



# Strategies for Building Community-Public Health Partnerships

LESSONS LEARNED FROM THE PROGRAM OFFICE OF THE PARTNERSHIP FOR THE PUBLIC'S HEALTH INITIATIVE



**Partnership**

*for the Public's Health*

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# Executive Summary

In 1999, The California Endowment awarded \$37 million to the Public Health Institute (PHI) to plan and implement the Partnership for the Public's Health (PPH). This six-year grant-making initiative pioneered efforts to build partnerships between communities and public health agencies in California. By establishing 39 local partnerships, encompassing 14 public health departments and 39 community groups throughout California, PPH aimed to gain large-scale community-based public health (CBPH) experience and identify factors, from capacity issues to policy and systems changes, that enabled public health agencies and communities to partner successfully. It also sought to develop experience and evidence of CBPH practice that would build momentum within the field and potentially influence policy statewide.

Several factors set PPH apart from other health initiatives. Unlike most major foundation initiatives, the Partnership for the Public's Health was community-driven, focusing on health issues that impacted the communities funded by the initiative. Based on the assumption that communities are more likely to participate if they help define their own local agenda, PPH did not tell communities which health issues they needed to address. Instead, the initiative encouraged partnerships to identify and respond to those health issues that were most important to their communities.

A second factor that set PPH apart was its focus on place. Place defines the physical, social and economic environment that provides access to food stores and health clinics, proximity to toxic sites, standard or substandard housing, quality of jobs and transportation and other determinants of health. Instead of targeting population groups, PPH funded local collaboratives that worked within defined geographic areas to improve the quality of life in their own place-based communities.

PPH was also distinct from other health initiatives because it was resident-driven; it worked with health departments of varying sizes; it was potentially large enough to create momentum for statewide change; it reflected tremendous ethnic and geographic diversity; and it provided separate funding to health departments and community organizations in order to minimize the power imbalances that can occur between community groups and large agencies and institutions.

PPH pioneered efforts to build partnerships between communities and public health agencies in California

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## **BUILDING PUBLIC HEALTH PARTNERSHIPS**

At the core of the PPH initiative was the relationship between public health departments and community residents. A key mission of PPH was to invest in building the partnerships between health departments and local communities—encouraging them to work together, agree on community health priorities and jointly develop strategies to address them.

Forming these partnerships was difficult. In many cases, partners had to overcome legacies of mistrust between communities and government agencies as well as power differentials that had characterized their interactions in the past. In addition, communities and public health departments often had little understanding and appreciation of their respective resources, roles and responsibilities.

Despite these challenges, many strong partnerships emerged during the course of the PPH initiative. In the process, the initiative was able to identify organizational models, success factors and strategies that enabled public health departments to work productively with local communities.

## **LEADERSHIP AND RESIDENT ENGAGEMENT**

Strong leadership was the crucial variable that enabled some public health departments to go beyond traditional practice and institutionalize CBPH practices. According to a report by the Center for Community Health & Evaluation, strong agency leaders were able to persuasively articulate the benefits of working with the community and influence organizational culture and decision making.

Resident involvement was another critical element of success. Neighborhood residents bring first-hand experience and skills, as well as knowledge of community needs, priorities and resources. They are also committed to improving the health of their families and community and can motivate friends and neighbors to participate actively in the process.

Productive, sustained resident engagement, however, is challenging to achieve. If residents are not paid or provided incentives to be involved, it can be difficult to maintain their interest. It is also helpful for them to experience “wins” early on. In community groups as well as public health departments, successful resident engagement took committed leadership that institutionalized resident engagement as a formal, budgeted priority.

## TOOLS AND RESOURCES

A key strategy for designing and administering the initiative was establishing a Program Office. It provided infrastructure and centralized, effective systems for grants management, progress assessment/mid-course corrections, communications, technical assistance coordination, evaluation oversight and dissemination of lessons learned, and it facilitated the clarification of goals as the initiative evolved.

A key function of the Program Office was the development of technical assistance resources to help PPH partners build capacities including fundraising, board development, cultural competence, language access, policy and media advocacy skills and an understanding of the broad determinants of health. Highly successful tools and strategies included a local coach model, a peer-learning network, flexible support tailored to meet the needs of each grantee and collaborative self-assessment to identify training needs. Building on its experience with the PPH initiative, the PPH Program Office proved instrumental to The Endowment in the launch and implementation of a second multi-site, four-year program, *Healthy Eating, Active Communities (HEAC)* in 2004.

## PARTICIPATORY EVALUATION

In choosing to use a participatory approach to evaluation, the Partnership for the Public's Health initiative made a noteworthy and difficult commitment to power-sharing and openness. When participatory principles are applied to a large project like PPH, a great deal of adaptation and innovation is needed to coordinate even limited stakeholder participation in the evaluation process.

The size and complexity of the initiative called for a multilevel evaluation design that facilitated communication and connection among all key stakeholders. The team included local evaluators who were chosen by the local

The Program Office provided infrastructure and centralized systems for grants management, assessment, communications, technical assistance coordination, evaluation oversight and dissemination of lessons learned

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collaborative partners and then worked closely with the local partnerships to monitor and document progress and support development of local evaluation capacity. Balancing the needs of all stakeholders, especially those of the grantees versus the funder, involved a great deal of negotiation and compromise.

In the end, excellent tools and processes were developed, including a participatory progress assessment process and modified approach to the case study method that combined qualitative description with quantitative information and standardized reporting.

## POLICY AND SYSTEMS CHANGES

Community health improvement is sustained through policy and systems changes. These efforts, during the PPH initiative, were most successful at the local level. PPH partnerships were able to identify and address community health issues including broad determinants of health, ranging from access to care, youth development, nutrition and physical activity to environment, violence, sanitation, traffic safety, housing and transportation.

The challenges of making statewide policy and system changes, however, were extensive. Health departments, to begin with, have limited flexibility to make significant changes in programming and organizational structures. In order for internal public health infrastructure changes to take place, policy changes must include specific funding to

support community-based work, reorganization of public health systems to support CBPH and incorporation of CBPH principles into academic programs to prepare the future public health workforce.

PPH advocated extensively for these changes on a statewide level. However, advocacy for local public health departments in California has concentrated almost exclusively on strengthening capacity for infectious disease control, which has eroded dangerously over the past few decades. As a result, some viewed the suggestion that public health ought to have a broader vision—involving partnerships with communities and other public and private agencies—as an unaffordable add-on to an already overburdened system.

Secondly, the infusion of federal funds and short planning timelines for bioterrorism and emergency preparedness monopolized the agenda of public health leadership throughout the state. The terrorist attacks of September 11, 2001, the economic downturn in the state, the diffuse nature of public health in California and the change in political leadership also posed major obstacles to successful statewide policy and systems changes.

Consequently, PPH did not achieve as much as hoped in its efforts to promote changes in statewide public health policy. Nevertheless, the initiative did help lay important groundwork for community-based public health in California. PPH helped create a common CBPH framework and language. It also nurtured a growing cadre of powerful, effective, articulate public health and community leaders with successful experience in community-based public health. In addition, the initiative's

focus on capacity building and partnership development helped create a deeper understanding of what is needed to sustain this work beyond an initiative's funding period.

## **NEW STATEWIDE FOCUS ON COLLABORATION**

Since the end of the initiative, the public health policy environment in California has changed significantly, moving toward a new focus on collaborative approaches for addressing the social and environmental determinants of chronic disease. Although bioterrorism-preparedness efforts drove legislation creating a new Department of Public Health, the department, once created, as well as the organizations that promoted it have embraced a larger vision for its mandate, given the growing acknowledgment of obesity as a serious health risk.

In addition, many local health departments, in spite of funding and organizational challenges, have been developing strategies to confront the challenges of chronic disease.<sup>1</sup> As a result of these combined forces, there is considerably less friction today over the priorities for public health in California, and there are many promising examples of agencies and organizations working together.

