

TCE/ PPH Annual Evaluation Report

Summary of Key Findings

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**Center for Community
Health & Evaluation**

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INTRODUCTION

The Partnership for the Public's Health (PPH) is a \$37 million, five-year initiative funded by The California Endowment to develop partnerships between California communities and local health departments. Fourteen¹ county and city health departments have been funded under the PPH Initiative along with 39² local community groups (including established service agencies and resident-based organizations). The grantees funded under the Initiative are extremely diverse in terms of ethnicity, geography, types of community groups, and past histories collaborating on community health improvement projects.

The Initiative evaluation draws on a combination of efforts by local evaluators based in each of the health jurisdictions and an overall evaluation team made up of Partnership for the Public's Health staff and an external evaluation team—the Center for Community Health and Evaluation (CCHE). This Summary of Key Findings is based on the third in a series of four evaluation reports. The third evaluation report covers activities through PPH Grant Year 3 (Sept 2002-August 2003). The final evaluation report will be disseminated in the spring of 2005, following the end of the PPH Initiative, and will provide a cumulative report of the progress and lessons learned from the PPH Initiative.

¹ Although 14 public health departments participated, for evaluation analysis purposes we considered the five participating Los Angeles Service Planning Areas (SPAs) separately, given that each had a unique leadership and governance structure. Considering the SPAs separately results in the number of participating health departments being 18 rather than 14. One of the SPAs was defunded in Grant Year 2, leaving only our total for health department at 17 in Grant Year 3.

² While there were 39 community groups/partnerships at the start of the PPH Initiative, two partnerships were defunded over the course of the Initiative. Loss of funding also meant that the evaluation did not have data on certain aspects of the partnerships accomplishments and progress, resulting in a fluctuation in the reported number of community group and partnerships through out this report.

Key Questions

PARTNERSHIP BUILDING QUESTIONS

1. What community capacities are being built through the PPH partnerships? Which capacities are most closely linked with community health improvement activities?
2. What specific actions should a community group take in order to partner effectively with its local health department to jointly carry out health improvement activities?
3. What capacities are required for health departments to partner effectively with communities?
4. What initial actions should health departments take in order to partner effectively with communities to jointly carry out health improvement activities?
5. What progress has been made by the local partnerships?
6. What plans are being made by individual partnerships to sustain the work started under PPH?

INITIATIVE DESIGN QUESTIONS

7. What outcomes have been achieved by the Initiative's statewide policy efforts?
8. What capacities has the PPH Office developed over the course of the Initiative?
9. What are the key lessons learned about an open-ended, place-based approach to community health improvement?
10. What are the key lessons learned about evaluating an initiative of this scope using a participatory approach?

1. What community capacities are being built through the PPH partnerships? Which capacities are most closely linked with community health improvement activities?

The community groups have used PPH funds to build a range of capacities, including the ability to maintain a stable internal organization and governance, develop staff skills, increase resident involvement, develop new leadership, collect and use data, cultivate relationships and alliances with other organizations, raise funds, and communicate with the community at large. An initial analysis suggests that some capacities are needed to create a stable organization, while additional capacities are required to work effectively with health departments and advocate for policy and systems changes.

Capacities needed for a stable organization:

- Cultivate trust among members
- Acquire needed resources
- Maintain effective leadership
- Identify and acquire appropriate infrastructure
- Agree upon and maintain a shared vision

Capacities facilitating work with health department:

- Engage residents
- Collect and use data
- Cultivate new leadership
- Serve as the legitimate voice of the community

Capacities facilitating policy and systems change:

- Mobilize residents
- Create new alliances

CCHE has developed a checklist to assess a community group's readiness to participate in a community-based public health partnership based on findings from the PPH Initiative.

