View from the Balcony

Observations on Programming from

Three Cluster Evaluations for the

W. K. Kellogg Foundation

Health Goal Group

by

Connie C. Schmitz, PhD
University of Minnesota
Center for Urban and Regional Affairs
Director, Cluster Evaluation
Community-Based Public Health (CBPH)

Rebecca Henry, PhD
Michigan State University
Office of Medical Education Research and Development
Director, Cluster Evaluation
Community Partnerships in the Health Professions (CPHPE)

Harry Peristadt, PhD
Michigan State University
Department of Sociology
Director, Cluster Evaluation
Comprehensive Community Health Models (CCHMs)

February, 1997
View from the Balcony:
Observations on Programming from
Three Cluster Evaluations for the WKKF Health Goal Group

by

Connie C. Schmitz, Rebecca Henry, and Harry Perlstadt

Background and Introduction

As major Cluster Evaluations conclude several years' worth of work, it is both prudent and exciting to ask, "What have we learned?" "Can we understand something about the arts of grant making, health programming, or evaluation that we didn't know before?" Specifically, what can we learn from the Cluster Evaluators -- those folks who have sat in the balcony these many years, observing the show, making sundry comments, and even giving an occasional stage direction?

The text which follows came about from the asking of such questions. It began as an informal conversation between Program Directors and Cluster Evaluators in the summer of 1996 and evolved over the course of several telephone calls and manuscript drafts into the text presented here. Attending the initial meeting (7-16-96) were: Program Directors Ron Richards and Steven Uranga McKane; the Director of the CCHMS Operations Office, Pam Paul Shaheen; and the authors listed above, who served as Cluster Evaluators for the three initiatives under review.

After the cluster evaluators agreed to summarize the August conversation in an informal written document, we realized that we lacked enough concrete information about each other's initiatives to really draw inferences about "lessons learned." Before synthesizing our observations, therefore, we decided to review how the initiatives were similar and how they were different. We did this by constructing the profiles seen in the ten-page chart appended to this text ("Overview of Three Cluster Initiatives"). This led to a more grounded and in-depth conversation in which we further clarified important points of similarity and difference between the three initiatives. Some of the more salient differences are listed beginning on the following page.

Note: CPHPE = Community Partnerships in Health Professions Education; CBPH = Community-Based Public Health; and CCHMs = Comprehensive Community Health Models.
Points of Difference between CPHPE, CBPH, and CCHMS

- **Timeline.** The three initiatives vary in terms of their timelines. CPHPE completed its one-year planning phase in 1991, its five-year implementation phase in 1996, and has now spawned a related, third phase with Graduate Medicine and Nursing Education. CBPH began one year later than CPHPE with a similar, two-phase planning and implementation model, but the implementation phase was shorter (four years, rather than five). Bridge money was provided to CBPH participants in 1996, but no new funds have been allocated as of this writing. In contrast to the other two, CCHMs is a "much younger" initiative, having just completed its planning phase in 1996.

- **Size of Investment.** The initiatives varied in terms of their size and funding. CPHPE and CBPH initiatives invited 15 consortia to participate in the competitive planning phase (Leadership and Model Development) and covered participants' travel expenses, but provided no other funds prior to implementation. In contrast, CCHMs accepted three partnerships into the initiative and allocated $448,000 per grantee for planning. During implementation, CPHPE and CBPH both funded seven partnerships, but CPHPE partnerships had about six million dollars divided across two sectors of academe (medicine and nursing) and community, whereas CBPH consortia had about two million dollars divided across the three sectors of academe, public health practice, and community. CCHMs partnerships will have about four million each for implementation. Not including blanket funds for WKKF staff, evaluation, or other supplemental support, the appropriations for three initiatives total about 70 million dollars (42 million for CPHPE, 14 million for CBPH, and 13.5 million for CCHMs).

- **Partnership Location.** The initiatives varied somewhat in the degree to which their grantees were geographically concentrated. Each CCHMs partnership was located in a single county, whereas most CBPH consortia were spread out over multiple project sites, sometimes spanning as broad a territory as four large counties, or the western half of an entire state. CPHPE locations were mixed; some served a single city and others served an entire state. This dispersion of project sites within a partnership may have direct implications for organizational models and governance. Strong affiliation with a shared geographic location may be an important aspect of successful collaboration. Even unitary site designations can be challenging, however, when the site is large (e.g., "county").
• **Problem Focus.** While "health status" might be seen as the ultimate outcome of interest for all three initiatives, the "problem" being addressed varied. CPHPE focused on the training of primary health care professionals in a community setting, but viewed the quantity and quality of the primary care workforce as a national as well as local issue, and one most amenable to federal and state policy influence. CBPH focused on intersectoral collaboration as a means to improve health professions training, public health practice, and community empowerment at the grass-roots level. Results were conjectured to "trickle up" to higher level organizational, systems, and policy change. CCHMs focused on the health delivery system and the assurance of affordable services for underinsured and uninsured people. CCHMs goals require significant collaboration and system change across sectors and interest groups, but at a distinctly local (county) level. The CCHMs project might need higher level policy change, however (i.e., federal and state waivers) to accomplish certain goals.

• **Policy Goals.** The initiatives varied in terms of what policy goals were articulated, by whom, and when during the course of the initiative.

* The policy goal for CPHPE, which was stated at the onset of the initiative by the WKKF Program Director, was very specific: to identify state and national financing for training of health professionals in community settings. The programming strategy was to educate policy makers about the benefits of community training for primary care providers. The Integrated Action Plan (IAP) in Year Two was designed to help projects identify sources of future funding to support community-based training after WKKF dollars ended.

* In CBPH, while the eventual goal of influencing public health policy was voiced early by both WKKF staff and grantees, specific policy targets for the initiative were not stated. Several efforts by consortia evolved at the local level, however, to educate citizens and students about policy processes, or to target issues of concern (e.g., environmental hazards, community representation in managed care, tenure policies in academia). A Policy Task Force (comprised of consortium representatives) worked for the latter two years of the initiative and formulated six "policy goals," which generally reaffirmed the participation of community members in local, state, federal, and foundation decision-making processes and funding.
* In CCHMs, the policy idea (which developed in 1992) was to have communities form self-insurance entities that brought consumers and purchasers together to negotiate with providers. These entities would need a waiver to deal with Medicare and Medicaid coverage. The Operations Office's role was to help educate and guide the communities through the policy arena and to facilitate their efforts to form entities and obtain waivers.

* Issues of Definition and Praxis. Finally, the initiatives differed in terms of their underlying theories of change, their operationalized definitions of "community" and "community-based" programs, and degree to which Foundation staff (or their Operation Offices) elected to prescribe, or require particular activities or products from their grantees. The roles that the funders and grantees played seemed to correspond to the WKKF Program Directors' understanding of how societal change ultimately comes about. This includes their conceptualization of "policy" and their role as change agents in advancing or nurturing "policy change."

Having said this, it was also apparent that the initiatives shared certain core beliefs, such as the value of collaborative partnerships that span sectors and disciplines, and the value of community interaction (however defined). Further, because each initiative involved multi-sector groups as grantees, there are some common issues concerning governance and leadership. Each initiative hoped to accomplish significant systems change or policy impact in a relatively short amount of time. Each initiative experienced stages of evolution and change, successes and challenges, as is inevitable in long-term initiatives.

**Topic Areas Addresses in This Paper**

Having set the stage, let us proceed now to sharing our observations. The following sections are organized around four central topic areas that emerged repeatedly in our conversations:

I. **Theories of Action.** What do we know about the initiatives' underlying "theories of action?" How were these basic program assumptions or principles similar or different across the three initiatives? How robust or valid did these theories of action prove to be, according to the Cluster Evaluations?
II. **Definitions and Roles for "Community" and "Community-Based" Programming.**

What sectors or boundaries (e.g., socio-economic, organizational, and geographic) of "community" were represented in these initiatives? What implications does definition have for partnerships? In what ways can initiatives be designed to best serve communities and the Foundation's policy or "systems" change goals?

III. **Governance and Leadership.** What were the perceived strengths and limitations of the organizational and governance models used in these initiatives? What factors or conditions appear to be requisite for their success?

IV. **The Foundation's Role in Programming.** How did Program Director, Cluster Evaluation, and grantee roles appear to vary across the three initiatives? To what extent did Foundation Program Directors define their role as "change agent" for the initiative? Is there an optimal balance in grant-making between direction and flexibility?

We offer this paper to the Health Program Goal Group, in the hope that our observations and suggestions further your discussion and planning, and perhaps improve our collective thinking about designing, leading, and evaluating large scale initiatives.
I. Theories of Action

"The concept of grounding evaluation in theories of change takes for granted that social programs are based on explicit or implicit theories about how and why the program will work (Weiss 1972, 50-53; Shadish 1987; Chen 1990; Lipsey 1993). The evaluation should surface those theories and lay them out in as fine detail as possible, identifying all the assumptions and sub-assumptions built into the program. The evaluators then construct methods for data collection and analysis to track the unfolding of the assumptions. The aim is to examine the extent to which program theories hold. The evaluation should show which of the assumptions underlying the program break down, when they break down, and which of the several theories underlying the program are best supported by the evidence."