It is fair to say that the Partnership for the Public's Health served as an important catalyst for these changes, fostering capacity in local health departments and building statewide momentum for community-based approaches to public health. The lessons documented in this report can help build the evidence base and strategies for a community-based public health structure in California and inform similar efforts nationally.

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<sup>1</sup> See, for example, Prentice B, Flores G, "Local health departments and the challenge of chronic disease: lessons from California," *Prev Chronic Dis* [serial online], Jan., 2007 ([http://www.cdc.gov/pcd/issues/2007/jan/07\\_0081](http://www.cdc.gov/pcd/issues/2007/jan/07_0081))

# Realizing the Vision

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## IMPLEMENTING COMMUNITY-BASED PUBLIC HEALTH IN CALIFORNIA

Public health must team with others, including local residents, to address factors that have the greatest impact on community health

For more than a century, public health has made communities healthier places to live by reducing illness and death associated with infectious diseases. This focus has resulted in the improved safety of food and water, the control of infectious diseases, reductions in vaccine-preventable illnesses and lower rates of maternal and infant mortality.

In recent decades, however, public health has had to expand its focus to the risk factors associated with the growing burden of chronic disease. Tobacco use, poor diet and lack of activity, for example, account for two-thirds of premature deaths associated with chronic disease.<sup>2</sup> Changing the social and physical environments that directly or indirectly magnify those risk factors has become an important focus of contemporary public health practice.

According to the IOM's 2002 report *The Future of the Public's Health in the 21st Century*,<sup>3</sup> the new model of public health entails a focus on population health, including multiple determinants of health; the strengthening of the public health infrastructure; and the creation of partnerships and accountability systems. Under this new model, public health agencies must continue to assert a strong leadership role in protecting the public's health, but they cannot do it alone. Instead, they must team with others, including local residents, to address the broad range of factors that have the greatest impact on community health.

This collaborative approach—community-based public health (CBPH)—is an ambitious undertaking that has grown in importance and visibility as public health has improved data collection methods and understood the genesis of disease, risk factors and social determinants. Some of the great public health successes in recent

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<sup>2</sup> Mokdad Ah, Marks JS, Stroup DF, Gerberding, JL, *Actual Causes of Premature Death in the United States, 2000*. [Published erratum in: JAMA 2005; 293(3):203–4, 298].

<sup>3</sup> *The Future of the Public's Health in the 21st Century*, November 2002: Institute of Medicine.

years—reductions in tobacco use and its associated diseases, as well as the passage of seat belt and helmet laws—involved public health agencies, organized communities, health care providers, researchers, schools, elected officials, advocacy organizations and media, among others. These alliances are what the federal Centers for Disease Control and Prevention and other national public health organizations have called “public health systems.” They are increasingly common practice in public health campaigns, such as those that aim to reduce the rates and health risks of obesity. For public health agencies to partner successfully, however, they need the skills and capacity to work effectively with communities, standards for accountability and new and more flexible resources to achieve their goals.

## **CBPH IN CALIFORNIA**

In California, state government has been slow to demonstrate strong leadership in implementing community-based public health. CBPH opportunities in California have emerged as a result of strong local public health leadership, successful experience in tobacco cessation and a growing understanding of health disparities. Local public health leadership has begun to develop frameworks (e.g. the Spectrum of Prevention) that emphasize partnerships and policy and successful community-public health activities. Local innovation fueled by public health leaders—with limited, if any, resources and creative financing—has provided the spark for a broader and more deliberate approach to CBPH.

This emerging body of work in California has been complemented by national efforts—such as the W.K. Kellogg Foundation’s CBPH initiative and the Robert Wood Johnson and Kellogg Foundations’ Turning Point initiative—to transform public health. These foundations saw these efforts as an opportunity to address health disparities and other

issues and developed a grantmaking program to scale up local innovations and stimulate policy development and leadership. It was hoped that ultimately the success of these efforts would lead to structural changes at the state level in public health funding, accountability and practice.

In 1999, The California Endowment awarded \$37 million to the Public Health Institute (PHI) to plan and implement the Partnership for the Public’s Health (PPH). This six-year grant-making initiative pioneered efforts to build partnerships between communities and public health agencies in California. By establishing 39 local partnerships, encompassing 14 public health departments and 39 community groups throughout California, PPH aimed to gain large-scale CBPH experience and identify factors, from capacity issues to policy and systems changes, that enabled public health agencies and communities to partner successfully.

According to Marion Standish, Director of The Endowment’s Disparities in Health program, The Endowment recognized that public health is the only governmental entity charged with protecting the public’s health, that it controls substantial resources and that it needed to modernize in order to protect the public from the health threats of the twenty-first century. “We needed to meaningfully engage public health systematically,” she said, “if we ever hope to address the social determinants of health and sustain long-term CBPH efforts in California.”

With PPH, The Endowment sought to develop a large enough cohort of community-based public health partnerships to influence state and national public health policy and funding. It also aimed to develop experience and evidence of CBPH practice that would build momentum within the field and potentially influence policy statewide. The PPH initiative began to create a roadmap for how communities and public health departments can work

together to reduce health disparities and improve the health and well-being of diverse communities.

Several factors set PPH apart from other health initiatives. First, PPH focused on building the partnering capacity of public health departments and community-based organizations and consequently did not prescribe a content area for them to focus on. Instead, community organizations and health departments, on their own and in partnership, defined these issues. PPH, moreover, provided separate funding to health departments and community organizations in order to minimize the power imbalances that can occur between community groups and large agencies and institutions. Community collaborative groups held more power in their role as partners because they were able to come to the table with their own funding.

PPH also differed from other health initiatives in that it was place-based, focusing on the geographic communities where people lived; it was resident-driven; it worked with health departments of varying sizes; it was potentially large enough to create momentum for statewide change; and it reflected tremendous ethnic and geographic diversity.

## **SUCCESSSES AND CHALLENGES**

PPH partnerships made significant gains in developing advocacy skills, policy awareness and new community leaders throughout the state. Local CBPH efforts varied greatly. While many partnerships addressed issues around access to care, they also addressed environmental factors like opportunities for healthy nutrition and physical activity and the broader determinants of health including housing, transportation, access to jobs and sanitation. Most partnerships were able to achieve at least one significant policy change in the community that directly supported their goals for improving health.

# The PPH initiative began to create a roadmap for how communities and public health departments could work together to reduce health disparities and improve the health and well-being of diverse communities

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Many PPH partners were inspired by the potential of CBPH. Nevertheless, the challenges—especially in such a large-scale project—were extensive. Health departments, to begin with, have limited flexibility to make significant changes in programming and organizational structures. Nevertheless, the PPH experience identified factors that positioned health departments to make changes in support of a sustained, community-based focus.

Secondly, PPH's theory of action lacked specific, statewide policy goals, such as pressing for an office of community health in Sacramento that would capture PPH efforts and disseminate the lessons from these efforts more widely. Instead, policy goals were expected to originate in local partnerships. As a result, the initiative spent a great deal of time trying to define and address its statewide objectives. Additionally, PPH expected that existing public health structures in the state would help develop the initiative's policy goals, but those constituencies never partnered with PPH on policy efforts. In hindsight, it would have been helpful for the initiative to set preliminary policy goals at the outset that would have later been infused by community priorities and experience.

Timing also proved to be an issue. The terrorist attacks of September 11, 2001, occurred during the course of the initiative. In the wake of these events, the new focus on bioterrorism derailed efforts to expand the capacity of the

## PPH nurtured a growing cadre of public health and community leaders with successful experience in community-based public health

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state's public health system to address the socioeconomic and environmental factors that affect community health. The economic downturn in the state, the diffuse nature of public health in California, and the change in political leadership also posed major obstacles to successful statewide policy and systems changes.

California, moreover, lacked strong state leadership on key public health issues such as health disparities. It also lacked a plan for public health improvement, as well as processes for assessing statewide public health capacity, creating performance standards and accrediting local public health departments. Prospects for collective leadership were often hindered by intransigent, antagonistic relations among key statewide public health organizations.