<p>Readiness Checklist for Community Groups</p> <p>How ready is your community group to implement a community-based approach to public health?</p> <ul style="list-style-type: none"><input type="checkbox"/> Does the community group have a clear vision and goals?<input type="checkbox"/> Is the leadership strong and stable?<input type="checkbox"/> Is the community group able to acquire the resources needed to carry out its goals?<input type="checkbox"/> Does the community group have an appropriate level of staff and infrastructure?<input type="checkbox"/> Is there an atmosphere of trust among people participating in the community group?<input type="checkbox"/> Does the community group serve a clear geographic or population base?<input type="checkbox"/> Has the community group successfully collaborated with other organizations or governmental entities in the past?<input type="checkbox"/> Does the community group involve residents in key roles, including leadership?<input type="checkbox"/> Is the community group able to collect and utilize data for assessment, advocacy, evaluation, and strategic planning?<input type="checkbox"/> Do community members know about the community group and view them as representing their needs?
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2. What specific actions should a community group take in order to partner effectively with its local health department to jointly carry out health improvement activities?

In order for community groups to work effectively with health departments they must:

- **Maintain a stable organizational infrastructure and leadership.** Community groups need a solid organizational infrastructure (e.g., office space, staffing, financial accountability) and strong leadership in order to work with health departments. Community groups with high levels of staff turnover, especially in leadership positions, are usually unable to foster a productive relationship with a health department.
- **Develop the ability to gather and use data.** Community groups that are able to collect and use data effectively for planning, mobilization, and advocacy are better able to communicate their needs to health department leadership. Working together to collect and use data is an effective way for community groups and health departments to collaborate, build trust, and increase outreach into the community. Health departments can supply community groups with appropriate data and/or provide expertise in data collection and analysis. Community groups then can provide health departments with an entry into the community for future efforts.
- **Familiarize community group staff and resident participants with health departments' structure and processes.** In collaboration with the health department, community groups need to ensure that residents have a basic understanding of the way health departments function, including how meetings are organized and conducted, the way decisions are made, and how to articulate demands and concerns. A more specific understanding of their own local health department is needed in order to collaborate effectively.
- **Establish themselves as a recognized voice of the community by having a significant constituency.** One of the most important assets that community groups can bring to health departments is their connection with the broader community. It is very important that community groups have solid linkages to the community at large and are recognized as organizations that legitimately represent the community. Activities that solicit resident input and demonstrate that the community groups are working to represent the best interests of the community greatly enhance the contribution that they are able to make to their partnership with the health department.

3. What capacities are required for health departments to partner effectively with communities?

Health departments have developed a number of capacities to successfully work with community partners. The following capacities appeared to be most important for establishing and maintaining effective community partnerships.

- **Health department leadership understands and can clearly communicate the value of working with communities.** It is critical that health department leadership be able to persuasively articulate the benefits of working with the community. Those health departments with the strongest mechanisms for working with communities have support

from key leaders within the health department who have the power to influence decision-making and organizational culture.

- **Creative financing that prioritizes work with communities.** One of the biggest challenges that health departments face is finding funds to work with communities. Health departments have adopted a number of different strategies for finding funding that is flexible enough to use for community-based public health. These strategies include: using local general fund or state realignment monies, using administrative waivers to streamline administration of funding streams, flexible use of categorical funding, and creative use of bioterrorism preparedness funding.
- **Institutionalized mechanisms for including community input in health department program planning and implementation.** Examples of input mechanisms include community advisory boards, direct involvement of community members in assessment and planning processes, and regular public forums. Support may need to be provided to help community residents participate, including providing stipends, childcare, transportation, and training.
- **Workforce policies that permit health department employees to work with communities.** Public health nurses, outreach workers, and other staff should be encouraged to work with the community through the provision of incentives for time spent with community (e.g., flexible work hours, performance rewards) and support from supervisors. Staff positions specifically dedicated to working with the community can provide a crucial link between the health department and community groups.
- **Staff training on community collaboration.** Trainings can be developed collaboratively with community residents to build the capacities of both health department staff and residents to work effectively on community health issues. Key competencies include outreach skills, media advocacy, community-based assessment, participatory research, and collaborative leadership.
- **Commitment to sharing data.** The epidemiology departments in most health departments provide a valuable link to communities. Data collected by health departments can assist community groups with grant writing, advocacy, and identification of community health issues that need to be addressed. The ability to provide community level data is critical to support these efforts.
- **Culturally competent staff.** Health department staff needs to speak the languages and understand the cultural norms of the communities in which they work. Bicultural staff provide important linkages to groups that may be hard to access through standard media channels.