-- Carol H. Weiss, 1995, pp. 66-67

"Nothing As Practical As Good Theory: Exploring Theory-Based Evaluation for Comprehensive Community Initiatives for Families and Children" (1).

As the appended chart illustrates (see p. 3), each initiative can be characterized by a collection of underlying assumptions about the nature of the problem being addressed and the avenues of intervention most likely to succeed. In this section we discuss areas of similarity and difference in these initiatives' underlying "theory of action." We also summarize lessons learned regarding the design of multi-sectoral initiatives, and the support strategies needed for partnerships during the planning and implementation phases.

Common Assumptions and Strategies Embedded in the Initiatives' Underlying Theories of Action

The single clearest similarity between the three initiatives, in terms of their underlying theory of action, lay in the importance each initiative gave to the planning phase as a precursor to implementation. Prior to 1990, the Foundation did not generally approve of "planning grants," thus, the development of the Leadership and Model Development (LMD) program in CPHPE and CBPH, and the development of "visioning" and planning phases in CCHMs (and other initiatives), represented a break with tradition and a major new strategy. While CCHMs funded their grantees during this period and the other two initiatives did not, and CCHMs allowed a longer pre-implementation time period, each initiative invested heavily in the planning phase. Each anticipated that grantees would need sheltered time to grapple with new ideas; to assess each other's strengths, needs, and their potential as a partnership; to gather information on local needs and assets; and to frame their ideas into a course of action. Some of the strengths and limitations of the LMD period have been noted in previous documents (e.g., Schmitz, 1993).
We feel that the preliminary planning period is enormously critical and should be continued for large scale initiatives involving multi-sectoral partnerships, but some modifications could be considered (see Lessons Learned, p. 9).

A second strong philosophical similarity is that collaboration across groups who were not used to working together was considered a powerful catalyst for change. The CBPH was firmly rooted in this belief, to the point that "academe, practice, and community" were joked about as "the holy trinity," but the sentiment was voiced often and ardent. In CPHPE, it was presumed that collaboration within the partnerships would influence and increase the relevance of the health professions curriculum to practice. In CCHMs, the effort to involve active participation from consumers, payers, and providers was made because of the belief that without collaboration from stakeholders in these sectors, change could not be accomplished.

We feel that collaboration is an important strategy that should be continued, but with greater appreciation for the challenges of collaboration and the conditions and strategies it requires.

Observations about the role and impact of collaboration in the three initiatives are elaborated below.

CPHPE: Role and Impact of Collaboration.

Collaboration occurred in two ways. First, nursing and medicine, which have traditionally not been linked in undergraduate education, came together to develop a multidisciplinary approach to health professions education. This involved collaboration around the content of curriculum and delivery of instruction. Second, academe and community collaborated to form a partnership that was responsible for implementing the community-based curriculum. The challenges to the CPHPE partnerships were how to give community a legitimate voice and how the partnership could hold its own in the face of powerful academic institutions. By using very different organizational strategies, the seven partnerships implemented multidisciplinary education in Community-Based Academic Health Centers (CBAHCs). The majority of faculty came from the community. By the fifth year of the initiative, the partnerships had obtained additional support through new sources, or policy changes that would assist in sustaining the organizations after WKKF funding had ceased. Thus, collaboration seemed largely successful, although in some cases, fragile.
CBPH: Role and Impact of Collaboration

In CBPH, collaboration was itself seen as a goal, not just a means to an end, and the model for "best practice" in public health assessment, policy development and planning, research, teaching, and service. While CBPH consortia discovered that collaboration was about 85 times more difficult than they anticipated, and some consortia were a lot better at collaborating than others, most members did experience an energy from working together than was probably unlike anything they had experienced before. There is strong evidence that collaboration had a powerful impact at the individual level, a varying level of impact at the organizational level (it depended on the consortium and the organization), and a less discernible impact at the community or "systems" level. Channeling that energy towards a shared goal was a difficult task, however. In a majority of CBPH consortia, collaboration was easier and more productive at the local project site, and more strained at the consortium level. By the end of the initiative, it was clear that many people had fallen in love with the idea of collaboration, but wanted to collaborate with other people, or other organizations than those initially funded by the grant. For all intents and purposes, however, the assumption that uniting these players would spawn many different kinds of projects and products was born out.

CCHMs: Role and Impact of Collaboration

CCHMs was less of a partnership among existing institutions and organizations, and more of a "blue ribbon" committee that was supposed to develop a Comprehensive Health Improvement Plan (CHIP). Initially, most people anticipated that a new entity would form in order to implement this plan, such as a health alliance. Over time, however, this goal shifted to various strategies for supporting advisory groups or oversight committees with the CHIP. As with CPHPE and CBPH, collaboration proved somewhat difficult for many participants. The categorical nature of most CCHMs representatives meant that they were not directly linked with, nor were they directly accountable to community-based groups. The burden of reaching out and collaborating therefore fell to the committees and staff. Without support from groups outside of the committee, many consumer and payer participants had little interest in, or incentive to invest in the collaborative development of a complex health plan. In addition, hospitals and other provider groups moved towards managed care independently of the CCHMs. Hospitals did not control the CCHMs governing body or funds. Hospitals did sit at the table, however, and after a year or so even began sharing their plans and revealing their independent actions. Some of these
honorable decision. Early formalization of the partnership (e.g., organizational status) provided no additional advantage.

- **Provide clear guidelines** for the recruitment and involvement of community people or community-based organizations if community capacity building is intended, or if community-responsive systems change is the goal.

- **Consider using a local third-party convener for a partnership,** if the politics of sector representation or member selection is volatile. Clarify that the convener role is separate from project direction.

- **Include specific content on the arts of collaboration, shared leadership, and conflict resolution in future training seminars.** Basic knowledge about the socio-cultural norms of the participating sectors needs to be shared. Additionally, basic knowledge about government processes, new health systems and policies (e.g., "managed care"), and other subjects that participants need to know in order to function equally at a specific partnership table should be taught. Such basic knowledge can't be presumed even for "professionals," and to not ensure this is to differentially disempower some groups.

- **Be realistic about the longevity of "arranged marriages."** Do not expect every partnership to evolve into a free-standing, sustainable organization. True collaboration, in the end, cannot be mandated, only nurtured.

- **Draw upon the strengths of existing partnerships.** Understand that organizations and coalitions already abound in target communities. Take into account how new funding may destabilize relationships between community groups, and actually fuel competition rather than collaboration. Unless the context suggests otherwise, it may be more productive to invest in existing partnerships than to start new ones.

- **Provide funds for the planning period.** Such money is critical for support staffing and the special assessment and communication tasks that need to occur.

2. **Support Beyond LMD / Visioning / Planning.**

- **Provide ongoing technical assistance and support during the course of the initiative.** This is necessary, due to expansion and turnover in membership, dissipation of core
ideas that initially give life to an initiative, and changes in the larger policy context. Whether such assistance is provided through special retreats, annual meetings, a technical program office, frequent flyer programs and consultants, or some combination of the above is negotiable and should depend on circumstances.

- **Prepare partnerships to deal with the "cost / benefit" equation of member participation.** Partnerships in these initiatives learned that they need to set up a reward structure for their members to encourage continued commitment and participation over time. This was especially important for community members, who had a more difficult time (compared to professional groups) in taking time off from work to attend meetings, and were not compensated for their work or travel. The Evaluation Teams have observed that if the rewards of participation do not offset the costs, the partnerships deteriorate.

- **Hold consortia accountable for their proposed goals and objectives.** Clarify the roles and procedures for Project Evaluators, Cluster Evaluators, and WKKF Program Staff so the accountability function clearly rests with the Foundation. Teach consortia methods for holding themselves accountable through joint work plans, and for resolving conflict when partners are unable to fulfill their end of the bargain.

**Different Assumptions and Strategies Embedded in the Initiatives' Underlying Theories of Action**

One way in which the three initiatives appeared to differ was in their beliefs about the sources of influence for change and how those sources should be deployed. Specifically, the initiatives presumed different answers to the questions: whence comes change, and how can change be orchestrated? Is change primarily a bottom-up, or a top-down phenomenon? Contingent with this is the different ways in which "policy" or "policy change" was incorporated into the theory of action. Observations about these differences are illustrated below, followed by lessons learned.

**CPHPE: Sources of Change and Principal Findings.**

An underlying assumption of the CPHPE was that academic institutions require strong outside influence in order to change such things as curriculum content and location of training. Several sources of "outside influence" were triggered by the initiative, beginning
with seeing the Foundation itself as a source of influence, through its funding and support strategies. Some of these support strategies brought the "outside world" to the doorstep of the initiative to interact with participants and to build momentum for change. For example, National Press Club meetings called public policy decision makers at the national and state levels together to announce and update them on the initiative. This was part of a programming strategy in which convincing policy influential of an initiative's promise and potential impact was believed to plant a self-fulfilling prophecy. A second sphere of continued pressure for change in academe was the local community in which the Community-Based Academic Health Centers (CBAHCs) were based. Community involvement, it was reasoned, would strengthen the quality and sustainability of the training model for primary care students and the research/practice model for primary care faculty and professional staff. Most important, however, was the role that national and state policy was expected to play in financing the new model of health professions education.