### **MOMENTUM FOR CHANGE**

Despite these challenges, PPH nurtured a growing cadre of powerful, effective, articulate public health and community leaders with successful experience in community-based public health. When asked whether they would continue their CBPH work after PPH funding ended, many health department staff stated their ongoing commitment to the collaborative model. They also urged creation of a larger “movement,” a critical mass of local health departments dedicated to advancing CBPH.

The PPH experience also suggests future funding approaches. Since many public health practitioners have little or no experience working with communities or understanding of the broader determinants of health, funders could provide critical support by introducing CBPH training into schools of public health throughout the state. Foundations might also help develop agreed-upon standards for public health engagement with communities. In addition, they could fund leadership development for public health practitioners who understand the importance of CBPH and are striving to practice it. By doing so, foundations could expose these professionals to best practices, evidence-building strategies and opportunities to voice key issues and priorities in community health, establishing a unified voice for CBPH that could set and act on a policy agenda.

The successes and challenges of the 14 California public health jurisdictions that were part of the PPH initiative offer many valuable lessons for funders. Those lessons, documented in this report, can help build the evidence base and strategies for a community-based public health structure in California and inform similar efforts nationally.

# Designing CBPH Programs

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## CHARTING NEW GROUND WITH A NONPRESCRIPTIVE APPROACH

Unlike most major foundation initiatives, the Partnership for the Public's Health was community-driven, focusing on health issues that the communities prioritized. Based on the assumption that communities are more likely to participate if they help define their own local agenda, PPH did not tell communities which health issues they needed to address. Instead, the initiative encouraged partnerships to identify and respond to those health issues that were most important to their communities. PPH sought to stimulate an organic process in which community groups and health departments, together, would set local priorities, building on the wisdom, expertise and experience of each partner.

### THE IMPORTANCE OF PLACE

Another factor that set PPH apart from other initiatives was the focus on place. Instead of targeting population groups, PPH funded local collaboratives that worked within defined geographic areas. This strategy was based on the premise that residents become engaged when the goal is to improve the quality of life in their own communities. The initiative focused on neighborhoods and communities, because of the impact that place has on health. Place is important not only because it encourages resident engagement but more importantly because it often frames the determinants of health. Place defines the physical, social and economic environment that provides health opportunity or not, such as access to food stores, health clinics, proximity to toxic sites, standard or substandard housing, quality jobs and transportation.

### USING GRANTS TO BALANCE POWER

PPH insisted on separate funding of community organizations and public health departments. This strategy was hotly debated. Some participants, in particular, objected to PPH's funding of public health departments, since they viewed them

The initiative encouraged partnerships to identify and respond to those health issues that were most important to their communities

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## By funding community groups separately from public health departments, The California Endowment sought to give communities equal status in the partnerships

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as large institutions that should be doing CBPH work as part of their basic public health mission. The California Endowment, however, opted to fund health departments to provide an incentive for their focus and engagement in PPH. In addition, The Endowment recognized that most funds for public health departments are categorical and leave little room for innovation, partnership and flexibility. Moreover, by funding community groups separately from public health departments, The Endowment sought to give communities equal status in the partnerships.

### THEORY OF ACTION

The initiative's design was based on a formal theory of action. It held that health departments play a key role in improving community health in the broadest sense, and that they are most effective in this effort when they partner with the communities they serve. Based on this partnership theory, the goals of PPH focused on five areas:

- ▼ Building the internal capacity of the funded community groups to identify local health concerns and partner with the health department to address them
- ▼ Building capacity within local health departments to practice community-based public health
- ▼ Developing effective partnerships between community groups and public health departments
- ▼ Identifying community health issues and implementing strategies to address them

- ▼ Improving community health
- ▼ Achieving statewide and local policy and systems changes to sustain these health improvements over time.

PPH selected participating health departments and community groups based on evidence of their capacity to work effectively with each other. Public health departments, in particular, were selected based on whether they had a vision and mission that matched those of the initiative and on their past success in collaborating with local communities.

PPH then independently selected the community collaborative groups in each of the health jurisdictions. PPH based its selection on the groups' accomplishments, their track record in resident engagement and their prior relationships with other government agencies.

# LESSONS

## ▶ The nonprescriptive approach offered many benefits as well as challenges.

Historically, it has often been difficult to engage residents in health-improvement projects when funders determine the focus. Nonprescriptive funding, however, allowed community partners to address local issues with strategies that made sense to community residents. Communities and residents became involved in a range of issues that were important to the community, and some partnerships are still working on the issues that they prioritized during the initiative.

On the other hand, the nonprescriptive approach required grantees, in some instances, to spend time figuring out what to do rather than gaining experience as partners doing something. In addition, it limited the initiative's ability to forge a statewide agenda.

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## ▶ Separate funding of health departments and community groups leveled the playing field.

Health departments would not likely have been such committed participants in the process, or even have come to the table in some cases, without funding; it was an important incentive and justification for their participation. Funding allowed health departments to leverage their resources to focus specifically on building strong partnerships with communities. Funding health departments and community groups separately also helped empower the community grantees and gave them more equal footing within the partnership.

## ▶ Grantees need ample time and support for planning, especially when there are no prescribed issues to address.

In every case, grantees were dealing with new partners and needed time to coalesce as a collaborative before beginning to address CBPH issues. Once the relationships between collaborative partners were sufficiently established, they were able to turn their attention to planning and assessment activities to develop community health improvement priorities.

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## ▶ Funders need to allow extensive time to achieve sustainable institutional change and community health improvement outcomes.

Partnerships of any kind take time, and health improvements are very long-term. Funders need to identify shorter-term health improvement benchmarks, recognizing that they likely will not see health improvement outcomes during the grant's lifetime. Though the five-year PPH initiative was longer than most, the change process for community groups and agencies is slow and labor-intensive. The process takes even longer when grantees must start by building their own organizational capacity to partner effectively. A long-term funding period would better promote the formation of strong partnerships and achievement of targeted, sustainable CBPH improvements.



# Tools and Strategies

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## FOR BUILDING COMMUNITY AND HEALTH DEPARTMENT CAPACITY

### THE PPH PROGRAM OFFICE

A key strategy for designing and administering the initiative was establishing a Program Office. A savvy team of professionals with a broad range of skills and experience was assembled by the Public Health Institute to manage the initiative and support the development of local partnerships and their community health improvement efforts.

The Program Office team focused on being responsive to the needs of grantees and the foundation to achieve initiative goals. The office provided infrastructure and centralized, effective systems for grants management, progress assessment/mid-course corrections, communications, technical assistance coordination, evaluation oversight and dissemination of lessons learned, and it facilitated the clarification of goals as the initiative evolved.

A key function of the program office was the development of technical assistance resources to help PPH partners build capacities including fundraising, board development, cultural competence, language access, policy and media advocacy skills and an understanding of the broad determinants of health. Highly successful tools and strategies included a local coach model, a peer-learning network, flexible support tailored to meet the needs of each grantee and collaborative self-assessment to identify training needs.

PPH can be touted as a model for the organization and management of large-scale, multi-site, community-based initiatives. Building on its experience with the PPH initiative, the PPH Program Office proved instrumental to The Endowment in the launch and implementation of a second multi-site, four-year program, *Healthy Eating, Active Communities (HEAC)* in 2004.

The Program Office developed technical assistance resources to help PPH partners build capacities from fundraising and cultural competence to policy and media advocacy skills

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## TECHNICAL SUPPORT STRATEGIES

**Local coaches.** To help the new PPH partnerships achieve their first task—developing a joint, four-year strategic plan—PPH used a “local coach” model. The coach, a local consultant with high skill levels in strategic planning and group dynamics, facilitated the joint work of each partnership and helped them assess community health needs, analyze results, come to agreement on priorities and work cooperatively to develop strategies for achieving these goals. The model proved very useful given partners’ wide skill variation and the relatively short, 10-month time frame partners had to complete their plan. Local coaches were available to each partnership for 10 to 15 hours per week. After the first year, more than 80 percent of the partnerships used their own resources to continue the involvement of their local coaches.

