sure that participants are capable of using the variety of resources at their disposal.

Overall, in reviewing the literature on systems change, we found five precursors to successful citizen involvement in health planning (Havelock and Havelock 1973; Tye 1973). First, the external change agent must be willing to play multiple supportive roles. Second, there must be some attempt to balance power between the dominant influential stakeholders and the usually voiceless groups coming to the table. Third, one of the sub-goals is to create a collaborative process for policy
formulation. Fourth, once the playing field is level, there is a greater likelihood that the management of the change process will be shared by those involved. Fifth, the community entity working toward change eventually seeks to sustain itself through institutionalization.

Knowledge Transfer

One cannot assume that citizens come to participate in planning processes with equal amounts of, or even any, knowledge about the entity or process to be changed. The type of knowledge needed is also difficult to predict. Consumers in some health care systems, such as those in Europe and Japan, participate in integrated and sequentially linked health services, from neighborhood clinics to area-wide hospitals to tertiary care national medical centers (Anderson 1989; White 1995). Presumably, the knowledge they need is similarly straightforward. In contrast, American consumers face a complex health care system with a multitude of insurance plans, little consistent oversight and regulation, and extensive competition within and among health care providers, government, employers, and employee organizations. The recent trend toward corporatization and managed care franchise systems, while understood as the free market's response to cost containment, has done little to simplify either the health care system or the knowledge needed by the consumer or purchaser of health insurance.5

Given differentiated information needs, how can one actively and sincerely involve citizens in the health planning process, and ensure that they have the necessary information to participate meaningfully? Doty (1980) found that knowledge transfer often begins with an exchange of individual experiences and value judgments. While sharing stories may foster group cohesion, it does not necessarily result in a shared understanding of how the health care system actually works. Rather, such anecdotal information must be augmented with cold, hard facts and straightforward prescriptions and mechanisms for change (Doty 1980; Wandersman 1984).

Indeed the research suggests that participants in health planning processes must be given concrete, practical information on the how-to's of health care reform. This includes information on the financing, operation, and mechanisms of the delivery system. However, this information must be presented in a manner that is easily digestible, understandable, and useful. If participants feel that the information will be helpful and meaningful, then they are more likely to both master and apply it to their own situations (Doty 1980; Havelock and Havelock 1973). It is also important to note that information should be provided to all participants, staff as well as volunteers, to ensure a comparable knowledge base.
Civic Engagement

Civic engagement is a crucial part of creating a community of shared experiences and reciprocal relationships that enables a group of people to develop and select programs that match their needs and values (Langton 1981; Wandersman 1984). However, a major obstacle to civic engagement is that relatively few people participate and those that do participate are not always representative of the population. This raises the questions: why don’t more people participate? and if they did, would it matter? In general, unless sufficiently motivated, many people will simply choose not to participate in any activity aimed at achieving some common good (Buchanan and Tullock 1971; Olson 1965). Furthermore, even those so inclined to participate pay a high cost in demands on their time, energy, and thought processes.

Simply increasing participation rates does little if those involved are not adequately representative of the populace. This potential disconnection between the better educated, middle- to upper-income participants and the general population is not inconsequential. It can be a major stumbling block to effective and meaningful civic engagement (Bates 1983; Doty 1980). However, an outside change agent functioning as a resource linker or political linkage agent can make a difference (Havelock and Havelock 1973; Tye 1973). This individual or entity can help to establish the necessary linkages to ensure that those who participate are as representative as is technically and politically feasible in a given community and/or situation.

Inclusion

The issue of inclusiveness is not whether citizens or consumers should be part of a democratic decision-making process, but rather which citizens or consumers should be involved, how they should be selected and the implications of this for the desired outcomes of the program or initiative. Election and appointment represent two of four possible methods for selecting citizen participants. Individuals can also be self-selected or chosen to represent some community or consumer organization (Doty 1980). Whatever the method of selection, the process should be well known and clear to the community and consumer groups which would be involved. A variety of individuals and groups must be able to affect the selection process. Furthermore, consumer representatives or delegates must be accountable and responsible to the group they represent or were chosen by (Citizens’ Board 1972).

While voluntary health planning at the local level has existed in the United States for some time, it has generally been dominated by the local health facilities and agencies, and carried out through interorganizational professional and business groups affiliated with them. These efforts did incorporate considerable consumer and citizen participation. But despite a variety of mechanisms for
broadening representation, the participants tended to be members of the business, professional, and managerial elites who also served on the boards of voluntary charitable and civic associations (Doty 1980). Yet even these well-informed citizens were overwhelmed by the number of meetings they were expected to attend, the amount of information they had to comprehend, and the personal time and expense they incurred (Bates 1983).

Decision Making

The literature presents two reasons for creating a joint decision-making process that brings consumers and purchasers together with providers. One is to design better programs and systems that are more effective and efficient in meeting the needs of the community. The other is to provide a check against elitism by creating a community of shared experiences and reciprocal relationships (Langton 1981; Wandersman 1984).