Findings. One major observation with regard to targeting policy as a source of influence for change was that "one size does not fit all." Much of the progress in policy change occurred at the state level. Being in seven different states, this meant that each partnership had to strategize a unique, customized approach. Several consortia learned that you can't change policy directly, but you can exploit policy opportunities. It should also be mentioned that the early nineties was a time of extraordinary change, generally speaking, in health care delivery and health professions education, and this atmosphere made it easier to get policy makers' attention. These external influences were also powerful for all of academe, not just those institutions funded by CPHPE.

CBPH: Sources of Change and Principal Findings.

In the CBPH, WKKF program staff and consortium members shared a holistic view of the "problem" which the initiative was designed to address. Essentially, the problem was one of poor health for vulnerable populations stemming, in part, from a weakened public health system. It was compounded by the fragmentation between public health research, education, service, and practice; and long-standing divisions between professional and community groups which further jeopardized the health of underserved citizens. CBPH stakeholders believed they could improve the system as a whole by building the capacity of the parts. Thereby, if the discipline of public health increased its capacity in community-based research, teaching, and service; if the field of public health practice increased its
capacity to partner with community in policy development, health assessment, and assurance; and if the community-based organizations in distressed neighborhoods could be engaged in leadership roles to "own" their problems and solutions -- then, the health of poor communities would improve. As such, change was believed to be best conceived as emanating from the grass-roots and proceeding upwards and outwards. Community capacity building, community organization and development were seen as precursors of change in community-institutional roles, in academic and practice "systems" ("small p"), and ultimately in health policy ("big p") and in health status.

Findings. While participants felt strongly about community ownership, and much capacity building did take place among many community groups, the Evaluation Team saw many CBPH consortia struggling to apply a strictly "bottom-up" philosophy. Lack of resources, lack of appropriate political affiliations, lack of knowledge or experience, lack of time, and other problems got in the way. The theory that all change comes up from the bottom (a precept that many CBPH listeners took from John McKnight's teaching) needs to be challenged. Successful CBPH leaders interviewed credited supportive deans and directors, and sometimes favorable political figures or contextual events, as supplying the catalytic support to move forward.

Pairing a capacity building approach within a systems change initiative was also problematic for the CBPH, especially since change was expected in a relatively short amount of time (i.e., four years). The Evaluation Team came to feel that if systems change is meant to be the initiative's primary goal, then existing partnerships with considerable skill in collaboration and policy matters need to be selected. A specific policy agenda needs to be named as a priority from the beginning. Conversely, if community or institutional capacity building is seen as the most important goal, then groups at all different stages of readiness and experience can be invited into the initiative, and appropriate expectations for intermediate outcomes and support strategies can be designed.

Many problems were nested within the CBPH "problem focus," yet the amount of funding available made it difficult for groups to invest enough time and dollars into any one area. For example, the weak public health system was considered a primary problem, yet most public health partners received very little to no funds from their consortia for personnel or programming. Poor health of marginalized groups was the long-term problem stated for the initiative (and of primary concern for the community organizations who were present), yet the funds were inadequate for the size of their needs. Additionally, it was difficult for
many community organizations to see how investing in curriculum change or research would improve their health in the foreseeable future. Thus, embracing the rationale of "building the capacity of the parts" in order to "change the system as a whole" required "big picture" understanding / experience, and faith that long-term funding could be acquired.

**CCHMs: Sources of Change and Principal Findings.**

In CCHMs, change was hypothesized as emanating from a representative group of stakeholders within a county. This belief rested on the assumption that health care is predominately purchased, delivered, and consumed "in local communities." If stakeholders came together, developed a common plan based on accurate needs assessment and health status information, and if they worked to build community support for desired directions, then change could happen. This expectation was itself based on the assumption that the "appropriate" stakeholders (i.e., "valid" representatives of "appropriate" stakeholder groups) have been convened. In part, community foundations were used as local conveners for the partnership because the Foundation program staff hoped that they would know which organizations and individuals could best serve as representatives for consumer, purchasers, and providers in that community. Further, the community foundations were selected because each had a history of promoting successful community change, and could serve as a fiduciary agent with respect to the health sector. Originally it was also expected that the community foundations would foster the CCHMs project, which would eventually become an independent decision making entity.

A team of consultants was assembled to support this change effort, and the Operations Office was originally envisioned as supporting policy linkages, particularly for any necessary waivers. These additional players suggests that while change is hypothesized to emanate from within a county-level "community" and extend out, a variety of external consultants and support personnel were considered necessary to educate and orient participants on the intricacies of the health care system. Change in policy was ultimately going to be needed.

**Findings.** Once they were underway, it seemed that some partnerships were not ready or willing to consider what the Health Work Group, the Operations Office, and the Cluster Evaluation Team initially saw as obvious policy implications. As it so happened, the CCHMs visioning and planning phase in 1994 coincided with the demise of the Clinton Health Plan. The Operations Office pulled back the goal of establishing self-insurance
entities, but continued their efforts to bring the communities up to speed on policy through articles, briefings, consultants, and meetings with legislators. The communities, however, were not ready or willing to consider policy implications and often took the line of least resistance. They favored replacing cut services, for example, or piggy backing on existing public health efforts in health promotion, or hospital-backed projects for information systems. In response to hospital mergers and physician buy-outs, two of the CCHM communities began to move slowing towards building an insurance purchasing cooperatives with business associations. This will not need any policy waivers. They problem-solved, rather than sought policy change.

As with CPHPE, understanding the independent effects of history and context became apparent. Because the partnership participants were not tied to the major institutions involved (e.g., hospitals, local health departments), some initiated or participated in changes outside of the formal CCHMs process -- perhaps in an effort to "stay one step ahead" of the group. Some participants claimed that they were already working on a "CCHMS" type concept when it was really only a glimmer in their eye before CCHMs came along.

Lessons Learned: Sources of Change

Despite their different problem foci and strategies for supporting change, all three initiatives found the goals of capacity building and systems change to be long term and resource intensive. Moreover, the process of orchestrating change was challenging. Perhaps the greatest lesson learned is that multiple sources of change need to be leveraged; it is not a simple dichotomy of "top down" or "bottom up." Additionally, as is readily known, these initiatives are subject to many outside influences; neither the Foundation nor the grantees can claim more than modest control over the change process.

Having acknowledged this, Kellogg initiatives have to operate within a set of parameters. They have to evolve within some sort of framework or theory of action, and too often these parameters are unclear. For future initiatives, careful attention should be given during the design phase to articulating the "problem" being addressed, the "systems" being changed, the contexts in which they reside, the possible sources of influence or change, and the parties who control leverage over change. The emergence of the "logic model" as a planning, management, and evaluation tool can help identify and explicate the parameters without over-specifying the initiative. Additionally, the Foundation's role in political
activities needs to be considered. As a 501(c)3 charitable organization, WKKF program staff have to ensure that their policy efforts are educational in intent and implementation. Some suggestions for future, large scale initiatives include the following:

1. **Work together as a Health Goal Group with evaluators and advisory groups to construct a logic model, to reach consensus on a planned initiative, before launching it on the public.** The Health Goal Group's logic model should set the parameters, especially the variables operating in the social change context and the expectations for long term outcomes. The model should anticipate to the extent possible the necessary resources and anticipated milestones. The specific activities and short term outcomes can be left open, or very broadly sketched, with the understanding that each grantee has the responsibility to adapt and complete the model. In this way, the Health Goal Group avoids the hidden agenda syndrome, but does not over prescribe.

2. **Require each site to construct its own version of a logic model by the end of the planning phase or first year of implementation.** This will help them, as a partnership, clarify their workplan and hold each other accountable. The logic models need to be revisited collectively on an annual basis, as new events transpire and formative evaluation data provide early feedback or reconnaissance data.

3. **Think through the timing and clarify the intent of future IAPs.** Experience with the IAP in both CPHPE and CBPH suggests that it had limited success as a strategy for enhancing sustainability or policy change. This was partly due to late introduction of the IAP strategy and some questions about its intent. Whose interests and agenda are the IAPs meant to serve? The Foundation's or the grantees? Individual partnerships, or the collective initiative?

4. **Recognize that partnerships will vary in their capacity and readiness to engage in policy change.** If capacity-building in policy matters is the goal, then require partnerships to identify objectives and strategies for increasing participants' knowledge, skills, experiences, and effectiveness in the policy arena. If policy change is the goal, then use "readiness to address policy" as selection criterion for funding.