**Peer learning.** Peer learning was also used whenever possible to support creative problem solving across sites. Funds, for example, were made available specifically for grantees to travel to other PPH sites to share strategies and lessons. PPH also sponsored annual conferences that allowed grantees to learn from each other’s challenges and successes. Other peer learning activities included grantee-led training sessions and conference calls that tapped into the skills that grantees brought to PPH or were learning through the PPH efforts in their communities.

**Pool of flexible funding.** Rather than trying to address all needs for support from the central program office, PPH made a pool of flexible funds available to groups for trainers or consultants and to develop individualized trainings. Each grantee could access up to \$5,000 for individualized, tailored trainings.

**Collaborative self assessment.** Although many community health improvement efforts rely on collaboratives to achieve policy and systems changes, relatively little attention is paid to the factors that create highly effective collaboratives. PPH used a tool developed by the Center for Collaborative Planning called “Perfecting Partnerships: Self-Assessments for Strong Organizations and Healthy Partnerships.” This program incorporated a collaborative self-assessment tool, along with a group process to identify key capacity issues and how to strengthen them. The assessment tool focused on five core capacity areas: shared vision, inclusiveness and quality of participation, communication, facilitative leadership and shared decision-making.

# LESSONS

## ▶ The local coach model proved very useful.

According to a study by the Group Health Community Foundation, partners valued local coaches for providing flexible, locally based technical assistance and serving as neutral facilitators who could help build partnership relationships and local capacity. Partners viewed coaches as especially vital to completion of their Local Partnership Action Plans, which guided the work of each partnership through the initiative.

## ▶ Successful coaches were trusted by all members of the partnership and understood the context and history of the local community.

They also:

- ▶ could navigate through challenging group dynamics
- ▶ had strong strategic planning and group process skills
- ▶ could be physically present at coalition meetings and events.

Goals for local coaches included supporting the strategic planning process and partnership development, as well as transferring some of their skills to partnership leaders. Coaches were highly successful in achieving the first two goals, which were critical to the future success of the local partnerships. In most cases, however, coaches did not achieve the third goal of transferring their facilitation and planning skills. To transfer skills to coalition leaders, coaches need additional, dedicated time to engage these leaders in skill-building activities and could benefit from having training and skill-building materials to help them.

## ▶ Peer learning was a powerful tool for public health departments.

Peer learning, PPH found, was the most powerful tool for building the partnership capacity of public health departments. PPH created several venues to bring together health department leadership, managers and staff to identify barriers to and strategies for partnering effectively with communities. Through interviews and meetings, health department personnel identified approaches for building community partnerships, including:

- ▶ elevating the value of engaging in CBPH
- ▶ funding infrastructure development of local health departments in ways that support CBPH
- ▶ funding infrastructure development of community groups so they can fully participate in partnerships
- ▶ securing financing that supports CBPH in the local health department and community
- ▶ developing evaluation methodology that highlights the value of community-engaged approaches to health improvement
- ▶ facilitating policy changes that support CBPH through financing, reorganization or developing community-based programs.

Peer learning models were most effective when they:

- ▶ brought people together from different health departments, including directors, managers and front-line staff
- ▶ highlighted models that worked well
- ▶ created opportunities for people in similar positions to share their experiences, successes and challenges
- ▶ created opportunities for staff and managers to talk with directors within their own health departments. This was limited to a few places, and was not facilitated or mediated by PPH. Had this been done more actively, possibly with professional and academic support, there might have been greater institutionalization and sustainability of PPH efforts in more places.

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**▶ Flexible funding for technical support was crucial to building capacity.**

Providing local groups with funding that was earmarked for training and capacity building allowed groups to identify local resources and develop relationships with individuals and organizations within their communities or regions. It also built the capacity of the group to identify and address their own training needs. It was important that these funds were administered centrally, so that community groups did not feel that money was being “taken away” from their own budgets to carry out these programs.

**▶ Partnership development benefited when partnerships were responsible for identifying and executing some of their own technical support.**

Incentives for community groups and public health departments to collaborate in planning and carrying out local training for their own staff were powerful tools for supporting partnerships and building relationships.

PPH established a “host model training fund” of up to \$3,000 per partnership that could be used for training, if partnerships provided matching resources. PPH also provided technical support, as needed, on how to plan and carry out a training program. Virtually all PPH grantees took advantage of this resource, and many pooled their funds to sponsor multi-day retreats and training programs for their coalition members. These programs created early “successes” for coalitions as well as opportunities to build relationships and other skills at the same time.

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**▶ Collaborative self-assessment tools can be very effective in identifying and helping coalitions build their capacity to function effectively as a collaborative.**

Most collaboratives, however, are not likely to take the time to use these tools unless it is a requirement of funding or tied to the incentive of some additional support—such as consultant services, funding or a specific training.

Based on the experience of PPH, it would be most beneficial to communities to introduce this kind of tool at the beginning of the initiative, so it becomes a standard practice. Repeating the self-assessment once a year, moreover, is an effective way to “tune-up” coalition functioning.

To partner effectively with community groups, public health departments had to foster a culture that valued community input and help staff develop skills for working with community groups and residents

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 **There are few existing training tools and resources to build health department capacity for engaging in community-based public health.**

To partner effectively with community groups, public health departments had to foster a culture that valued community input and help staff develop skills for working with community groups and residents. Several tools, developed at the national level, provided guidelines for building these public health department capacities. They included APEX/PH, the Ten Essential Services developed by a CDC consensus panel, and the CDC/NACCHO community health-improvement tool called MAPP—Mobilizing for Action through Planning and Partnership. The limitation of these tools, however, is that they focus on county-wide efforts and are not always applicable on a neighborhood level.

To share successful strategies for building health department capacity, PPH also offered mini-grants of up to \$25,000 to health department and community partners interested in publishing and disseminating training tools and materials to others interested in CBPH. Two different health departments developed tools that focused specifically on improving the capacity of local health departments.

The Contra Costa Health Services Agency, Public Health Division, for example, developed a cadre of eight tools for local health departments, including *The Spectrum of Prevention: A Framework for Public Health* (video) and *The Ladder of Community Participation*. In addition, the City of Long Beach Public Health Department, in conjunction with their community partners, developed a manual titled *Health Leadership Training Guide: Empowering Communities through Public Health Awareness and Advocacy*.

It should be noted, however, that PPH did not fully materialize into the statewide technical resource for CBPH while the initiative was operational. And in addition, California's Department of Health Services did not assist development of or provide support for CBPH in local health jurisdictions. It took HEAC and applied obesity prevention work, for public health departments to stir broad interest in PPH's consultancy, training resources and tools.



# Creating an Evaluation Community

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## PERSPECTIVES ON PARTICIPATORY DESIGN

The PPH initiative applied a participatory evaluation approach on a larger scale and in a more complex setting than most earlier projects

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In choosing to use a participatory approach to evaluation, the Partnership for the Public's Health initiative made a noteworthy and difficult commitment to power-sharing and openness.

Participatory evaluation means different things to different people. To some, it means including participants in the learning and evidence-building process, but not necessarily giving them control. To others, participatory evaluation requires that the people and programs being evaluated have full control and oversight of all evaluation activities.

In most cases, participatory evaluation has been implemented in small community projects with a limited number of stakeholders. In these situations, control and oversight by all stakeholders over evaluation questions, methods and reporting may be a reasonable expectation. However, when participatory principles are applied to a large project like PPH, a great deal of adaptation and innovation is needed to coordinate even limited stakeholder participation in the evaluation process. Because evaluation of the PPH Initiative applied a participatory evaluation approach on a larger scale and in a more complex setting than most earlier projects, the experience provides important lessons about the difficulties and benefits of this approach.