Several problems confront attempts to create a joint or shared decision-making process. One key issue is the capacity to build consensus. Bringing all stakeholders to the table may introduce hidden or alternative agendas that could side track or stymie the mission. A second issue is whether citizen input is advisory or governing. If it is governing, one must also be clear as to what is being governed.

A third key issue is the size of the decision-making body. It is necessary to consider the likely effect of board size on both processes and outcomes. Estimates of reasonable sizes for decision-making bodies range from five to 70 (Caplow 1976; Houle 1990). The advantage of a small board is that it can act as a deliberative body. However, care must be taken to ensure that the board is large enough to get the job done. Larger boards allow for more participation and thus have the potential to be more representative. They also increase coordination problems and introduce considerable time constraints (Bates 1983; Locke and Schweiger 1990).

Project Organization

Advocates for change are often more ideological and value oriented than pragmatic and performance oriented (Weber 1947). Initially community groups tend to prefer a more informal, non-bureaucratic structure (Rothschild-Whitt 1976). Some groups do over time, however, experience a need to shift to a more formalized structure with staff support and some source of funding (Citizens’ Board 1972; Riger 1984). Staff can provide invaluable services to volunteers. They present an opportunity to assemble and disseminate information, and perform a host of other functions that can increase the efficiency and quality of volunteer work. Often times, they may possess the skills, expertise, or time to accomplish tasks that are beyond those of citizen boards and committees (Citizens’ Board 1972; Doty 1980; Yin et al. 1973).
The need for external funding furthers the formalization of community processes. Even so, care must be taken to balance the funding and goals of the donor(s) with the needs, goals, and desires of recipient projects (Williamson 1985). Many funded projects enjoy relative autonomy and only occasional oversight by the funding or sponsoring agency. Quarterly reports are submitted, one or two site visits made, and an annual networking meeting held that brings together staff and citizen participants from all the sites. Intervention occurs only during a crisis when the local project is unable to self correct or is clearly going down the wrong path. In contrast, the projects could be run as branch offices with limited autonomy. A regional office has oversight responsibilities and can intervene more easily than the central office. The sites then try to establish a buffer between the funding or sponsoring agency and themselves.

Project Leadership

The literature highlights two aspects of leadership in citizen-driven projects. First, newly formed groups, such as planning partnerships, may respond better to an emergent leader than a designated leader or project director. Emergent leaders actively involve participants and subtly take charge of situations when necessary to move groups and processes forward (Guetzkow 1968; House and Baetz 1990; Maier 1970; Trice and Beyer 1993). Second, an empowering or supportive leader promotes cohesion and involvement among all members in the decision-making process. This person’s style, networking capabilities, and visibility can effect the flow, direction, and success of a project (Prestby and Wandersman 1985; Kumpfer et al. 1993). Thus emergent and supportive leadership is crucial to citizen participation.

THE CCHMs MODEL OF CITIZEN PARTICIPATION IN HEALTH PLANNING

This section presents the case study of the CCHMs initiative in light of the seven critical issues for citizen participation in health planning. The discussion goes from the specific to the more general. It describes and analyzes how the three communities dealt with project leadership and organization, decision making, inclusion, civic engagement, and knowledge transfer. Finally, it discusses how all these factors, as well as actions of the W.K. Kellogg Foundation contributed to an effort to achieve systems change.

First, however, it is necessary to describe the innovative program management approach taken by the Kellogg Foundation. The CCHMs initiative was committed to systems change through a democratic planning process. If this was to be successful, the initiative would need to deal with local decision makers and the health policy arena in a variety of ways. The foundation, therefore, established an operations office staffed by a director with health policy experience and an associate
director who had worked as a consultant on a broad range of community organization, coalition building, and service delivery programs. The operations office would, in turn, hire consultants who would provide technical assistance in the areas of health law/legislation, medical care financing, health care delivery systems, administration/project management, ethics, and governance/decision making.

As a separate entity, the operations office would be able to take a more proactive, directive, and policy-oriented role in the CCHMs initiative. Specifically it would help the communities pursue requests for any federal and state waivers and approvals needed to implement their community health improvement plans. It would also inform the general public and policymakers about the initiative. In creating the operations office outside the Kellogg Foundation, the CCHMs initiative added a level of supervision and oversight that approaches the branch office model. By the end of the planning phase, the operations office was in frequent contact with the three project directors and highly involved in reviewing the work of the cluster evaluation.5

Project Leadership and Organization

A traditional procedure for finding community leadership is for a small group of influentials to approach an individual with prior volunteer activities or service who would be able to call upon his or her business or organization for staff support, and encourage him or her to become the project champion. This is a fairly non-bureaucratic structure. But coalitions or partnerships that are formally created by granting agencies face the dual challenges of identifying leaders and creating a local organization since the individuals who might spontaneously organize in response to specific community problems have not voluntarily done so (Olson 1965; Nownes and Neeley 1996).