5. **Update written guidelines for WKKF staff on the extent to which they can engage in policy oriented activity.**
II. Definitions and Roles for "Community" in "Community-Based" Programming

A second important area for discussion is that of community; how it was defined in the three initiatives, who represented community and the roles they were expected to play, and the impact of the initiatives on community. The three initiatives were similar in two important ways: in their mandate that community be at the table in some fashion, and in allowing grantees to operationally define community. They differed in terms of the dimensions of community that were represented at the table, and how the term "community-based" was actually interpreted. In this section we will describe these similarities and differences, and comment on some challenges facing all community-based initiatives.

Similar Strategies Regarding "Community."

The Kellogg Foundation is well known for its tradition of bringing underserved or traditionally marginalized populations to the table and insisting that they take on meaningful roles in decision making. Each of these initiatives began with the mandate that representatives of community be present. In CPHPE, this mandate was fulfilled by all seven partnership organizations, in that a majority of the members were from the community. A criteria for funding CBPH consortia was that community-based organizations had to be present when proposals were developed and serving a legitimate role in order for the grant to be awarded. While membership quotas were not discussed, the expectation was that community members would serve as a driving force. In CCHMs, the steering committees/governing boards were expected to be filled with 1/3 consumers, 1/3 purchasers, and 1/3 providers. Participants were expected to be stakeholders, although sub-categories (such as underinsured or small businesses) were not specified or required.

The three initiatives were also alike in that they allowed the grantees to more specifically define "community." This led, however, to very different definitions of community, and very different dimensions of community being represented on governing boards or steering committees.

- In CPHPE, community was ultimately defined by each grantee's board membership, and was done so in reference to the CBAHC where teaching occurred. In so doing, community was defined in terms of a health service catchment area. The partnerships
worked with local health care facilities that had area residents and representatives of community-based organizations on their boards. Several sites created regional boards to ensure community input. Most made outreach attempts to educate people living in these areas, and to help them obtain health care.

- In CBPH, consortia were similarly allowed to define community. Lacking specific geographic boundaries and focus on service, however, the initiative used "community" to refer broadly to groups with poor health outcomes experiencing needs that could or should be targeted by public health. This meant people of color, people living in poverty, people who had been victims of oppression in American society. The communities who came to the table consisted of organizations with some experience in mobilizing neighborhoods or groups (e.g., ethnic, gender, or issue-based), and with previous or potential connections with academic and public health institutions.

- In CCHMs, "community" was defined by WKKF as health care consumers, purchasers (i.e., businesses), and providers in a county. WKKF did not specify that CCHMs had to involve underinsured and uninsured individuals, nor was the one-third formula for representation enforced. Sites were encouraged, but not required to have a diverse racial, ethnic and gender mix; to bring in people from various corners of the county; and to include business groups that were not inclined to engage in health care insurance planning for expanding insurance coverage or universal access.

Differences Regarding "Community."

Despite the fact that the words, "community-based," were common to both the CPHPE ("Community-Based Academic Health Centers") and the CBPH ("Community-Based Public Health"), and the term is frequently used in many programs, community-based programs are not all alike. Given the different definitions seen in the above paragraph, some different meanings to the term "community-based" were observed.

CPHPE: Shifting Students Out of the Hospital to the Community.

In CPHPE, "community-based" was one of the least controversial concepts. By the time the initiative was launched, many people in health professions education had come to endorse the need for out-of-hospital training for nursing and medicine students. The hospital was no longer accepted as the ideal educational setting for primary care. The
CBAHC was a new concept, however, in that it went beyond simply placing students in an ambulatory setting. It implied that activities central to academe would take place there. Formal didactic teaching, scholarship, socialization to the profession, and continuing education for all providers would be the hallmark of the CBAHC. Not all of these activities, however, characterized every center. What the centers did offer, however, was a training experience that reflected real community need.

Community representatives tended to come from existing organizations and groups. Some were on pre-existing community health center boards which were selected as training sites, others were leaders of neighborhood groups that were served by the CBAHCs. Those sites that developed regional or area community boards that paralleled the CBAHC boards had the strongest community representatives. As the project evolved, the community representatives began voicing their opinions and insisted that the universities not cut back their commitments to them after WKKF funding ceased.

The initial power base for CPHPE rested firmly in the universities. They received the grants, controlled the curricula, and chose the training sites. The sharing of power with community members grew slowly, but steadily over the five years. At several sites, academic members actively reached out to involve community representative and elected them to leadership positions on the partnership boards. At other sites, however, it took pressure from the Program Director and reporting from the Evaluation Team to get the institutions to share power with the community. Power was generally shared earlier in partnerships with multiple university sites, and later at partnerships with a single university site.

**CBPH: A Question of Power and Capacity-Building.**

In the CBPH, the term "community-based" was an extremely important concept. It was interpreted according to a continuum of power, with "community-placed" at one end of the spectrum, and "community-rooted" at the other. "Placed" infers an external force (typically representing establishment institutions), locating programs which are developed and controlled by professionals in a neighborhood of need. In a "placed" program, the neighborhood is less likely to be viewed as an environment with resources and assets; residents are more likely to review (rather than initiate) program decisions and actions. CBPH members also argue that while the community helps the institutions in a "placed" program (e.g., by supplying volunteer faculty or preceptors, patients for clinical training,
and subjects for research), the community does not often benefit in terms of greater
capacity or power. In fact, the client or victim role is reinforced. In contrast, community
"rooted" programs are based in a community's cultural ethos and in its cultural institutions.
It goes without saying that they are clearly owned by community people. Some CBPH
members rejected the term "empowerment" because they saw themselves as already having
power, but lacking in opportunities, relationships, and resources to exercise that power.

Community members were a dominant force in most CBPH consortia. Despite this fact,
differences of opinion regarding the definition of community made collaboration at the
consortium level difficult for some consortia. In the absence of a shared geographic space,
strong working relationships, or clearly shared missions, the discussion of community
often became emotionally charged. In some cases the disagreement over the definition
symbolized underlying power struggles which might have occurred, regardless of how the
term was defined. In other cases, the Evaluation Team felt that McKnight's definition of
community (which excludes organizations and people who work on behalf of community,
but are not of the community) polarized groups unnecessarily.

The concept of community-based programming may be inherently more difficult to
operationalize in a large consortium that has multiple community sites, or in multiculturally
diverse consortia where shared beliefs, issues, and working relationships have not yet
evolved. The problem of taking a community-based approach to scale is also one that the
Evaluation Team felt was underestimated and remains to be clearly understood. If, for
example, a capacity-building and strong grass-roots approach is taken, the result for
institutions engaged in partnership is that a lot of time and resources are devoted to a
potentially small neighborhood group -- sometimes, at the expense of other deserving
groups. For public health agencies serving a large constituency, for example, the notion of
taking CBPH "to scale" required rethinking how community could be defined, represented,
and involved. The challenge is really one of how to achieve citizen participation in a
democratic, pluralistic society. Despite these struggles, participants whole-heartedly
embraced the general concept of community-based programming. It remained the central
tenet of CBPH.

CCHMs: A Categorical Approach to Community-Based Solutions.

In keeping with its broad definition of "community," all stakeholders who shared a
problem and its solution were invited to the visioning / planning table. CCHMs favored a
categorical representative model in which individuals who fit certain criteria (e.g., "Hispanic physician," "female-owned small businesses") were identified and invited to join the steering committee and work groups. They were a diverse mix of individuals, and on the whole, they were not directly linked with (and were therefore unaccountable to) existing community organizations or groups. In addition, developing a formal plan from scratch was substantially different from their experiences in community development or social action projects -- so much so, that they were often adrift.

While the Community Foundations were neutral players in the health care arena, they did have connections to various key stakeholders and were themselves influential in community decision making. The struggle was not so much between health providers and the rest of the community, as between certain vested interests and their views of what changes in the health care system were acceptable and how change should occur. The three sites each had to learn to share power and decision making. The key was the CEO of the Community Foundation, and his or her willingness to empower the Project Director and steering committee. At the end of the planning phase, one site had learned to share power, a second was still dominated by its Community Foundation, and the third experienced a leadership vacuum which was filled in by lower level staff and some community volunteers.

**Lessons Learned in Community-Based Programming.**

Some interesting challenges to community-based programs arise from the many ways that "community" and "community-based" can be defined. The term "community" has great symbolic and political importance, but operational ambiguity. This appealing and popular concept invites problems with collaboration unless consensus can be achieved upon an operational definition for the initiative at hand, or for the specific purpose being addressed. While the Foundation's commitment to "helping people help themselves" should clearly remain a guiding philosophy for future grants, we recommend the following:

- **Take a more proactive role in the whole discussion of defining community with your grantees.** Begin by recognizing that "community" is a construct; its definition literally has to be "constructed" in order to have meaning. There is no such thing as "the" community, but many communities, and many dimensions to community. If the Foundation could sort through some of this with grantees, and at the same time avoid judgmental and value laden language, that might save grantees some unproductive time arguing "who is real community," or who can legitimately represent community. The
Foundation could invite discussion of how representatives could be selected to strategically represent different dimensions of community. This might more realistically steer people away from a single definition of community for all time and all purposes, and towards a pragmatic view that de-romanticizes community and addresses the political ramifications of the definition.