### EVALUATION DESIGN AND INFRASTRUCTURE

The size and complexity of the initiative called for a multilevel evaluation design that facilitated communication and connection among all key stakeholders. The PPH Program Office, which was established to support and monitor the initiative, contracted with the Center for Community Health and Evaluation (CCHE) for evaluation design and management. CCHE brought to PPH evaluators experienced in design and implementation of evaluations of

community health initiatives. The team included local evaluators who were chosen by the local collaborative partners and then worked closely with the local partnerships to monitor and document progress and support development of local evaluation capacity. The PPH Program Office also hired an evaluation coordinator to work with CCHE to ensure coordination of program and evaluation activities. Finally, an Evaluation Advisory Sub-Committee supported PPH by sharing insights from the experiences of other community-based health improvement initiatives and offering their expert advice on every aspect of the PPH evaluation process.

### **CREATING AN EVALUATION COMMUNITY**

The participatory nature of an evaluation is commonly envisioned as a relatively democratic relationship between evaluators and grantees. This connection must also be built into many other relationships. The close working relationship that developed between the staff of CCHE and PPH was unusual for an external evaluator and program office. CCHE and PPH shared information from grantees and coordinated program and evaluation activities through regular meetings and communication. Monthly conference calls, moreover, facilitated the active participation of local evaluators in the design of the evaluation process, methods and instruments, helping to ensure that they were appropriate to grantees' needs. The conference calls also provided opportunities for local evaluators to share ideas and tools that they had developed with their partnerships.

In addition to these regular meetings, CCHE periodically solicited feedback directly from grantees regarding evaluation methods and instruments. The goal was to find as many avenues for stakeholder input as possible within time and logistical constraints. Balancing the needs of all stakeholders, especially those of the grantees versus the funder, involved a great deal of negotiation and compromise. In the end, excellent tools and processes were developed, including a participatory progress assessment process and modified approach to the case study method that combined qualitative description with quantitative information and standardized reporting.

Participatory evaluation was new to most PPH partners. As a result, they needed an orientation to the multiple purposes of evaluation, the nature of and rationale for participatory evaluation and a clear designation of the roles and responsibilities of each stakeholder (i.e. the local evaluator, community activists and health department staff). It was particularly important to communicate the fact that a participatory evaluation confers upon grantees responsibility along with authority.

# LESSONS

- ▶ **Addressing the interests of multiple stakeholders through a participatory evaluation is likely to yield multiple perspectives on accomplishments.**

Grantees want to know how to improve their programs, and grantmakers want to understand the outcomes of their investment. Participatory evaluation argues for the presentation of each perspective, particularly when significant differences emerge.

- ▶ **Progress in building local evaluation capacity depends on the willingness of grantees to assume an active role in evaluation.**

Striking a balance between participation and the time constraints of grantees presented an unresolved challenge for participatory evaluation. Linking evaluation findings to sustainability efforts, particularly grantwriting, was the most effective strategy for stimulating grantee interest in evaluation. Adequate funds for evaluation training are essential. Stipends for residents who organize and conduct local evaluation activities should be seriously considered.

- ▶ **It is essential to create opportunities for learning among the members of the evaluation team at all levels of the initiative.**

This learning occurs through the exchange among local evaluators, the community and initiative-level evaluation staff. It also applies to creating a mechanism for ongoing dialogue between the evaluation team and funder. Periodic discussion and reflection helped ensure that the interests and questions of the funder were addressed in the evolving evaluation design and that the rationale for key evaluation decisions was fully understood. The dialogue also created a deeper understanding of the potential, limitations, and costs of participatory design.

From The Endowment's perspective, however, there were some downsides to participatory evaluation, especially for such a large initiative. The volume of data made it hard to know which factors were important and which were not. In addition, because the relationship between evaluator and grantee is so interactive, objectivity is sometimes lost, and evaluators come to see themselves as advocates for grantees rather than more or less objective observers looking for opportunities to strengthen the initiative's work. There were also some challenges in having the Program Office manage the evaluation. Finally, the scope and complexity of the initiative made it difficult to distill findings in a digestible manner. That, in turn, made reporting to foundation trustees difficult, overly complex and nuanced in all ways.



# Building Strong Public Health Partnerships

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## COLLABORATING TO ACHIEVE LONG-TERM CHANGE

The initiative identified organizational models, success factors and strategies that enabled public health departments to work productively with local communities

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At the core of the PPH initiative was the relationship between public health departments and community residents. A key mission of PPH was to invest in building the partnerships between health departments and local communities—encouraging them to work together, agree on community health priorities and jointly develop strategies to address them.

Forming these partnerships was difficult. In many cases, partners had to overcome legacies of mistrust between communities and government agencies as well as power differentials that had characterized their interactions in the past. In addition, communities and public health departments often had little understanding and appreciation of their respective resources, roles and responsibilities.

Public health department staff frequently lacked mechanisms for effectively communicating with and involving community members. Prior to PPH, some health department staff undervalued residents' ideas and approaches to health issues. Others found it challenging to work with volunteers, whose availability is often limited by job and family responsibilities.

At the same time, communities often lacked an understanding of the local public health department's responsibilities and operations. Some groups found it challenging to work with a government agency that seemed inflexible and slow to act and whose public health priorities seemed to ignore issues of local concern. In many cases, community members did not know how to access the resources of their local health department, as they began addressing the health issues they had identified.

Despite these hurdles, however, many strong partnerships did emerge during the course of the PPH initiative. In the process, the initiative was able to identify organizational models, success factors and strategies that enabled public health departments to work productively with local communities. Based on lessons learned from the initiative, The Endowment continues to push for strengthening capacity, standards and accountability for community-based public health partnerships.

# LESSONS

## ▶ The speed and success of CBPH efforts depended on community groups' readiness to partner.

Drawing on the PPH experience, the Center for Community Health and Evaluation, the external evaluator for the initiative, identified several key community group capacities that facilitated partnership development:

- ▶ clear vision and goals
- ▶ leadership that is stable and able to build consensus and nurture new leaders
- ▶ an appropriate level of staff and infrastructure
- ▶ participation of residents in key roles, including leadership
- ▶ an atmosphere of trust among participants in the group
- ▶ the ability to acquire the resources needed to carry out its goals
- ▶ a clear geographic or population base that it serves
- ▶ a successful history of collaboration with other organizations or government agencies
- ▶ recognition as a legitimate voice of the community
- ▶ the ability to collect and utilize data for assessment, advocacy, evaluation and strategic planning.

## ▶ Public health departments must have the will, skills, infrastructure, policies, resources, cultural sensitivity and desire to partner successfully with community organizations.

As partnerships formed and developed over time, it became clear that many local health departments faced unique hurdles in partnering to promote community health.

Public health department staff work in environments that are often very different from the work environment of community partners. Categorical funding streams tied to specific health outcomes may conflict directly with a community-driven focus for public health. As a result, all of the health departments were challenged to find flexible funding, outside of traditional sources, that would allow them to continue to support community priorities.

Public health departments developed numerous effective strategies for building partnerships, including:

- ▶ developing a customer-service approach to address needs/issues presented by community members
- ▶ developing flexible spending and staff-time allocation to facilitate community partnerships
- ▶ training staff on how to work with the community in general and with specific communities as needed.

Communities and health departments often had different priorities, goals, agendas, ways of working and timetables

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**▶ It was challenging for some public health departments to form partnerships with several community groups at once, as required by the initiative's design.**

This was especially true in Los Angeles and all public health jurisdictions that were responsible for an entire county and lacked sufficient staff to work simultaneously with numerous local community organizations.

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**▶ Power sharing is at the center of partnership.**

Learning to work together, share power and appreciate each others' assets was key to building a productive community health partnership. More power traditionally resides with local health departments, which have greater access to government resources than community groups do. Partnering for community health, however, often required shifting the power balance in the partnership. As one health department staff explained, public health departments have resources, data, government connections and some clout. Community partners, however, have more power when it comes to working with residents on everyday issues such as beat cops, speed bumps and grocery stores and other neighborhood concerns.

**▶ Successful partnerships created a shared vision.**

Communities and health departments often had different priorities, goals, agendas, ways of working and timetables. In many cases, the health department was more data-driven, while the community was motivated more by a passion for residents' well-being. Many PPH community grantees did not have an existing working relationship with the local health department. Some even had past experiences that had left them wary about working with the public health agency.