4. What initial actions should health departments adopt in order to partner effectively with communities to jointly carry out health improvement activities?

The following are some initial actions that health departments involved in PPH have taken to increase their contribution to community health improvement:

- **Work with the community to provide timely community-level data** and/or assist with data collection and analysis.
- **Educate the community** about the structure and processes of the health department so that community groups are better able to partner.
- **Find ways to foster change in the health department culture** so that greater emphasis is placed on working collaboratively with communities.
- **Make money and resources available for work with communities.** This often requires creative financing strategies, such as mini-grants to community groups.
- **Participate in strategic planning and assessment processes, such as Mobilizing for Action through Planning and Partnerships (MAPP)**³ that involve extensive community input. (See Appendix A for a more detailed description of MAPP)
- **Develop a work force that understands the importance of working with communities** and puts this understanding into practice on a daily basis.
- **Provide formal structures for community participation and input,** (e.g. advisory boards and regular community forums).

CCHE has developed a checklist for evaluating a health department’s readiness to implement a community-based model of public health based on findings from the PPH Initiative

Readiness Checklist for public health departments	
How ready is your health department to implement a community-based approach to public health?	
<input type="checkbox"/>	Is there evidence that organizational leadership is committed to working with communities?
<input type="checkbox"/>	Is the leadership willing to dedicate workforce time and resources to the effort?
<input type="checkbox"/>	Is the health department willing to share data and work in collaboration with community groups to collect and distribute health data?
<input type="checkbox"/>	Is the health department willing to collect data on the broader determinants of health?
<input type="checkbox"/>	Has the health department successfully collaborated with community groups in the past?
<input type="checkbox"/>	Is the health department willing to spend time and resources building community capacity?
<input type="checkbox"/>	Is the health department willing to relinquish some control over the way health improvement activities are planned and implemented?

³ [Mobilizing for Action through Planning and Partnerships](#) (MAPP). MAPP, developed by the National Association of County and City Health Officials (NACCHO) and the Center for Disease Control (CDC), is a community-wide strategic planning tool for improving community health. Facilitated by public health leadership, this tool helps communities prioritize public health issues and identify resources for addressing them.

5. What progress has been made by the local partnerships?

Local Partnerships were assessed as having high, high moderate, moderate, or low progress in each of the five goal areas. Partnership Summaries (Appendix D) provided the information on partnership progress in each of the five goal areas of the Initiative—1) community group capacity building, 2) health department capacity building, 3) partnership capacity building, 4) community health improvement, and 5) policy and systems change. Data from these summaries were used as the primary data for this progress assessment. Two progress assessments have been conducted to date. The first was based on progress from the beginning of the Initiative through Grant Year 2 (Fall 2000-August 2002); the second was based on progress from the beginning of the Initiative through Grant Year 3 (Fall 2000-August 2003). A more detailed explanation of the assessment process and the definitions of the assessment categories can be found in the main report.

Internal Capacity Building: Community Group: The majority of grantees are making notable progress in building internal capacity; 24 of 37 partnerships (65%) were assessed as making high or high moderate progress. The number of partnerships rated high in their progress toward building internal capacity (N=7, 19%) remained the same between Grant Year 2 and Grant Year 3. Factors associated with high levels of progress in this goal area include strong and consistent leadership, a stable core group of members, paid staff to conduct outreach, and recruitment activities.