- **Be up front if you want to use a particular definition of community for a particular initiative or purpose.** If a particular definition is chosen, however, it must be enforced to have meaning.

- **Employ the "community of solution" definition in initiative than are meant to change systems or policy.** Such a definition is necessary, because all players in the system have to be at the table to collaborate for change to occur. *Hold the group accountable, however, to improving outcomes for the "community experiencing the need,"* and do not let rhetoric to divide the partnership into "real" community vs. outsiders.

- **Understand that the challenge of representing a sector is not limited to community.** The same issues occur with academe and practice, with providers and purchasers, or with whatever sectors are involved in an initiative. It is the classic "validity" problem that occurs whenever a larger population or entity is sampled for research or evaluation. It is the challenge of selecting organizations and leaders who can validly represent the larger constituency and simultaneously contribute to the work of the partnership.

- **Recognize that defining community is a political act, and one that may need facilitation.** Especially in a "systems change" initiative, the definition of community, the selection or convening of organizations, and the identification of representatives should be done strategically and carefully, according to some publicly shared ground rules of procedure, and driven by an understanding of the system or policy being addressed. Additionally, representatives may need some training on what it means to serve as a liaison and to represent a sector, vs. representing themselves or their private views.
III Governance and Leadership

A third area of discussion pertains to partnerships or consortia as organizations. Evaluation findings pertinent to governance and leadership were fairly similar across all three initiatives. Each initiative assumed that grantees would form some sort of structure for working together to accomplish the goals of the initiative (e.g., governing boards, steering committees). Both CPHPE and CBPH began with the assumption that these consortia should be long-term, self-sufficient, and sustainable entities. For this reason, in CPHPE especially, early emphasis was put on fairly formal structures leading to 501(c)3 non-profit, charitable organizations. (In later years, however, this emphasis was dropped.) In CCHMs, steering committees were expected to evolve into an independent "health alliance" that could implement the program. This section will discuss the various ways these intentions played out, and some lessons learned for future initiatives.

Evolutions in Organizational Structure.

**CPHPE: Respecting Function Over Form**

In monitoring how the partnerships evolved as organizations, the Evaluation Team observed that the formal structure of the organization seemed less important than the functions performed by it. Partnerships that controlled their own budgets and participated in the selection of faculty and staff for the initiative had greater influence, regardless of whether they were legal entities or simply advisory boards. Additionally, all seven partnerships required years to develop. When the consortia acted too quickly in formalizing their structure, mistakes were often made. Lastly, the burden of spending wisely was great for fledgling partnerships; they needed early guidance in how to use grant dollars.

**CBPH: Decentralizing Decision Making to Permit Greater Autonomy**

In the CBPH, the mood of the initiative shifted during the second year from emphasizing consortia as sustainable, formal organizations to valuing the personal and organizational ties being formed and the underlying goals of institutional/community collaboration. Lessons that consortia shared about the costs of administering large, complex consortia seemed to be that "less is more." For example, one consortium that set out to create a free-standing CBO to house the CBPH disbanded the idea in 1994. The costs of starting a new
organization and obtaining its non profit status proved enormous. Instead of supporting
the three partnering entities, the effort drained them. Additionally, in hindsight, the
approach seemed contrary to building on the assets of the community, and exacerbated
competition among existing CBOs in the community.

In contrast, another CBPH consortium that adopted strategies to increase communication
and decision making around discrete issues (e.g., curriculum), and avoided building a
formal structure, enjoyed higher morale and greater progress. This consortium seemed
better able to channel its resources into shared projects and mutual learning, and to avoid
internal power struggles. On the other hand, however, an equally productive consortium
chose a traditional governance structure to manage its large membership and geographic
territory. Upon receipt of their award, they designated board positions, wrote detailed by-
laws, and agreed upon rules for decision-making, budget allocation, and self-evaluation.
The organizational model served them well and continues today. In fact, this consortium is
the only one in which partnering organizations voluntarily contribute a portion of their
budget back to the governing body to serve as their administrative structure.

These findings led the Evaluation Team to feel that success depends not so much on the
organizational structure used, but on the degree to which skilled leadership is present
across all sectors. It also helped us conceptualize some of the lessons learned about
collaboration and the underlying basis for a partnership. No amount of imposed structure,
no amount of skilled leadership, can help a partnership that lacks a clear purpose for being
and a mutually reinforcing dynamic that springs from the organizations and their members.

CCHMs: Subsidiary vs. Independent Entities.

At the end of the planning phase, CCHMs had not evolved into entities that were
independent of the Community Foundations, as anticipated. One site did begin building a
county-wide membership organization that could become an independent 501(c)3 entity that
could elect people to the governing board. In fact, the staff helped a general member
challenge the credentials of two "consumers" resulting in the election of two additional
"true" consumers to the board. On the other hand, at another site, the Executive Director of
the Community Foundation summarily dismissed the workgroups and committees, and
later received the resignations of the co-chairs. Despite the prescribed "one-third" formula
for sector representation, health care providers comprised half of the total steering
committee membership, and providers only about twenty percent. The sites experienced a
fair amount of turnover in membership as they entered the transition year from planning to implementation. This turnover seemed related to "burn out" and differences over the content of the Community Health Improvement Plan.

Evolutions in Leadership

Turnover in Project Directors was, interestingly enough, a shared phenomenon across all three initiatives. The Project Director (PD) position can be an extremely vulnerable one, in that PDs have to operate at the political nexus of partners who often have little shared history, and are working in a generally charged political environment. PDs have to hear all sides, remain "neutral" in order to facilitate conflict resolution and carry out implementation, yet PDs belong to groups themselves (e.g., ethnic or socioeconomic, gender, professional training). Maintaining trust and credibility with the diverse parties at the table requires a great deal of personal leadership ability, experience, and support that not all PDs have. Some experiences from the three initiatives are presented below.

CPHPE: PD Turnover a Reflection of Consortium Functioning.

In CPHPE, turnover in PDs was associated with lower satisfaction of partnership members. At one site, pressure was placed on an individual to step down from a co-directorship position, while at another, a series of weak project directors were appointed by the deans who didn't trust each other or the project directors. The Evaluation Team observed that when leaders of the partnerships were deans (or others with administrative authority in an academic institution), trust was very difficult to achieve. The most effective leaders seemed to be the "boundary spanner" who could focus the vision and trust for the partnership, and not in terms of what a particular institution might gain or lose.

CBPH: Shared Leadership Was the More Successful Model.

As with CPHPE, conflict around the PD position was associated with general consortium dissatisfaction. It seemed that consortia who began with a traditional, PD-centered structure, or a PD who tried to supply primary vision and direction for the consortium, encountered the most conflict. Over time, the PD role tended to evolve. By the end of Year Four, the PD position was more generally conceived as someone who facilitated and carried out the decisions of the governing board. Leadership was seen as emanating from governing board chairs and sub-consortium "teams" or coalitions, rather than the PD.
CCHMs: Shift Towards Stronger Project Direction.

In CCHMs, as with the other initiatives, leadership proved to be a key factor in the consortium's success or failure. But unlike the CBPH, the PD position evolved into being a more centrally powerful position than not. The original strategy for CCHMs sites called for a facilitator who could support the community volunteer effort. One site stuck with this approach, but soon found that the facilitator (with only a secretary for support) was overwhelmed both by the technical substance of the health project and by the lack of follow through by volunteers. Despite assistance from the community foundation, the "facilitator model" failed and this site was put into receivership by the Operations Office. The position was redefined and a search for a Project Director (rather than facilitator) was begun.

A second type of problem emerged at another site where the PD simultaneously became the CEO of the Community Foundation. This person tried to be proactive, but was unable to balance the demands of the volunteers, the Community Foundation, and the WKKF Operations Officer. The next PD was a compromise candidate who was very low on everyone's ranking, but came from "the right part" of the county. He was very laid back, and eventually resigned. The third site was more successful. A facilitator who was a "carry over" from a previous project was hired, along with a staff with experience in health and community organizations. With the support of the community foundation, this facilitator was functioning like a PD by the end of the transition year.

Lessons Learned for Supporting Leadership in Multi-Sector Partnerships

- **Organizational form should follow function, and structure should be allowed to evolve over time as partnerships mature.** Mandated structures do not appear to enhance the prospect of success, either in terms of collaboration or sustainability.

- **A hierarchical model of leadership does not appear to work well in multi-sector partnerships that are based on collaboration.** Strong PDs were fairly routinely "cut down to size" by the different power brokers around the table. If a PD was too highly or visibly aligned with one interest than another, he or she could not be trusted, and was therefore marginalized or challenged.

- **The successful PD needs an impressive array of strengths:** strong facilitation skills, self-confidence and maturity, the administrative skills to manage a board, and the ability
to keep the vision of the partnership up front and center. A PD does not have to have the vision, but the ability to keep the partnership focused on it.