Those partnerships that were most successful paid attention to developing a shared vision for their collaboration. This process often helped them recognize their commonalities, understand each other's assets, resources and limitations and have realistic expectations of what each could contribute.

As one community group leader noted, "We shared responsibility to improve community health and brought different resources to the task." Another explained: "Our whole PPH partnership has been about learning where our interests and assets intersect."

▶ **Strong partnerships bridged cultural differences.**

While working together, health departments, community groups and residents often discovered cultural differences based on values, historical experience, heritage, language, socioeconomic background, world views or institutional mission. Successful partnerships formed their own culture as they worked to bridge those differences, solve major problems and adapt to internal and external challenges. They also created an environment of respect that acknowledged the range and validity of diverse perspectives and allowed for the meaningful participation of all members. Strategies for effective partnering included:

- ▶ touring the health department and the community
- ▶ taking time at meetings to share the history and structure of each organization and explain how tasks are accomplished
- ▶ becoming more or less formal in work styles to bridge organizational differences
- ▶ simplifying language and reducing the amount of jargon used in meetings
- ▶ jointly hosting and participating in trainings, community celebrations and educational forums
- ▶ providing language interpretation to enable meaningful participation by all community members, not just English-speakers
- ▶ creating an environment of open communication and identifying mechanisms for sharing information regularly
- ▶ rotating leadership and sharing power
- ▶ finding ways, through social and work-related activities, to build relationships between health department staff and community group members.

▶ **Partnership formation and maintenance is a cyclical, dynamic process.**

Like many groups, CBPH partnerships go through the four-stage process of “forming, storming, norming and performing”—testing boundaries, airing conflicts, resolving them and accomplishing tasks. This cycle repeats every time a new partner comes into the group and changes the mix. As a result, partnership building did not just occur in the beginning months and years of the initiative. It was a continual, dynamic, often challenging process for even the most stable, successful public health and community group partners.

Partnership building was a continual, dynamic, often challenging process

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# Leading Change

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## DEVELOPING STRONG HEALTH DEPARTMENT AND COMMUNITY LEADERS

Strong public health department and community leadership is vital for successful CBPH partnerships. As a result, it is essential to enable new leaders to emerge. The fact is that no single leader, no matter how successful, can represent all the interests within a diverse community or possess all the capacities needed to support a dynamic organization.

### **PUBLIC HEALTH DEPARTMENT LEADERS**

During the initiative, strong leadership was the crucial variable that enabled some public health departments to rise above crisis management onto a more visionary path and institutionalize CBPH practices. According to a report by the Center for Community Health & Evaluation, strong agency leaders were able to persuasively articulate the benefits of working with the community and influence organizational culture and decision making.

In several public health departments, CBPH leaders were in top positions; in others, they were in middle management or front-line staff. Because community-based public health does not receive encouragement or support at the state level, leadership tended to be local and reflected the unique political and administrative environment of particular public health departments. Geography and size did not make a difference—public health department leaders successfully embraced CBPH in large, small, urban and rural jurisdictions.

After seeing how siloed many program managers and staff can become within their own agencies, it is critical for initiatives like PPH to create more opportunities for peers to interact and learn from one another across health departments and to identify potential leadership training opportunities that would support them in this work. Unfortunately, PPH efforts to provide a platform for some of the most committed health department leaders did not increase their influence with peers or with the state health department.

Looking forward, The Endowment and the PPH Program Office, based on lessons learned, have developed a new framework for developing multiple aspects of health department leadership and CBPH capacity.

Strong leadership was the crucial variable that enabled some public health departments to institutionalize CBPH practices

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# LESSONS

- ▶ **Public health departments that were most successful in partnering with communities had a broad base of leadership.**

Some public health directors were clearly committed to community-based public health, but lacked an organizational development strategy to make community work anything more than a sideline activity or short-term grant program that did not change the focus of the organization or existing categorical programs. Conversely, there were examples of deeply committed staff and middle managers, who, without the support of the public health director, could not move the vision of community-based public health beyond the program level to influence the organization itself.

When leadership was truly dispersed from top to bottom, however, the structure and culture of the organization supported CBPH, especially in public health departments with established organizational divisions committed to working with communities. In these agencies, the legitimacy of CBPH work was not only reinforced, but the staff also became peer leaders in advancing the CBPH ethos. These formal organizational divisions nourished staff leadership and would not have been possible without support from senior management.

- ▶ **External sources of leadership were important in some public health departments.**

Community advocates, agency executives and elected officials were variously useful sources of support for community-based approaches to public health. In Mendocino County, for example, the public health department organized a Public Health Advisory Board that included partnership members as well as physicians and representatives from county government. Incorporating those external sources of support and leadership into public health department program and advisory functions helps sustain their impact and contributions.

- ▶ **Some local public health officials formed regional forums to pool leadership and learn from one another.**

An eight-jurisdiction group in the San Francisco Bay Area, for example, came together with PPH support to develop regional strategies to address health inequities. They also focused on internal capacity building and organizational development processes, enabling staff and senior managers from the nine public health departments to consult with and learn from one another about how to engage communities. A six-county collaboration in the Central Valley is also in the early stages of sharing leadership skills and knowledge to encourage CBPH practice and work more effectively with communities.

▶ **Community-based approaches to public health transcend specific public health professions and trade associations.**

As a result, one difficulty in gaining broader support for CBPH is that existing public health organizations are built around professions. They typically represent their own interests and do not commonly adopt approaches that cross professional boundaries.

### **COMMUNITY LEADERS**

Leadership development is also essential to the sustainability and growth of community organizations. Staff turnover is a fact of life in community groups, which work with very limited, short-term budgets to address complex, long-term projects. As a result, burn-out can occur among even the most seasoned and committed leaders.

New leaders often emerge naturally through participation in working committees, volunteer boards, programs or projects. In one Shasta County partnership, for example, PPH-funded minigrants turned dozens of local residents into project leaders. In addition, structured leadership training programs can give residents the skills to step into leadership positions.

▶ **Community groups should make succession plans.**

Given the high turnover that many community organizations experience, it is important for them to ensure that they have new leaders in the pipeline. To prepare them, groups should also structure opportunities for them to take the reins and gain experience in different kinds of leadership situations.

▶ **Leadership training programs can successfully develop and identify new leaders.**

At the outset, nearly all PPH community partners identified leadership development as a priority for action. Those that incorporated a broad training program that taught residents the basic components of community health improvement—from assessing needs and mapping assets to developing programs, changing policy and fundraising—created a cadre of program leaders who could participate effectively in a variety of arenas. Partnerships provided leadership training in a wide range of skills, using a variety of formats and approaches—ranging from weekend workshops to year-long training programs—that took into account participants’ work and family responsibilities.

Groups that wanted to expand their advocacy role provided leadership training in public speaking, presentations, decision-making processes and data collection and interpretation. Other organizations focused on improving internal operations and provided training in financial management, board development, meeting organization and facilitation.

The trainings were most successful when they combined skills needed in the organization with the interests of participating residents. Without that mix, residents typically gained skills but did not necessarily contribute to the growth, development and leadership of the organization.



# Engaging Residents

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## TAPPING COMMUNITY WISDOM AND BUILDING SKILLS

Resident involvement unlocks huge potential for community health improvement. Neighborhood residents, most importantly, bring first-hand experience, skills and knowledge of community needs, priorities and resources. They are also committed to improving the health of their families and community and can motivate friends and neighbors to participate actively in the process.

“Agency partners are great,” stated one community health service director, “but bringing it down to a neighborhood level is a whole new thing. It reshapes our thinking.” As a partnership director added, “There’s no way that we can understand local needs in this area and develop programs to meet them without involving the people that our partnership is serving.”

Productive, sustained resident engagement, however, is challenging to achieve. If residents are not paid or provided incentives to be involved, it can be difficult to maintain their interest. It is also helpful for residents to have early “wins.” In community groups as well as public health departments, successful resident engagement took committed leadership and a firm desire to make it work. Partnerships also need to institutionalize resident engagement with a formal budget—for interpretation and transportation needs, for example.