Internal Capacity Building: Health Department: Slightly over half of health departments achieved high or high moderate progress (9 of 17). The number of health departments with high progress increased from three in Grant Year 2 to five in Grant Year 3. Over 80 percent of participating health departments instituted two or more structural changes to support more effective work with community. Twelve of the 18⁴ health departments reported that they are now able to provide community specific health profiles. Factors associated with high levels of progress in health department internal capacity building include a strong commitment to working in partnership with community groups that predates the PPH Initiative, establishing regional health department offices to serve specific communities, and conducting assessments (through surveys and focus groups) to identify community concerns.

Partnership Development: Twenty-three of the 37 partnerships achieved high or high moderate progress in partnership development. (62%). Progress in partnership development was notable in Grant Year 3, with a total of 10 partnerships with high progress compared with only three in Grant Year 2. Factors associated with high levels of progress include: joint training and capacity building, evaluation processes at the local level that provide formative feedback, and clear governance and/or communication structures.

Community Health Improvement: Sixty-three percent (24 of 38) partnerships achieved high or high moderate progress in their work in community health improvement. The number of partnerships rated high increased from five in Grant Year 2 to eight in Grant Year 3. Eighty-two percent of the partnerships have implemented three or more community health improvement activities, and 85 percent of all the partnership activities reach beyond traditional public health activities to address the broad determinants of health. Factors associated with high levels of progress in partnership development include addressing a range of priority health issues,

⁴ As noted earlier, for evaluation purposes we consider the five partnering Services Planning Areas to be different health departments, despite the fact they are all in Los Angeles county.

responding to issues identified as important by the community, working in a small or well-defined community, and effectively mobilizing residents.

Policy and Systems Change: About one-half of the partnerships (18 of 37) achieved high or high moderate progress in policy and systems change. Those that achieved high progress increased from five in Grant Year 2 to seven in Grant Year 3. The vast majority of partnerships (74%) were able to change at least one local policy by the end of Grant Year 3. Factors associated with high levels of progress in policy and systems change include, addressing issues the community identifies as critical, having motivation and endurance, maximizing alliances and connections, and having energized/mobilized residents.

6. What plans are being made by individual partnerships to sustain the work started under PPH?

Sustainability of a partnership requires a commitment on the part of members to continue to work together. Sustainability of programs and activities requires either additional funding or in-kind support from partners or other community or governmental organizations. Almost all PPH funded partnerships report they are committed to maintaining their relationship, although perhaps not at the same level of intensity. More importantly, a number of partnerships are raising the resources required to sustain their activities.

Preliminary results⁵ show that community groups, health departments, partnerships, and jurisdictions submitted 195 proposals for over \$25 million in Grant Year 3. Of these proposals 112 were funded resulting in more than \$9 million dollars granted. All community groups in the Counties of Mendocino, Contra Costa, Long Beach, Shasta, and Stanislaus have received new funds in the past year. Monument Corridor in Contra Costa received the single largest award for a community group (\$1 million from First Five funding to build a Family Resources and Learning Center), while the City of Pasadena Public Health Department received the single largest award (\$700,000) for health departments (also-First Five funding to reduce immunization disparities for African American and Latino children). Some of the most aggressive fundraising efforts occurred in Mendocino County where the community groups and the health departments submitted more than 30 proposals, 20 of which were funded for more the \$750,000, Stanislaus County where more than 15 proposals were submitted with 4 funded for approximately \$500,000, and Shasta County where more than 30 proposals were submitted and more than \$500,000 has been awarded in the past year.

7. What outcomes have been achieved by the Initiative's statewide policy efforts?

The statewide policy effort has:

- **Developed and disseminated a statewide policy agenda** to promote and support community-based public health.
- **Assessed support for community-based public health (CBPH)** in the State of California and developed a strategy for beginning to mobilize support for CBPH.