The Kellogg Foundation, which supports community-driven projects, earnestly desired that participative leaders emerge and become champions for their community’s health improvement plan and subsequent implementation projects. This would be accomplished by gaining the commitment of community leaders, creating a team to launch the project, and building an operational structure for the project (Joint Commission 1994). The CCHMs initiative chose to work through the local community foundations which, in turn, selected the initial steering committees and proposed an organizational structure for the project. In addition, the CCHMs project brought with it both a set of goals and sufficient outside funds to support a small staff. The dynamics of these leadership and organizational factors were played out within the general decision-making context of each county.

Each of the CCHMs sites experienced some sort of shift from communal to associative groups and dealt with it differently. In Linchpin County, a previously funded Kellogg community-based health project had an informal structure with a facilitator and a small group of committed participants who would share the work and utilize consultants as needed. The CCHMs initiative expanded the core group,
and the facilitator of this earlier project became the CCHMs project director. The site was able to hire a staff that had experience in health planning and program implementation. The staff was also capable of serving a support function, which in turn lowered the cost on volunteer leadership, as well as demands on their time and resources. In fact, the staff carried the ball and was able to balance out the conflicting demands of the county influentials, the claims of consumer participants, and their own managerial and professional judgments.

The staff in Linchpin County created and maintained a participatory decision-making process, leaving the volunteer leader (a top management person in a leading manufacturing company) with the routine tasks of chairing meetings and signing documents. Eventually an executive committee was created and the membership base expanded. As it made its coordinating mission clear, the site became the target of requests for support from other groups and had to establish a set of rules and procedures for handling them. The site developed an internal structure—hierarchy, division of labor, business accountability—in order to deal with its external environment and the requests for support, collaboration, and outreach. It also attempted to maintain its autonomy from the operations office. Because it had its own staff, the Linchpin site insisted on its own terminology, claimed it was already doing things, and could not coordinate with the other sites which lagged six to nine months behind. Because it had its own stable of consultants, Linchpin could ignore some of the consultants made available through the operations office yet make requests for others to fill in the gaps.

The Oldtree site tried to develop an informal, non-bureaucratic volunteer structure. This site did not hire a project director but rather a facilitator. The facilitator was expected to supplement the efforts of the volunteers who would take it upon themselves to set the agenda, lead the meetings, take minutes and write reports. Two prominent professionals from the legal and health sectors were appointed co-chairs for the steering committee. Both appeared to be more behind-the-scenes types who were not comfortable running public meetings. Finally, the hand picking of workgroup chairs by the Oldtree Community Foundation and CCHMs steering committee was expected to result in a smooth running project with little disagreement.

As it turned out, the amount of coordination and support needed for the executive group, the steering committee, and five workgroups overwhelmed the facilitator. In addition, the two co-chairs were either on vacation or out of town for what seemed to be extended periods of time. As a result, the workload fell upon the workgroup chairs. Several workgroup chairs began holding informal coordinating meetings and tried to build an infrastructure. But when the steering committee co-chairs returned, they essentially quashed the emerging leadership, not only because it was a potential threat to the county influentials, but because the workgroup chairs were moving the initiative in a direction away from systemic change.

The CCHMs project in Oldtree County, then, was caught between the constraints imposed by the small philanthropic circle in the county, on the one hand,
and the advice of the operations office and CCHMs consultants, on the other. The site resisted the pressures to shift to a more bureaucratic formalized structure but finally had to hire a project director (who had a background in health planning) and additional staff to complete the planning phase. Participatory leadership was never able to establish itself and the health improvement plan was finally written by a small select committee after the full-time project director was hired.

The third county, Beehive, had a more egalitarian, behind-the-scenes way of identifying leaders for voluntary, public interest, and community service groups. An informal network of business and civic leaders would discuss an issue and either a leader would emerge or they would settle on an obvious group to take the lead. The others would then provide in-kind support and resources as appropriate. The sponsoring Beehive Community Foundation hired its own first executive director and assigned CCHMs as a start-up project. A part-time staff was hired that was capable of support functions but had almost no expertise in health or planning. CCHMs consultants were then used to bring both the staff and citizen volunteers up to speed on the health care system. The staff essentially supported the volunteers and facilitated their meetings and reports without being able to strongly influence or direct them.

Three co-chairs (a purchaser-employer, consumer, and provider) were selected, and it took some time for them to sort out the leadership roles among themselves. At one point they had a staff member chair the meetings so that they could participate more directly in the discussions. This went against the Kellogg philosophy of volunteer community leadership. Within a few months the consumer member emerged as the first among equals. But the position required a lot of time and energy, particularly for driving to meetings and missing work. When this person requested a small travel stipend or to be included in a trip to a national conference, he or she was told that volunteers could not be paid and that the trips should be spread around. This person experienced burn-out and did not carry over in a leadership role into the implementation phase.