As one PPH staff member put it, “resident engagement doesn’t work when it’s an afterthought. It has to be the centerpiece of any community and public health partnership.”

Resident engagement has to be the centerpiece of any community and public health partnership

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# LESSONS

## ▶ Resident engagement increased when groups offered a range of opportunities for involvement.

Residents get most enthusiastically involved in their personal areas of interest. One resident, for example, might be especially interested in funding issues and financial sustainability, while another might be interested in outreach or youth activities. Only a small group of residents might actively participate in planning, while a larger group might be interested in more action-oriented implementation projects. Offering several routes to involvement boosted the rate of resident participation.

In San Diego, for example, residents had a choice of teams and topics they could work with, from community safety and nutrition to parenting and substance abuse. Residents often started with one team, then moved into others as their interests changed over time.

According to a partnership coordinator, residents “are more willing to get involved when there isn’t a rigid agenda.” The director of another San Diego partnership agreed: “It’s so important to keep the issues moving. Different people step up, depending on their interests, and that’s what keeps this partnership alive and energized.”

## ▶ Making meetings accessible for residents was critical for their involvement.

This often meant scheduling meetings at nights and on weekends, with plenty of advance notice, and holding them in familiar, accessible locations like churches, schools, parks and people’s homes. They also encouraged participation by creating a welcoming atmosphere with food, childcare, interpretation and translation, youth involvement options and transportation for youth and seniors. Most partnerships learned many of these crucial strategies through trial and error.

## ▶ Community members were more likely to engage in health improvement efforts that provided them with opportunities to learn new skills.

Some residents, moreover, moved from their own training to greater involvement in efforts to improve their communities. In Long Beach, for example, the PPH partnership produced dozens of new community health leaders who provide health education to families and other community residents, organize health fairs and cleanups and teach classes on nutrition, health and physical activity.

“They’re the driving force of a lot of community agencies in the area,” said a community partnership coordinator. “Some of them may not have more than an elementary-school education, but they’re taking the lead on local issues and being invited to give speeches at universities.”

▶ **Involving residents from different cultures was a critical part of resident engagement.**

It was especially important to identify leadership in each culture and bring them to the table. In San Joaquin County, for example, the public health department collaborated with diverse partners representing Stockton’s distinctive Southeast Asian, Latino and African-American communities. These collaborations were intensive and took up “an enormous amount of time,” noted the county’s director of public health, but they also transformed the way the department works—increasing awareness, for example, of how cultural beliefs and attitudes can affect health. The partnership’s diversity also proved to be a strength, especially in mobilizing support for community health services.

When the county considered scrapping mobile health programs that traveled to underserved areas of South Stockton, for example, a diverse coalition of PPH partners and other community-based organizations turned the tide. Residents of local groups joined Hispanic, Hmong, Lao and African-American residents of South Stockton at a county Board of Supervisors meeting to show their support for the jeopardized health programs. As a result, the supervisors voted to continue most of the services and pay for them out of scarce county funds.

“The diversity of our coalition was part of the leverage that saved these programs,” explained a community partner. “Decision makers see that we represent multiple groups, not just one narrow interest. When all the community’s different residents work together, things happen.”

▶ **Several factors were instrumental in enabling health departments to make changes that supported a sustained community-based focus:**

- ▶ **Leadership that understood and clearly and consistently communicated the value of working with communities.** It was critical that health department leadership was able to persuasively articulate the benefits of working with the community and actively look for opportunities to apply a community-based approach in existing programs as well as in planning new programs.
- ▶ **Creative financing that prioritized work with communities.** PPH health departments adopted a number of different strategies to identify funding that was flexible enough to support community-based public health, including local general fund or state realignment monies, 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 included community advisory boards, direct involvement of community members in assessment and planning processes, hiring of community residents as staff and regular public forums.



# Local Policy and Systems Change

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## COMMUNITY PARTNERS TAKE THE LEAD

Community health improvement is sustained through policy and systems changes. These efforts, during the PPH initiative, were most successful at the local level. PPH partnerships were able to identify community health issues including broad determinants of health, ranging from access to care, youth development, nutrition and physical activity to environment, violence, sanitation, traffic safety, housing and transportation.

Examples of policy and systems changes ranged from increasing ambulatory care and transportation services, limiting alcohol distribution, establishing a dioxin monitoring station and creating a local park. In Shasta county a partnership helped persuade the school board to adopt a healthy-foods policy for the district and in an unincorporated area of Los Angeles, another partnership helped build support for a new garbage disposal district.

Sustaining community partnership efforts requires broad changes at both local and state levels. The following three policy and systems changes would bolster partnership efforts and improve community health in California:

- ▶ Local public health systems should support broad prevention strategies for improving the health of communities. To achieve significant community health improvements, public health departments need organizational structures, financing, staffing, data capabilities and leadership that support collaborative work with communities and public and private organizations.
- ▶ Performance Standards should be established to support community health improvement. Performance standards should be tied to broad goals for community health improvement. Models of accountability should also extend beyond formal public health governance to include community and other agency partners.
- ▶ State-level public health officials should provide strong leadership to achieve major community health improvement goals. To significantly improve community health, state health departments and organizations must support broad public health improvement strategies as well as collaborative partnerships that extend beyond the formal boundaries of public health agencies.

Policy and systems changes were most successful at the local level

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# LESSONS

- ▶ **Local health departments, as public institutions, are somewhat constrained in their ability or willingness to take a lead role in advocacy efforts.**

As a result, community groups often take the lead when solutions to their health concerns require advocacy for local policy or systems changes. The community's ability to articulate local perspectives, personalize the issues and mobilize large groups of residents to attend public forums and hearings can effectively capture the attention of local policymakers.

The community's ability to articulate local perspectives, personalize the issues and mobilize large groups of residents can capture the attention of local policymakers

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- ▶ **Public health departments can help build the capacity of communities to engage in the public policy process.**

These efforts can include helping community members develop advocacy skills and demystifying the policy process through leadership training programs.

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- ▶ **Local health departments can assist and support community advocacy efforts.**

Many of the 14 health departments that participated in the PPH initiative provided training, data and other documents to support the community's policy positions and presentations. Health department directors were also able to open doors for community leaders to meet with key local decision makers. Open avenues of approach between local politicians and health directors were essential in order to keep politicians aware of important local health issues. The mere presence of health department leaders at public forums also helped to support and add legitimacy to community efforts.

# A Challenging Mission

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## CHANGING STATEWIDE PUBLIC HEALTH POLICY

Federal, state and local public health is still largely focused on traditional functions, primarily infectious disease control, maternal and child health and health education. As a result, there are major barriers to making policy changes to support community-based approaches to chronic disease prevention and addressing the social determinants of health and health disparities. Without funded systemic and institutional change, CBPH approaches and programs—while innovative and led by dedicated public health and community workers—will likely remain marginalized.

In order for internal public health infrastructure changes to take place, policy changes must include specific funding to support community-based work, reorganization of public health systems to support CBPH and incorporation of CBPH principles into academic programs to prepare the future public health workforce.

PPH advocated extensively for these changes on a statewide level. However, those efforts collided with two major forces in California public health and revealed the magnitude of the task. First, prior advocacy for local public health departments in California has concentrated almost exclusively on strengthening capacity for infectious disease control, which has eroded dangerously over the past few decades. As a result, some viewed as an unaffordable add-on the suggestion that public health ought to have a broader vision, involving partnerships with communities and other public and private agencies. Some also feared it represented a privatization of public health and would divert scarce resources from local public health departments to other entities. In addition, some questioned whether there was scientific evidence to support CBPH or a work force capable of carrying it out.