- **Principles of shared leadership and governance, not just (individual) leadership skills, need to be taught** to governing board leaders, Project Directors, and staff during pre-implementation planning, or by ongoing technical assistance efforts.

- **Foundation staff who are working with collaborative partnerships may need to adjust their expectations and style of interaction.** For example, they need to anticipate that group decision making will be slower and that communication lines will become more elaborate, in order to accommodate the multiple, diverse leaders who are present. Foundation staff should not assume that the PD has the power to make it all happen, or that they are the only contract persons who need to be "brought into the loop.”

- **Think through the implications and consequences of designating which entity (or entities) will serve as fiscal agent for a partnership.** Several decisions are involved as grant awards are made, e.g.: one fiscal agent or two per grant? Should the fiscal agent be a community organization or institution? Should fiscal authority be separate from program design and implementation? Regardless of the decision, the underlying lesson is that the placement of money confers power and triggers a hierarchical relationship among partners.

- **Think through how far the Foundation should go to ensure competent leadership, specifically, the position of Project Director.** Given how challenging this position is, and how pivotal for success, one might conclude that the selection of the PD is too critical to leave entirely to the discretion of the local governing board or grant recipient. Each Evaluation Team observed PDs who were not well prepared for the job, or who did not serve their partnership well. At a minimum, the Foundation should consult with the governing board leaders about the nature of the PD position and its job requirements, and might consider providing some input about the qualifications of potential candidates.

This brings us to our fourth and final section, which concerns the larger discussion of WKKF programming roles.
IV Prescriptive vs. Non Prescriptive Programming

A final area of discussion concerns the various roles that Kellogg program staff appeared to play, and the degree to which the programming style seemed prescriptive vs. non prescriptive. While the observations offered here are perhaps the least well-supported of the four areas in terms of systematic data collection, they still might serve as "food for thought" in future initiatives that intend to have a policy or strategic change impact.

When the three initiatives are compared in terms of prescribed or required elements (see appended chart), they appear fairly similar. All grantees were required to have goals, objectives, and some sort of organizational structure. During implementation, both CBPH and CPHPE required members to attend annual networking meetings, host annual site visits from Kellogg staff and Cluster Evaluators, and submit annual project reports. There were occasions in all three initiatives where WKKF Program Directors had to intervene with partnerships who were struggling to the point of paralysis. Such intervention was warranted, generally effective, and well received. Despite these similarities, the initiatives did vary in terms of programming style, with CPHPE and CCHMs reflecting a more directive and hands-on approach, and CBPH a less directive style.

Differences in Programming Role and Use of Evaluation

CPHPE: The Foundation Becomes Part of the Intervention.

This initiative illustrated what might be called a prescribed focus and strong Program Director style of programming. By prescribed focus we mean not just that the CPHPE had specific goals and objectives, but that these goals and objectives were mandated from the beginning. Partnership workplans were required and very closely supervised by program staff, especially in the first three years. Additionally, the Program Director assumed major responsibility for implementing a strategy to inform public policy makers at the national level. All CPHPE partnerships were expected to work with the Foundation in building an Integrated Action Plan (IAP) that united efforts and expectations at the initiative level. Cluster Evaluators studying the CPHPE came to feel that the programming style was itself an "independent variable," an element of the "intervention."

Programming style can influence how a Cluster Evaluation is framed and how it operates. In the CPHPE, Cluster Evaluators were not ambivalent in terms of whom they were
working for; they identified the Kellogg Foundation and the CPHPE Program Director as their primary stakeholder and audience for evaluation data. While the participants were important members of the initiative, most of the feedback gained from the evaluation process went first to the Program Director, then to participants. Individual site visit reports, for example, were not written for partnerships nor sent to Project Directors, although aggregate findings were disseminated. Formal reports were directed towards external audiences in the larger policy setting, in keeping with the overall change strategy of the initiative.


A fairly different programming environment was observed in the CBPH. In the CBPH, the Foundation outlined a number of broad goals and a general set of objectives. The particular objectives were set by individual consortia, however, and they enjoyed a great deal of flexibility and room for experiment in how they operationalized them. CBPH consortia were quite varied in their composition and problem focus. Altogether, 67 different organizations were involved, and each came to the initiative with different missions and characteristics. Thus, their objectives were quite diverse.

Given the definition of community and emphasis on community ownership, the reaction of CBPH participants to the introduction of the IAP process at the beginning of year three (fall, 1994) was unfavorable. Participants did not feel that the IAP had been drafted with their input, and the plan seemed to expect greater policy and health outcomes impact than they had committed to. After that time, Foundation staff increased the amount of joint decision making with consortia members. A Policy Task Force was funded through a separate grant to consortium members, and this representative body developed their own goals and objectives with regard to defining policy objectives and strategies.

The CBPH Cluster Evaluation team responded to the community-centered, consortia-driven nature of the initiative by considering consortia and the Foundation as equal stakeholders in the evaluation. Reporting procedures for protecting consortia member anonymity had to be cautiously worked through before site visit data and surveys could be accomplished. Site visit reports were not sent to the Foundation until sites had reviewed the reports for accuracy and interpretation. When our interpretations did not match those of participants, we appended their comments as addenda to our reports. In sum, the Evaluation Team considered the consortia leadership as primary users of Cluster Evaluation data. Without
this orientation, the Evaluation Team felt we would have been “dead in the water” politically speaking, unable to solicit members’ cooperation in the evaluation, and also “missing half the story.”

CCHMs: Close Monitoring From an “Operations Office.”

The programming style of CCHMs featured close monitoring and trouble shooting, but not dictating decisions or activities. Because the three CCHMs sites were all within a three-hour drive from Battle Creek, distance was not a barrier to site visits, network meetings, or lengthy telephone conversations. This proximity enabled close relationships which differs from the traditional model in which a Program Director may make one or two site visits a years, or telephone projects on a monthly or quarterly basis. The Operations Office was considered to be very supportive by the sites in times of crisis. They helped sites deal with a variety of management problems involving the Project Directors and staff. As concerned outsiders, they mediated disputes among stakeholders and forged agreements that pooled resources and created joint ventures.

In terms of Cluster Evaluation roles, the vision/planning phase was initially expected to be relatively uneventful. The Evaluation Team therefore planned to simply document events for their own reports. But as the planning phase became complicated and drawn out, the role shifted to more site-level formative and process evaluation. The Evaluation Team extended its efforts to accommodate this, but eventually recommended that local evaluators be hired. The Evaluation Team participated with the sites in jointly hiring Project Evaluators. (In the CBPH and CPHPE, the Cluster Evaluators did not share in this task.) As with the other two initiatives, each CCHM site received a data disk of results from surveys conducted locally. As was true with CBPH but not with CPHPE, each site reviewed all relevant descriptions and findings for accuracy before the data/reports were submitted to the Foundation.

**Reflections**

What this comparison between the initiatives invites is the extent to which a Foundation should lead or direct an initiative that purports to be community-based. This is an important philosophical question. *The conundrum is this: If a Foundation does not set a strong course, a clear direction, how can it expect to achieve the societal purpose for which the investment is being made?* At the same time, *can the Foundation always presume to*
know what is best, especially at the local level? Does strong direction inhibit the capacity of grantees "to help themselves," or stifle the wisdom of community and institutional partners to define and solve their own problems?

Perhaps the success of an initiative is always dependent upon personalities and the way in which programming staff juggle the unexpected and play a complex role in a challenging, unpredictable situation. But perhaps some optimal balance between consistent direction and flexibility, clarity and facilitative support can be found. Perhaps the current program staff can benefit from a respectful discussion of their different orientations, and brainstorm just how to achieve the best outcomes for grantees and society, with the different programming styles that will inevitably occur.
Conclusion

This paper has described ways in which three important initiatives were similar and ways in which they were different, and provided some observations to stimulate discussion and serve future health programming. While the initiatives are not "over," and their many points of difference make strong generalizations hazardous, the following comments summarize the clearest recommendations we can offer at this time:

1. **Continue to use planning or visioning phases prior to implementation.** These are enormously fruitful experiences for people. During this period much critical groundwork is laid in terms of relationships, philosophical grounding, education and training, and positioning resources for action.

2. **Use multiple strategies to support partnership organizations during implementation.** Recognize that consortia represent "moving targets." Because their membership and focus are likely to change over time, they will need continuous doses of interaction and support to stay relatively in tune and on the same page of music.

3. **Take the time to build clear theories of action with informed audiences and key stakeholder groups before launching a large-scale policy or systems change initiative.** Involve Cluster Evaluators and other professional support staff at this stage to research the empirical basis of evidence for the program's "logic model." Use the analysis of the system as a guide for defining "community" and the sectors that need to be represented. Use the logic models as tools for communication and accountability, and teach partnerships how to do the same.

4. **Clarify whether initiatives are essentially capacity-building in nature vs. policy or systems change initiatives.** Consider the implications of the focus for grantee selection, coalition formation, realistic goals and expectations, timelines, and support strategies. If policy oriented, define the policy targets or agenda early and often. If capacity building is the intent, connect the capacities to be developed with clear intermediate milestones, not just a broad, long-term goal.