The community foundation CEO/project director in Beehive adopted a proactive coordinating style and did not rely on the usual informal networks. This apparently crossed the fine line between facilitating participative decision making and a benevolent one-person staff-driven project. When the highly proactive project director was forced to step down and was replaced by a more passive individual, the staff, who still lacked expertise and authority, began working with the volunteers to coordinate decision making and finalize the plan. Despite the turnover of project directors, staff, and emerging volunteer leadership, the workgroups were able to identify a few projects for the Beehive health improvement plan and the steering committee was able to work through them and submit it to the Kellogg Foundation. If ever there was an example of community task group success in the absence of clear overall leadership and with minimal staff support, Beehive is it.
Decision Making

CCHMs firmly believe in bringing all the major stakeholders to the table and helping them build a consensus. In several instances the operations office played a key role in negotiating differences not only between provider and the citizen representatives, but more importantly among the providers themselves. The CCHMs initiative also focused on building consensus on the future of the health care system and would impinge on treatment or quality of care issues only to the extent of calling for continuous, comprehensive, and preventive-oriented care that might include better case management and referrals.

In terms of broader decision-making issues, CCHMs were constantly insisting on a governing as opposed to an advisory role in the planning and restructuring of the local health care system. One of the major issues surrounding the sequence of health planning legislation from 1966 through 1979 was how much legal authority to grant the consumer participation entity and over what functions—budgetary, planning, and contract/grant approval (Doty 1980). The Health Systems Agencies (HSAs) were authorized by the federal government to act as state and regional decision-making bodies on its behalf. But they had no official link or mandate to deal with the real power groups in the community including third party payers, rate setting commissions, licensure bodies, and professional service review organizations (PSROs) (Bates 1983).

In contrast, the CCHMs projects were created by the private, nonprofit Kellogg Foundation and given authority to decide upon the project’s structure, staffing, budget, and proposal for continued Kellogg funding. When the Linchpin project was perceived by groups in the county as possessing HSA-like review and approval rights over other proposals to the Kellogg Foundation, it suddenly had to develop a set of rules and guidelines to handle this contingency. Beyond that, the CCHMs projects had no government or other citizen mandate to make binding decisions on or for the local health care system. Yet some physicians and hospital administrators in all three counties saw CCHMs as a decision-making arm of the Kellogg Foundation that could influence hospital mergers or thwart building plans. In short, the CCHMs initiative did not clearly differentiate between internal governance of the CCHMs project and relationships with the Kellogg Foundation on the one hand, and external or community-wide governance which was envisioned but unauthorized and therefore primarily advisory on the other.

The internal CCHMs decision-making process varied across all three sites. To a large extent it reflected how the counties usually made decisions. In Linchpin County decisions appeared to be strongly influenced by the dominant business/manufacturing firm and major nonprofit institution. At meetings, people were sometimes asked if they were speaking for themselves or their employer when they made a particularly innovative or controversial suggestion. The “big two” participated in an informal kitchen cabinet-type process with about two dozen other major influential organizations and associations in the county. The decision-
tively ended any technical self-perpetuation by the governing board and opened
the process up for individuals and consumer or citizens groups to nominate people
for board positions.

Two of the consumer representatives were seen by some to be too closely
aligned with providers. When an individual in the community membership organ-
ization wanted to challenge the credentials of these two consumer representa-
tives, considerable effort was made to come up with new definitions of consumer,
provider, and purchaser. The project staff then assisted this person by providing
the requested information and materials, making overheads, and putting the issue
on the agenda. The successful motion created two new interim consumer seats,
while the challenged consumer representatives were allowed to serve out the
remainder of their terms.

The Oldtree site seemed to enact the worst-case scenario. The Citizens’ Board
(1972) noted that whoever makes appointments to assure proper proportional rep-
resentation can stack the deck. This usually is the established power group and
they pick and choose very selectively, favoring people who are familiar with the
complexities of health care but who may not be strongly linked to the constituency
they categorically represent. This process works as long as the short lists are not
leaked and evidence of exclusion not revealed. When the Oldtree Press published
an incorrect steering committee list, the small preplanning group held out against
subsequent pressures to include the “dropped” individual for quite some time. In
addition, once in place, the steering committee members handpicked people to
serve with them as co-chairs on the various workgroups. While designed to assem-
ble a core of dedicated and interested volunteers, it did not contribute to the early
legitimacy of the CCHMs enterprise.

Although the Kellogg guidelines for committee composition called for approxi-
mately equal representation for consumers, purchasers, and service providers, the
Oldtree preplanning and steering committees chose not to use the one-third for-
mulation. They ended up allocating 54 percent of the seats on the steering com-
mittee to service providers, 29 percent to consumers, and 17 percent to purchaser-
employers. These proportions carried over to the workgroups with consumers
accounting for 25 percent and purchasers for 22 percent. In essence, Oldtree
reverted to the pre-1974 HSA pattern of provider dominance.