⁵ CCHE is working closely with local evaluators to refine the criteria for collecting these data, especially for health department funding related to PPH and partnership funding.

- **Identified and analyzed community-based public health models and strategies** implemented by local health departments across the state of California.
- **Increased the quality and use of community-level data** by health departments.
- **Promoted a statewide strategy for utilizing the Mobilizing for Action through Planning and Partnership (MAPP) process** to promote a community-based approach to public health.
- **Developed links** between the PPH Initiative and other local, state, and national community-based public health efforts.
- **Provided state policy makers with advice on legislation** that would promote a more community-oriented approach to health.

The PPH Initiative has been working in an environment where political and fiscal realities affected progress. These challenges had a strong influence on the policy work done by PPH. Examples of contextual and unexpected issues that the PPH Office encountered include:

- September 11th and the resulting preoccupation with bioterrorism (BT). In California, like most other states, BT funding occupied the attention of key public health figures and reinforced the primary emphasis on infectious disease control. This resulted in difficulty attracting an audience for the PPH policy message.
- Unprecedented budget cuts in California that greatly affected public health funding, particularly for the local health departments.
- Absence of state-level public health leadership in support of community-based approaches to public health.
- Desire of key state public health organizations for control of resources granted to the Public Health Institute (PHI) for the PPH Initiative.⁶

8. What capacities has the PPH Office developed over the course of this Initiative?

The capacities developed by the PPH Office include:

- **Creation of a centralized structure** that promotes a coordinated approach to grants management, technical assistance, and dissemination of information.
- **The ability to assess partnership's needs and connect them to a wide range of trainings and technical assistance** tailored to the unique needs of each grantee, partnership, and jurisdiction.
- **A single, visible, well-recognized entity** that is able to advocate for changes in the public health system, including a focus on the broad determinants of health.
- **Leadership that is able to communicate to the community a uniform set of values**, such as respect for cultural diversity, awareness of power differentials, and promotion of a paradigm shift in public health.

⁶ Based on key informant interviews with the PPH Policy Workgroup.

- **Planning and design of an initiative aimed at promoting community-based public health.**
- **A learning community** for PPH and PHI staff, grantees, and other groups engaged in community health improvement activities and policy work that supports community-based public health.
- **Facilitation of a greatly expanded dialog about innovative public health practices across the state of California.**
- **Expertise in supporting the MAPP process.**
- **Dissemination** of information about community-based public health best practices and PPH lessons learned (e.g., via Web site, briefs, white papers).

9. What are the key lessons learned about designing a multi-site community-based health improvement initiative?

Two key innovative design elements of the PPH Initiative are 1) the decision to ask communities to define their own community health improvement goals and 2) the decision to focus on a place or community rather than individuals or programs. The lessons learned with regard to these design elements include:

Communities tend to choose community health improvement goals that address the “broad determinants” of health. As a result of the decision to allow partnerships to define their own health improvement goals, most partnerships (33) are addressing a broader range of health determinants, such as housing, transportation, traffic safety, environmental justice, and public safety rather than those traditionally undertaken by local health departments. Broad health improvement goals allow community groups to choose work that residents view as important (therefore encouraging resident involvement) and give the flexibility to choose multiple goals that appeal to the varied interests in a community. The open-ended approach also encourages alliance building among agencies that may have had difficulty finding common ground when dealing with disease-specific issues.

A focus on “place” or “community” builds local capacity to sustain health improvement efforts. The PPH Initiative demonstrates that a “community,” “geographic,” or “place-based” approach can bring significant benefits to health improvement efforts. These benefits include:

- **A place-based approach facilitates community mobilization.** Residents are better able to understand the need for action when health improvement issues have a direct impact on their daily lives. Examples of rapid and/or effective community mobilization in the PPH Initiative included West Contra Costa (Contra Costa County) where a large oil company has created a community health hazard, Shingletown Action Committee (Shasta) where traffic accident fatalities had reached alarming rates, and Inglewood/Lennox where residents have mobilized to address concerns about prostitution in their neighborhood.
- **Community capacity building appeals to a wider range of participants when the focus is on general skill building** (e.g., policy advocacy and leadership). If the goal is to build the capacity of residents to change their communities, health improvement activities can focus on training local leaders and can allow them to address the issues that emerge

within a narrowly defined community or area. This approach has the potential to pull in more people than trainings that emphasize disease-specific interventions or skill building.