5. **Clarify what you mean by "community" and "community-based" for a given initiative.** If appropriate, be clear with grantees as to which definitions can be considered faithful
to the intention of the initiative, and which are not. Enforce whatever rules for representing community are agreed to.

6. **Consider when and how collaborative partnerships can be instrumental for success, and when this strategy is optional.** As colleague Arthur Himmelman has noted, don't expect vulnerable neighborhoods and overworked bureaucracies to form new partnerships every time a new initiative is launched. Among other alternatives, consider: building the capacity of existing partnerships so they can address problems of their own choice; selecting mature coalitions to play strategic roles in a policy change initiative; allowing grantees to propose a partnership strategy as they see fit.

7. **Don't underestimate the challenge of changing health status, "systems," or of building capacity in community and institutions.** These are all major endeavors that require long-term funding and short-term milestones to help grantees mark their accomplishments and reflect on their progress. Study the relationship between the following variables: funding level (i.e., the amount of dollars invested by WKKF and grantees), the number and scope of target objectives, the size of "community," and "success." We don't know what "the right amount" of funding is for initiatives, but it seems that there should be more consistent funding for future grants.

8. **Build leadership capacity across multiple sectors.** Teach shared leadership skills, which include collaboration and conflict resolution skills and multicultural competency, among other things. Don't assume that people of color have multicultural skills, simply because they are of color, or that people working in institutions don't have them, simply because they don't live in distressed neighborhoods.

9. **Practice what you preach.** If you expect grantees from all walks of life to collaborate, then demonstrate that you at the Foundation know how to collaborate with each other. If you expect projects to use evaluation for improvement, then model this philosophy by structuring in sufficient time to learn from your efforts. Share information and benefit from your collective experience and wisdom. There's a lot there.

10. **Supply WKKF Program Directors with sufficient support staff and time.** especially when large scale, multi-sector change initiatives are launched. As the previous nine suggestions indicate, this work is difficult. It demands significant expertise in the content areas being addressed and time to carry out from inception to completion.
References


Overview of Three Cluster Initiatives

Community Partners in the Health Professions (CPHPE)
Community Based Public Health (CBPH)
Comprehensive Community Health Models (CCHM)

<table>
<thead>
<tr>
<th>Program Descriptor</th>
<th>CPHPE</th>
<th>CBPH</th>
<th>CCHM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goals</td>
<td>1. To increase the number of suitably trained health professionals outside of the hospital setting.</td>
<td>1. Develop community-based models of research, education, service, and practice; strengthen the practice and teaching of public health by creating partnerships with an informed and involved public.</td>
<td>1. Enhance the integration of the health delivery system. Make it a comprehensive system which integrates medical, health, and human services and elevates the roles of health promotion, disease prevention, and primary care.</td>
</tr>
<tr>
<td></td>
<td>2. To enhance the relevance of health professions education by providing training in primary care and community settings.</td>
<td>2. Build capacity of the community, academic, and health practice agencies to make small and large &quot;p&quot; policy changes.</td>
<td>2. Increase community wide coverage, i.e., access to affordable and appropriate care within a community defined basic health service plan with a strategy to include the under- and uninsured.</td>
</tr>
<tr>
<td></td>
<td>3. To develop community-based academic health centers as an alternative to hospital-based education.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1996 - GMNE</td>
<td>1996 - Bridge money</td>
<td></td>
</tr>
<tr>
<td>Sectors Involved and</td>
<td>39% Academic Institutions (Medicine &amp; Nursing)</td>
<td>30% Academic Institutions (Public Health, Med, Nurs)</td>
<td>35% Health Care Consumers</td>
</tr>
<tr>
<td>Percent of Membership</td>
<td>61% Community</td>
<td>22% Public Health Practice</td>
<td>14% Health Care Purchasers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>48% Community (CBOs)</td>
<td>51% Health Care Providers</td>
</tr>
</tbody>
</table>
### Program Descriptions, cont.