Beehive also had a small group identify individuals who could represent spe-
cific consumer, provider, and purchaser interests. They, however, strictly followed
the one-third distribution recommendation, and even created subcategories within
consumers, purchasers, and providers. The process was a bit more open. For
example, it was known that some of their first choices had turned them down and
some seats were unfilled during the first few months. On the other hand, once peo-
ple knew about the project, they were more than willing to volunteer to be on a
workgroup or committee. Of the three sites, Beehive had the highest proportion of
consumers involved and participants reported the fewest number of groups that
should have been included, but were not.
Civic Engagement

The CCHMs initiative was highly concerned with citizen engagement. Accordingly, one of the functions of the operations office was to act as a political linkage agent for the initiative as a whole. It tried to create external linkages by arranging meetings for site staff and leadership with state legislators and health department personnel. In the beginning it regularly distributed articles and reports on health care delivery and policy in hopes of preparing participants for such meetings. Many were overwhelmed by the information and without a specific plan or policy to promote, meetings with policymakers were perhaps a bit premature. More important, however, were the internal linkages that the operations office supported.

The operations office labeled the links between consumer representatives and consumer constituencies as outreach, the two-way communications from constituents to representatives and from representatives to constituents. This was accomplished through media releases and newsletters, participation in public hearings and forums, and administration of information-gathering methods such as surveys and focus groups. After the sites were initially identified, the operations office helped run a series of open forums on health care issues to determine the community’s interest in creating a health improvement plan. In one or two counties these meetings were used to recruit individuals for CCHMs committees and task forces. The idea was to tap into the general community and avoid going directly to the established health sector constituencies and vested interests.

Once the projects were officially funded, communications and outreach became community responsibilities, rather than those of the operations office. As CCHMs progressed, it was discovered that attendance at open public meetings to gain input and feedback on various working papers and the plan itself was disappointingly low. It was also determined that a more attentive audience could be found by presenting at meetings of various civic, business, professional, and religious groups in the community.7

The three counties dealt with these issues quite differently. Whenever the Linchpin staff was invited to make a presentation to a community group, it always invited people to join the CCHMs general membership organization which grew to over 500 members by the end of the planning phase. The staff also conducted its own county-wide surveys and wanted the results of a series of cluster evaluation surveys as soon as they were available. Linchpin also ran their own focus groups to verify and explore some of the cluster-level findings about community attitudes and interests.

Beehive County, which had a more diffuse and somewhat open way of reaching community consensus and decisions, tended to alter its course in response to its perception of the winds. It held open public meetings until attendance was so poor as to require a different approach whereupon they increased their presentation and communications with existing community groups of various kinds. It participated in health fairs to both publicize itself and gather some information on what people
The CCHMs operations office actively encouraged both citizens and staff to participate in the various retreats and consultant sessions. The ability of the project staff to act as an intermediary between consultants and citizens or to implement the recommendations that came out of such events, however, was very mixed. Perhaps the staff needed some additional training on how to be knowledge or research utilization specialists (see Havelock and Havelock 1973). Several areas of knowledge and processing were not effectively transferred. While some training was offered on managing meetings, the recommendation of a two-meeting rule to ensure ample time for review and input from all groups and rigid time allocations on agendas were quickly dropped. Most important, the whole concept of a planning process and how it develops both policy recommendations and work plans was never fully understood by either staff or citizens. This completed a vicious circle—the failure to utilize the consultants and their start-up materials was linked to a self-fulfilling prophecy of low participant and staff expectations for a payoff for investing in knowledge retrieval and application that emerged from lack of experience with a formal, citizen-driven planning process.

Systems Change

The CCHM’s theory of action was a rational sequence of steps for systems change. It identified three core objectives of integrated health delivery, community-wide coverage, and community decision making, and then called for a community-driven planning process that would begin with a community health assessment and vision statement; create an information sharing and health data system; establish policy, advocacy, and dispute resolution mechanisms, and culminate in the delineation of projects that would expand health care coverage and improve the quality of health care in their communities. All of this was to be accomplished through broad-based citizen participation.

We will explore systems change using the five characteristics of a successful external agent found in the literature: playing multiple roles; balancing power relationships; promoting collaborative policy-making; requiring shared project management, and facilitating sustainability through institutionalization.