- **Community-focused activities build social capital.** Many partnership activities, (such as community events, establishment of community centers, neighborhood clean-up days, and youth leadership trainings) increase social bonds and community member investment in the local community.
- **A larger population is ultimately affected by a place-based approach than a traditional service provision and health education approach.** Changing the economic, social, and environmental contexts of a community has the potential to affect the health of a much broader group of people than traditional service provision and health education. All members of the community benefit from positive community changes.

The challenges of both design elements (open-ended and place-based) are similar and include:

Slow start up. In order to address the needs of a specific community it is first necessary to assess community issues and select health improvement goals. This process can be time consuming and appear to delay progress.

Need for new types of partnerships and coalitions. A place-based approach needs to draw on the resources available in the community and, therefore, often requires partnerships between community-based organizations that have not traditionally work on health issues. This may require additional time for relationship building, planning, and implementation of health improvement projects.

Health departments may have difficulty determining what role they should play. Given the tendency for a place-based approach to result in projects that address the broader determinants of health, public health departments may struggle to fit this work into their bureaucratic structures. Also, a place-based approach requires intensive work with a relatively small geographic area, which is not generally feasible given the numerous demands on health department personnel and resources.

Results are more diffuse and harder to measure. Once a community-focused project is implemented, tracking the impact is difficult due to confounding variables (e.g. environmental factors, such as pollution in the local area and/or contextual factors, such as other programs and services) that must be addressed when dealing with communities or populations, rather than individuals.

10. What are the key lessons learned about evaluating an initiative of this scope using a participatory approach?

There are a number of lessons learned about how to use a participatory approach to evaluation in a complex, multi-site initiative, including:

Building Evaluation Capacity

- Evaluation capacity building needs to occur at multiple levels and to engage all stakeholders.
- Local evaluation capacity building should be tailored to local needs.

Implementing a Participatory Evaluation

- Grantees need adequate orientation in order to understand the rationale for a participatory evaluation design, their responsibility in evaluation work, and how it may differ from other evaluations in which they have participated.
- The design of a participatory evaluation should be developed during the planning phase of the initiative/project and then negotiated with grantees at the beginning of the initiative.
- Multiple strategies should be used for engaging communities in the evaluation since readiness and receptivity to evaluation vary greatly across communities.
- Balance the need for detailed local information with the resources required to collect data.
- Grantees need to invest time and energy in evaluation.
- Local evaluators should be cautious about playing multiple roles.
- Develop clear and efficient mechanisms for grantee input on data collection tools
- The relationship between the local- and initiative-level evaluators should follow participatory principles (e.g., inclusion in the design process, transparency of decision-making, and commitment to capacity building).

Design and Implementation of Progress Assessment

- Assessing progress in a participatory manner is challenging.
- Progress assessment mechanisms should be designed at the beginning of the initiative and should be communicated clearly throughout the funding period.
- Progress assessments should emphasize the reflective process as much as the resulting score.

Overall Evaluation Design

- Resources should be allocated for emerging evaluation questions.
- Flexibility should be built into the evaluation design.
- Local evaluators should be employed for multi-site evaluations.
- Initiative-level evaluators should work closely with local evaluators to coordinate local and initiative-level data collection and reporting.
- Data collection should involve a combination of qualitative and quantitative indicators to ensure that a full range of accomplishments is documented.
- Time should be built-in at the end of the initiative for stakeholders to review final results and reports.