| Grantees | 7 partnerships in 7 states  
6 fiscal agents were in academe,  
1 was a city hospital trust  
Each partnership had one or more designated site for Community-Based Academic Health Centers (CBAHC). |
|-----------|---------------------------------------------------------------|
| 7 consortia in 7 states  
Most fiscal agents were in academe; 2 were in health departments; 1 was a CBO.  
Multiple project sites within states. Geographic spread varied, from urban ghettos to whole cities to multiple (4) counties or coalitions across a state. |
| 3 community foundations in 3 counties in Michigan. Each had a population of approximately 150,000.  
The fiscal agents were the 3 community foundations. |
| Membership Size | N = 120 total (average per year);  
 n = 17 per partnership (average)  |
| 0 = 265 (annual average)  
(Not counting all participant members at sub-consortium or coalition level)  |
| 1 = 435 (1995-96)  
n = 145 participants per site boards, including committees and work groups. |
| Average grant award | Planning = 0  
Implementation = 6 million per partnership |
| Planning = 0  
Implementation = 2 million per partnership |
| Planning = $448,000 per county  
Implementation = 4 million per county |
<table>
<thead>
<tr>
<th>Program Descriptor</th>
<th>CPHPE</th>
<th>CBPH</th>
<th>CCHM</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Theory of Action</strong></td>
<td><strong>Problem:</strong>&lt;br&gt;Lack of primary care physicians with appropriate training.</td>
<td><strong>Problem:</strong>&lt;br&gt;Poor health status of marginalized groups</td>
<td><strong>Problem:</strong>&lt;br&gt;Uncoordinated health care delivery, lack of affordable health care for the uninsured and underinsured.</td>
</tr>
<tr>
<td>(Underlying assumptions, program models, theories of social change)</td>
<td><strong>Current (1990) training did not reflect multidisciplinary reality of practice, nor the reality of community needs.</strong></td>
<td><strong>Eroding public health infrastructure</strong>&lt;br&gt;<strong>Discipline and practice of public health &quot;out of touch&quot; with community</strong>&lt;br&gt;<strong>Disempowered community</strong>&lt;br&gt;<strong>Fragmentation in services and resources</strong></td>
<td><strong>Assumptions:</strong>&lt;br&gt;Health care is predominately purchased, delivered, and consumed in communities. Information on health status and systems is required for informed decision making. Shifting revenues and incentives to primary care and prevention will improve health status.</td>
</tr>
<tr>
<td><strong>Change Strategy:</strong>&lt;br&gt;Academe requires strong outside influence to change. WKKF, by funding partnership organizations (CBAHC), provides a sustained source of influence on academe.</td>
<td><strong>Change Strategy:</strong>&lt;br&gt;Change in systems results from interaction across all 3 sectors.</td>
<td><strong>Change Strategy:</strong>&lt;br&gt;A planned change model from visioning to action can facilitate and guide the reform process. Active participation of consumers, payers, and providers can build collaborative community support. Communities can shape public and market policy at local, state, and national levels. External agents, working in partnership with communities, can serve as catalysts for change. Community foundations can serve as neutral conveners and bring diverse stakeholders to the table.</td>
<td><strong>State and Federal policies must be targeted into the sustainability plan.</strong>&lt;br&gt;The clinical years, when professional socialization is strongest, should be the focus of intervention. <strong>Multidisciplinary education offers a more relevant experience for health professions students.</strong>&lt;br&gt;Community involvement will strengthen the quality and sustainability of the model.</td>
</tr>
<tr>
<td>Community Orientation</td>
<td>CPHPE</td>
<td>CBPH</td>
<td>CCHM</td>
</tr>
<tr>
<td>-----------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Definition of &quot;Community&quot; and &quot;Community-Based&quot;</td>
<td>The definition of &quot;community&quot; was modified to focus on clients served by the CBAHCs. Ultimately, &quot;community&quot; was defined by each grantee's board membership. Generally, &quot;community&quot; refers to the local constituencies and coalitions that come and go around timely issues. Generally, &quot;community-based&quot; meant a CBAHC was: Located in a neighborhood of need; Governed by a majority of community residents</td>
<td>The definition of &quot;community&quot; varied somewhat by consortium (and within consortia), with most of the tension between defining community only as people who live in underserved neighborhoods and experience health problems directly, vs. people who advocate for community, work in CBOs, or in other ways &quot;represent&quot; community (i.e., racial heritage), but may also enjoy benefits of a privileged group (e.g., have education and training, salaried government job, live outside the neighborhood). Generally, &quot;community-based&quot; meant a program or project was: Located in a neighborhood of need; &quot;Owned&quot; by community residents and CBOs. Rooted in community principles of action and knowing. Responsive to assessment of community assets and goals, not just needs or deficits.</td>
<td>&quot;Community&quot; was defined as health care consumers, purchasers, and providers. A program is &quot;community-based&quot; when it: Is under the auspices of a local community foundation, a 501(c)3 charitable organization; Conducts community meetings to gain feedback and sanction decisions for visioning and planning; Designs and implements communications and other outreach activities.</td>
</tr>
<tr>
<td>Governance Model of Consortia</td>
<td>CPHPE</td>
<td>CBPH</td>
<td>CCHM</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>Characterized by 2 factors; organizational formalization and locus of power.</td>
<td>3 of the 7 were very formal (i.e., incorporated entities) that were closely linked to academe. 2 were independent unincorporated organizations. 2 were advisory to other organizations.</td>
<td>Varied from formal structure (i.e., chair, vice chair, etc.) to very informal (no Project Director, no elected positions or by-laws).</td>
<td>Patterned after Health System Agencies (HSAs) with 1/3 consumers, 1/3 purchasers, and 1/3 providers.</td>
</tr>
<tr>
<td>The locus of power was mostly shared between community and academe, but leaned toward academe.</td>
<td>Multi-levels of project governance emerged due to multiple sites and large size of consortia membership.</td>
<td>In reality, governance reflected how participative decision making was traditionally carried out in the county; it therefore ranged from a power elite model to bringing to the table representatives of categorical groups – various consumer types; large and small businesses, health facilities and individual providers.</td>
<td></td>
</tr>
<tr>
<td>Most Project Directors were university-affiliated</td>
<td>Co-leadership models of governance evolved, with community in top leadership roles, but academe often provided catalytic and stabilizing force.</td>
<td>1 site’s board had a single chair (purchaser), one site had co-chairs (consumer and provider), and one site had tri-chairs (all three sectors).</td>
<td></td>
</tr>
<tr>
<td>Loose consensus decision making.</td>
<td>High conflict and turn-over in project directors (6 of the 7 consortia over 4 years). This role tended to de-escalate over time in terms of &quot;power,&quot; from central leader to facilitator.</td>
<td>1 site had a sufficient number of staff with expertise; 1 site had a marginal number of staff with expertise; 1 site had only a facilitator and secretary for the first 18 months before hiring a project director.</td>
<td></td>
</tr>
<tr>
<td>Consortia governance proved to be high maintenance, labor intensive administrative structures.</td>
<td>Loose consensus decision making.</td>
<td>2 of the 3 sites had difficulty separating the grantee organization (Community Foundation) executive director role from the project director role.</td>
<td></td>
</tr>
<tr>
<td>Program Objectives</td>
<td>CPHPE</td>
<td>CBPH</td>
<td>CCHM</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Program Objectives</td>
<td>1. Increase number of students trained out of hospital.</td>
<td>1. Build community capacity to organize around issues of public health</td>
<td>Planning Phase: 1. Create a Community Health Improvement Plan (CHIP) which incorporates a community vision and systemic approach to:</td>
</tr>
<tr>
<td></td>
<td>2. Increase the amount of curricula time spent in CBAHCs.</td>
<td>2. Deliver health services better to underserved populations.</td>
<td>(a) Enhance the integration of the health delivery system, and</td>
</tr>
<tr>
<td></td>
<td>3. Develop or revise multidisciplinary course curricula.</td>
<td>3. Strengthen programs in health promotion and disease prevention.</td>
<td>(b) Increase community-wide coverage.</td>
</tr>
<tr>
<td></td>
<td>4. Establish community/institutional partnership structure to oversee the CBAHC.</td>
<td>4. Assess community assets and goals (needs).</td>
<td>2. Use an inclusive decision making process that includes strategies for:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Recruit community people into academe (students, faculty, &amp; staff) and into health practice.</td>
<td>(a) An integrated administrative structure,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>6. Provide mentoring, education, employment, or other types of upward mobility opportunities for disadvantaged youth.</td>
<td>(b) A community-based health information system, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7. Build a collaborative consortium comprised of the 3 partners.</td>
<td>(c) Community health assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>8. Build knowledge about community-based public health through research and evaluation.</td>
<td></td>
</tr>
<tr>
<td>Which Program Elements Were Required or Prescribed by WKKF Program Staff?</td>
<td>CPHPE</td>
<td>CBPH</td>
<td>CCHM</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Program Objectives?</td>
<td>Yes. All of the objectives listed on page 6 were prescribed and monitored.</td>
<td>Not literally prescribed or required. Multiple goals and objectives (see previous table) were generated by consortia. These goal statements all have roots in the Foundation’s original RFP.</td>
<td>Yes. The Comprehensive Health Improvement Plans had to address: (a) integration of health services and promotion of prevention and primary care; (b) increasing coverage and access to health care; and (c) inclusive decision making process for implementation.</td>
</tr>
<tr>
<td>Workplan Specifics or Monitoring?</td>
<td>Very close monitoring of required workplans by WKKF in the first 3 years. Early programming style might be described as aggressive and prescribed, later it became more project centered.</td>
<td>Workplans were not prescribed or closely monitored. Workplans we saw varied in quality from basically non-existent to very complex and detailed.</td>
<td>An Operations Office was established to monitor the sites, run training and networking meetings, facilitate policy linkages, coordinate consultants, and oversee evaluation. Relatively close monitoring by the Op. Office, particularly with respect to inclusive participatory decision making, planning and outreach as a process, and staff structure and support. This was not a hands-off, twice a year site visit approach.</td>
</tr>
</tbody>
</table>
| Consortia Organizational Structure? | Required, but not prescribed.  
Encouraged to be formal (i.e., 501(c)3 non profit status).  
Community involvement was required.  
Many emerged to mirror academic committee structures. | Not prescribed. A generally hierarchical or Project Director centered organization was anticipated, but lots of variation occurred. Overtime, 2 consortia opted to further decentralize, and to backtrack from strong central collaboration to a looser form of networking across independent teams.  
501(c)3 status was not assumed or prescribed, and as a model was basically rejected by all consortia. | Required a governing board of 1/3 consumers, 1/3 payers, and 1/3 providers and reasonable distributional representation on workgroups and committees.  
Worked towards separation of the project organization from that of the host Community Foundation. |
| Consortia Organizational Process? | Shared decision making between community and academe.  
Network meetings required attendance by a representative group of participants. | Involvement of all 3 partners was a much repeated theme.  
A high form of collaboration was expected by Foundation and adopted by grantees as a model of practice after the LMD.  
Community ownership was a much repeated theme and an enforced expectation. | Inclusive, accountable participative community decision making process.  
Visioning as the start of a planning process.  
Participant leadership of committees and workgroups.  
Consideration of community health profiles (county level health statistics) in planning process. |
<table>
<thead>
<tr>
<th>Required Activities?</th>
<th>Annual visits with WKKF program directors.</th>
<th>Annual site visits with WKKF program directors.</th>
<th>Periodic visits with Op. Office staff (as needed)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Annual site visits with Cluster Evaluation Team.</td>
<td>Annual site visits with Cluster Evaluation Team.</td>
<td>Periodic network meetings of Project Directors and some staff.</td>
</tr>
<tr>
<td></td>
<td>Participation in Project Director Meetings twice a year.</td>
<td>Participation in annual Project Director Meetings.</td>
<td>Informational presentations at each site by consultants on such things as community health profiles, statistics, information systems, outreach and communication, organizational process, and evaluation.</td>
</tr>
<tr>
<td></td>
<td>Participation in annual network meetings twice a year.</td>
<td>Participation in annual meetings of the CBPH initiative at large.</td>
<td>Periodic visits with Cluster Evaluators.</td>
</tr>
<tr>
<td></td>
<td>Participation in annual evaluation meetings once a year.</td>
<td>Participation in annual meetings of Cluster and Project Evaluators.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lots of other spin-off events at the national and local level, hosting of international visitors and WKKF Board.</td>
<td>Participation in planning the annual meeting of the CBPH initiative (1994-96).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Project Evaluation.</td>
<td>Project Evaluation.</td>
<td>Project Evaluation (required after one year)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Required Written Products?</td>
<td>Integrated Action Plans were encouraged but not enforced.</td>
<td>Community Health Improvement Plan (CHIP). Among other things, the Plan had to demonstrate:</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Completed Integrated Action Plans.</td>
<td>Annual Project Reports.</td>
<td>(a) Project structure and staff for operating, monitoring, and evaluating the implementation phase,</td>
<td></td>
</tr>
<tr>
<td>Annual Project Reports</td>
<td></td>
<td>(b) Community matching funds and multi-stakeholder support pledges,</td>
<td></td>
</tr>
<tr>
<td>Participation in jointly designed and implemented evaluation data collection, e.g.: pre-post student and faculty surveys, survey of partnership boards and committee members.</td>
<td>Documentation of consortium activity and outcomes, a.k.a. the &quot;Indicators&quot; developed by the Cluster Evaluation Team: every 6 months (1994-96). Cost-Benefit surveys (two administrations). CBPH video documentary.</td>
<td>(c) Evidence of public support for the plan.</td>
<td></td>
</tr>
<tr>
<td>Submission of membership data every 6 months to the Cluster Evaluation Team (1992-96).</td>
<td>Communication Plans were encouraged but not enforced.</td>
<td>(d) Identification of state, federal, and market policy changes required for implementation.</td>
<td></td>
</tr>
</tbody>
</table>