Of the four change agent roles of catalyst, solution giver, process helper, and resource linker (Havelock and Havelock 1973), the Kellogg Foundation itself appears to have played the catalyst role. It knew that change was required in the health care system and saw the community as a place where a demonstration could be mounted. With some minor changes, Tye’s (1973) political linkage agent model can become a summary statement of the essential assumptions and desired social changes that permeate the CCHMs materials. The Kellogg Health Goals Group assumed that the local health care system was restricted by state and federal regulations as well as market imperfections. Major stakeholders—consumers, providers, purchasers—were impotent and frustrated in their efforts to improve access and quality of care while containing costs. The Kellogg Foundation wanted to
bring these three groups to the table, equalize the power relationships among them, and empower them to become collaborative in their attempts at policy formation to facilitate the planning and management of change.

In order to accomplish this, the role of political linkage agent had to be refined and vested in an entity that was somewhat removed from the foundation itself. The solution was the operations office. Established by contract outside the foundation, the operations office was to play the roles of both process helper and resource linker. It would assemble and coordinate a set of consultants who would educate the participants about the intricacies of the health care system and train them in the art of systems change. It would disseminate information on relevant studies and policy proposals, arrange background talks and briefings with policymakers and influentials at the state and federal level, hold networking meetings for staff and participants from the three sites, and offer their services as mediators and negotiators if conflicts arose.

It was clear that the Kellogg Foundation wanted to inform citizens about issues facing their health care system and to educate them about policy formation through participation in the CCHMs planning and implementation process. With the coming of the Reagan Administration, support and financing of social and health planning was eliminated. The Bush Administration encouraged a return to volunteerism and community self-help and funded a series of community partnerships to deal with substance abuse. In the early 1990s, then, the general social and political climate fit the traditional Kellogg approach. Their historical emphasis on community members working together to improve their lives could be combined with their interest in promoting specific partnerships in order to change the health care system.

By the time the foundation funded the CCHMs planning phase in 1994, the national political pendulum had swung away from prescriptive, professionally driven health care planning. CCHMs was designed as a systems change, policy-oriented initiative which would require a fairly high level of knowledge and training in health planning. Although realizing the need and offering some degree of technical assistance, the operations office was unable to insist that the project staff be sufficiently familiar or proficient with the health planning process. The participants were also being asked to undertake this planning activity in a health care sector that had become increasingly complex and laissez-faire in nature. It is therefore not very surprising that in the CCHMs planning phase there was much confusion within the communities concerning both the process and outcome of systems change.

Throughout the planning phase the three sites pursued different paths and models of systems change. For example, Linchpin made extensive use of outside consultants of its own choosing to supplement its own staff expertise to assist with organizing and implementing the complex planning process. The Oldtree site, after attending a national conference on healthy communities, wanted to improve health status through health promotion rather than attempt to plan for increased
access or integrated health services. This diverted attention from the real systemic change that was occurring—Medicaid managed care, hospital mergers, and primary care practices affiliating with health care systems. The Beehive site planned to revitalize school health nursing services which had been cut several years earlier and jointly support two other efforts initiated by the local hospitals and the county health department, none of which would substantially alter the system.

While the beginnings of a process of collaboration for policy-making and shared management is evident, the time period under study here was too short for any real progress to be made. To be sure, CCHMs brought a wide variety of stakeholders to the table. The problem was keeping them on task and working toward a policy consensus and shared management. In Oldtree, just before the start of the CCHMs planning phase, the state had begun transferring Medicaid patients into managed care and two of the three nonprofit hospitals merged, creating two competing health systems. The decision-making climate was highly charged and vested interests protected their turf from encroachment by CCHMs. The project facilitator, CCHMs operations office and finally the new project director continually faced a combination of hidden agendas and overt conflicts among the participating stakeholders in Oldtree. It was difficult for any meaningful collaboration to occur within this context.

In Linchpin collaboration became a staff function. The staff drew upon a variety of reports and conversations with leaders, consultants, and participants to create a workable set of proposals. Nevertheless the county medical society and a business group were uncomfortable enough with a proposal to join with a neighboring county for a health insurance purchasing alliance that they considered a court injunction against CCHMs.

In contrast, the Beehive site experienced somewhat lower levels of disagreement and higher levels of informal collaboration. Working on projects with broad community support such as early immunization and school health nurses, meant that people were ready to collaborate. On the other hand, once the community foundation CEO/project director left, the operations office intervened at several key points on other projects, serving as an outside mediator and seeking a common ground among the divergent hospital and medical interests.

Each site was slowly developing its own strategy for sustainability through institutionalization after the end of the Kellogg funding. In Oldtree the proposal under serious consideration was to formally incorporate the CCHMs project as a publicly supported 509(a)3 nonprofit which would be operated and controlled by the Oldtree community foundation. This would solidify the top-down approach of the community influencers. In contrast, the community foundation in Beehive wanted to separate itself from the CCHMs project and was encouraging CCHMs to become a 501(c)3 nonprofit with educational or charitable purposes. Finally, the staff and leaders in Linchpin wanted CCHMs to wither away. Essentially other entities such as business groups, hospital or health systems, and the county health and welfare department could take over appropriate pieces of the program.
CONCLUSION

We have established that the W.K. Kellogg Foundation functioned as an external change agent and through itself and the CCHMs operations office was able to assume three critical roles for a change agent, that of a catalyst, process helper, and resource linker. We have also noted that an essential element of the CCHMs model was the desire to bring the major stakeholders—consumers, health care providers, and purchasers of health insurance—together to discuss health care issues on a relatively equal footing. This was accomplished to some degree in all three sites. CCHMs were less successful in creating a collaborative process for policy formation because of the changing socioeconomic and political context and its dependency on staff and volunteers who understood local health politics but not broader health policy. The operations office provided much welcomed managerial support, crisis intervention and mediating services that kept the projects going. Finally, sustainability efforts apparently focused on future funding, although the projects as organizations were clearly drifting toward quite different structures that could evolve into a new local agency that could administer a community wide coverage plan or coordinate health referrals and information exchanges.

The main objection to planning is that it often takes place with little if any public input or scrutiny. Participatory health planning efforts require a well-thought out outreach and media plan that not only targets the general public, but specific stakeholders and other interest groups. In addition, adapting the pluralistic interest group approach to membership and representation directly links the planning entity with other organized constituencies (see Vladek 1977). Such relationships could bring together well-informed citizens who represent a diverse set of groups to develop the plan and then educate their constituencies in support of the plan.

What can be learned from the CCHMs planning efforts to change the organizational forms of health care delivery? An outside-inward change strategy means that leadership will slowly emerge. The eventual leaders are most likely people within existing social networks with vested interests in the health care system. It is important to distinguish between those with self-interests and those with a broader community orientation. The latter should be supported and rewarded in a meaningful way. Perhaps some volunteers who take on the burdens of leadership and coordination should receive compensation for their efforts directly from the community-based planning entity. Finally, leading a citizens’ group requires some knowledge of group processes and dynamics. The division of labor between staff and volunteers should be delineated at the beginning and allowed to evolve.

Community processes inevitably rely on volunteers, but volunteers leave or get burned out if not sufficiently supported and appropriately rewarded. Further, the complexity of the health planning process increased the necessity for a knowledgeable and technically competent staff. The project director has to balance the partnership’s desire to work on immediate solvable problems with the funding agency’s intention to stimulate locally driven systems change. The importance of
the funding agency throughout this process cannot be overstated. Indeed, it may be the very nature and source of funding that shapes both project leadership and project organization. The formation of an operations office between the funding agency and the citizen planning entity dedicated to organizational support and conflict mediation may prove beneficial.

The CCHMs experience suggests that much thought needs to be given to the proposition that a citizens' committee can come up with a comprehensive health plan without substantial support. Orientation to the planning process as well as the utilization of staff and consultants who can transfer and explain the knowledge of the health system is required for an informed policy and planning effort. The usual difficulties that staff might encounter in launching a new initiative with largely volunteer labor were compounded by the fact that both staff and volunteers needed considerable training and support in both the process envisioned for CCHMs and the substance of health care policy, planning, and systems change. The resources provided, in the form of consultants paid by the Kellogg Foundation, came as a very diffuse package. In addition, communities lacked clear guidelines on when and how consultants could and should be used, and how much consultant time would be allocated to each community.

Identifying and supporting leaders with substantive knowledge in health care systems and already skilled in planning processes may have been a more effective but less participatory approach to accomplish the systems change goal. It is noteworthy that this approach was resorted to when no comprehensive proposal was forthcoming after several deadline extensions. As long as the communities were moving forward, less than optimum progress appears to have been accepted as the realistic consequences of a difficult process. Changing the organizational forms of health care delivery, and changing the system itself, is frequently judged to be too important to leave to chance or uncontrolled forces. The real challenge is to realistically develop a planning mechanism that involves citizens in an appropriate and meaningful fashion that will meet the needs of their communities and gain community acceptance.

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NOTES

1. A cluster evaluation is the process of assessing the progress, outcomes, and impacts of a multisite program initiative. It was initiated by the W.K. Kellogg Foundation (Saunders 1997) and has become more widely used (Barley and Jenness 1993).

2. A more comprehensive review of the citizen participation literature is presented in a separate paper (see Perlstad et al. 1998).
making pattern seemed reminiscent of Hunter's (1953) community power structure where a small cadre of business and community influential agreed upon courses of action and then encouraged their subordinates and others to develop and carry them out. The community health investment plan for Linchpin was essentially developed by the staff after receiving input from the major stakeholders and organizations in the county.

In Beehive County decisions were generally made in a consensus fashion with reasonably open discussion. Implementation was not dependent on a single leader or group. Rather, through a number of interlocking civic groups, such as Kiwanis, project ideas were developed and then one group agreed to take the lead. Others were asked to chip in and volunteer, so that many were involved. Using this approach the community has managed to accomplish many tasks, including building a new playground with individuals from high school service clubs to labor unions working side by side. The CCHMs project in this county had a tri-chair arrangement and rather decentralized structure. It managed to carry on its planning efforts although it had two project directors during that time.

Oldtree County had a very small philanthropic circle of wealthy, semiretired business people and descendants of prominent families who appeared to make decisions well behind the scenes. Following tradition, this small circle tended to carefully select individuals to participate on projects and then dismiss them if things were not going well or did not achieve expected results. The CCHMs project in Oldtree did not have a project director for most of the planning phase. The steering committee selected people who were somewhat dependent on them to co-chair workgroups. The two steering committee co-chairs would receive workgroup reports and then meet with an informal executive group to figure out how to reconcile the committee's recommendations with what they perceived to be the wishes of the small philanthropic circle and the Kellogg Foundation's requirements for continued funding. In the end, the plan was put together by the executive group with the assistance of the newly hired project director who had considerable experience in health planning.

Inclusion

Like many other health planning and advisory groups, the CCHMs initiative was most concerned with diversity and bringing a mix of interests to the table. It therefore required that the participants be fairly evenly divided among consumer, provider, and employers or purchasers of health care coverage. The actual process was left up to each site and the variations are most instructive.

In Linchpin the small powerful and influential group enlarged itself to 48 members to initiate the CCHMs project. After the initial planning year this became rather unwieldy and the group was reduced to a 16-member governing board. Of greater significance was the early creation of a community membership organization which would come together annually and elect board members. This effec-
were interested in. It held press conferences but found that either prepared copy or video tapes were more likely to get into the media. What did appear in the media were clear and concise presentations of the proposed health improvement plan and ways of providing feedback from attending meetings to calling the CCHMs office. Despite a lack of staff expertise, the Beehive site did hand out brief surveys about health care coverage and access at meetings and other events, and one board member mailed out a survey to physicians. Beehive was also interested in any results from the cluster evaluation surveys.

Oldtree County’s initial outreach efforts in recruitment and public and media relations were very limited. During the entire planning phase their project newsletter was almost entirely focused on health education information with little or no space given to the progress and issues facing the CCHMs initiative or its planning activities and products. They were least likely of all three counties to be interested in cluster-level data and did little if any information gathering on their own. This was undoubtedly related to their inability to agree among themselves about their perceptions of what the project should be doing and what the community needed. One particularly telling event was a community breakfast to celebrate the first drafts of the workgroup reports. At the end of the meeting, those present were thanked and told that the workgroups would no longer be needed. What linkages that had existed into the broader community were apparently broken.

Knowledge Transfer

The CCHMs operations office foresaw the need to bring all participants up to speed on the complexities of the health care system and the how-to’s of health care reform. To this end, they initially assembled a group of consultants in the areas of health care organization and finance, data information systems, policy and governance, communications, and community outreach. These consultants wrote background papers and created handbooks for the community boards and committees. They were available for on-site meetings and training sessions.

The CCHMs initiative assumed that consumers and purchasers of health insurance would already be motivated to appreciate and request technical assistance. Several problems arose in all three sites, but one seemed universal. We found in our surveys and interviews that the consumers complained about the amount of information and reading that was required for the planning effort. This was previously encountered by citizen participants of the HSAs (Doty 1980). We also spoke with the consultants, who indicated that the communities and committees differed considerably in their interest and investment in what the consultants had to offer. For example, some were ready to look at community health profiles, a compilation of demographic, morbidity, mortality, and other relevant health statistics, as a starting point for developing their health improvement plans while others knew what they wanted done without such input.
3. Community foundations are nonprofit organizations that obtain contributions from a wide range of donors and then make grants and support a variety of local projects, thereby creating a flexible pooled endowment to serve the community as a whole. They can provide funds to or act as a fiduciary agent for other community organizations or projects.

4. CCHMs began before the National Committee on Quality Assurance (NCQA) started to create measures, develop surveys, and provide information to enable consumers and employers to make informed choices among health plans.

5. The administrative complexities of doing the cluster evaluation led to the creation of the CCHMs Evaluation Manual, available from the authors.

6. The philosophy of the Kellogg Foundation and the CCHMs initiative did not adhere to a conflict confrontational or adversarial model so prevalent in the literature of the 1960s.

7. This supports the theory of interest group pluralism as the way to engage the community and assure accountability (Vladek 1977).

8. Given CCHMs health planning and implementation objectives with their policy implications, the Beelove project might have more flexibility as a 501(c)(4) civic league or social welfare organization.

9. The solution-giver role was not part of the Kellogg model. The foundation philosophy holds that people are in a better position to know what they want and how to get it than outsiders or experts. Beyond its rather general desired outcome, the foundation prefers a non-directive strategy of helping the community define the problem and become their own problem solvers. This means, however, that the roles of process helper and resource linker become more crucial.

REFERENCES