Secondly, the infusion of federal funds and short planning timelines for bioterrorism and emergency preparedness monopolized the intellectual resources of public health leadership throughout the state, crowding nearly everything else

Without funded systemic change, CBPH approaches and programs will likely remain marginalized

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## PPH did not achieve as much as hoped in its efforts to promote changes in statewide public health policy, but it helped lay important groundwork for CBPH in California

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off the agenda of statewide public health planning. Local health departments, facing substantial budget cuts, also shifted staff from threatened programs to bioterrorism funding, further undermining the base of support for community-based public health. Moreover, these circumstances reaffirmed the centralized command-and-control culture associated with emergency response—at the very time that PPH was calling for power sharing, institutional humility and community partnerships.

An additional factor may have been the absence of strong leadership at the state level. While California has some areas of strength in its public health infrastructure—its tobacco control program, for example, is a model for the nation, if not the world—there is little evidence of creative vision overall. Public health was a low priority in a combined health and human services agency that was subject to tight political oversight. As a result, PPH was unable to benefit from a statewide public health planning process or create momentum in the profession.

Consequently, by the end of the initiative in 2004, PPH had not achieved as much as hoped in its efforts to promote changes in statewide public health policy. Nevertheless, PPH did help lay important groundwork for community-based public health in California and learned important lessons and strategies for promoting statewide policy changes. The initiative helped create a common framework and language. It gave rise to a cadre of public health professionals who think differently about their mission and scope and the broad factors that determine the health of their communities. It also helped raise the visibility of chronic disease prevention as a public health mission. This has been incorporated into the work of a new statewide Department of Public Health, approved by the legislature in September 2006, even though it was not part of the original, legislated vision for the department.

# LESSONS

- ▶ **To persuade a public health audience, arguments must be based on evidence about the health of populations and efficacy of prevention strategies.**

It is not enough to assert the inherent value of working with communities, even though that philosophical principle might appeal to some. The public health case for working with communities must be based, instead, on evidence that it is necessary in order to change the conditions that affect community health. CBPH, like other developing currents in the history of public health, must create the evidence base to justify itself. Although that evidence is growing—as indicated by the Community Guide to Preventive Services ([www.thecommunityguide.org](http://www.thecommunityguide.org)) or the developing interest in Health Impact Assessments—it has not yet achieved the status of accepted practice.

- ▶ **The PPH concept was too diffuse and abstract to influence the public health world.**

The end goal of PPH was improved community health, but the vision of CBPH was often vague and difficult to communicate effectively. PPH involved 39 different partnerships between public health departments and communities, each looking at evidence and sorting out relationships in order to decide their own priorities. As a result, there was little common focus among the partnerships and little basis for a defining innovation in practice. The only common element was PPH itself, and that was not enough to convince the skeptical or the harried that CBPH strategies and principles were sound.

- ▶ **Statewide public health policy work must be done strategically, and it must include an understanding of public health professionals and the contexts in which they do their jobs.**

PPH underestimated the depth of tensions over priorities for public health throughout the state and how beleaguered many dedicated public health professionals are as they attempt to do their best within a deteriorating public health infrastructure. Although PPH hosted a series of conversations among the various statewide public health organizations, those outreach efforts failed to reassure their leaders that we were not asking them to build a new edifice on a crumbling foundation or disperse the responsibilities and resources of local public health departments to others. All in all, PPH was not perceived as an ally engaged in complementary work, but as an adversary making impossible demands. Although PPH built a strong base of support among like-minded colleagues, its agenda did not cross the threshold into broad acceptance.

- ▶ **PPH overemphasized the top-down approach in advocacy.**

Although the vision of PPH was to build strong partnerships between local public health departments and communities, with shared responsibility and accountability, its statewide policy advocacy efforts were not generated by that grassroots base. Faced with the short timeframe of a foundation initiative and the need to act quickly on simultaneous fronts, the initiative could not develop that base quickly enough to craft and carry a policy message. Because a broad base is a much more persuasive force than a small band of advocates, PPH will ultimately see more long-term success when its grassroots base is strong enough to promote its policy agenda.

 **Persistence only pays off over time.**

In statewide policy advocacy, PPH took uncharted paths. The value in that process is learning from mistakes and correcting them. In retrospect, persistence was perhaps the most important element of the initiative's policy efforts. By focusing consistently on community-based public health and supporting local efforts to pursue it, PPH helped set CBPH roots around the state that will yield policy and system changes in the future.

Looking forward, the following steps will help create further policy and systems changes in support of CBPH:

1. Develop capacity in the new California Department of Public Health to support and guide local CBPH efforts.
2. Use the obesity prevention platform to build a critical mass of CBPH-engaged local public health departments and communities.
3. Integrate CBPH into federal (e.g., USDA and CDC) and state agreements with local public health departments.
4. Foster the expansion of local public health departments and their involvement in civic planning and decision making to benefit a health-supportive built environment.
5. Seek avenues to support policy that will provide a permanent funding stream for chronic disease prevention through CBPH approaches, beginning with obesity prevention focusing on environmental change.
6. Support day-to-day preparedness for the greater burden of disease as well as other forms of preparedness.
7. Develop cross-sector leaders in CBPH, including PPH alumni and others from the Healthy Eating, Active Communities (HEAC) program and aligned CBPH work.
8. Continue to strengthen community capacity to partner effectively in CBPH.

# It's Not Just the Money

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## SUSTAINING COMMUNITY-BASED PUBLIC HEALTH PARTNERSHIPS

While financial resources are key factors in sustainability, it takes more than money to sustain community health improvement efforts. It also takes a substantial investment of time—perhaps ten years—to build capacity and infrastructure in community and public and private agencies to see community health improvement efforts take root and flourish.

Nevertheless, PPH built an important foundation for community-based public health in California. The initiative's focus on capacity building and partnership development also helped create a deeper understanding of what is needed to sustain this work beyond an initiative's funding period.

Communities also need the social capital, organizational networks (within and outside the community) and financing, staff and leadership to address a wide range of community health issues. Public and private agencies need to understand how their missions overlap with the goals of community health improvement.

It takes a substantial investment of time—perhaps 8 to 10 years—to build capable communities and get CBPH moving forward on the ground

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# LESSONS

## ▶ Partner relationships are a cornerstone of sustainability.

Nearly all PPH partners committed to continuing their work together beyond the grant period, though they realized that the intensity of their interaction might be reduced. Several identified resources to keep their coordinators on staff. The partners will also go forward with an understanding of how they can support and provide resources to one another and enlist other community organizations to help advance CBPH work in California.

## ▶ Partnership leaders, in many cases, will also continue to play a role in community health improvement, particularly in community organizations.

If these individuals maintain leadership roles in their communities, they will help sustain the work of the initiative. Several have secured jobs with community organizations or local health departments, further pointing to the potential for lasting impact.

## ▶ Health department policies can promote organizational changes that institutionalize the capacity to do CBPH work.

Some health departments adopted policies that include indicators of community involvement in staff performance evaluations. Others altered job descriptions to recruit new hires with experience in community health work. Both of these internal health department policy changes will enhance the sustainability of CBPH efforts.

## ▶ Enduring voices that speak for the community are vital components of sustainability.

A major obstacle that health departments and other public agencies confront in doing community work is determining “who” speaks for local residents. Partnerships that demonstrated their ability to mobilize diverse segments of the community around a variety of issues came to be recognized as legitimate voices of the community. Some continue to be sought out for their input as community issues emerge, increasing the potential for sustainability. As one community group partner in Mendocino noted, “We pull people together and provide a forum for addressing a lot of issues, from public transportation to mental health... We’ve really become the voice of the community—we’re its residents, volunteers and leaders.”

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**▶ Sustainability includes the capacity to take on additional issues as they emerge.**

Partnerships that focused on more than one issue were able to enlist the support of broader constituencies. They were also likely to generate new support both within and outside of the community as their agenda expanded.

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**▶ Funding issues, of course, are critical to sustainability.**

The challenge for both health departments and community partners, especially in times of limited resources, is to seek funding that addresses recognized needs of the community.

Grantmakers can help grantees in their sustainability efforts by discussing, providing training and offering resources for sustainability planning early in the funding cycle.

Grantmakers should also be willing to invest in grantees for a new phase of development. Moving on to a new community may be attractive for a variety of reasons, but it may also mean missing important opportunities to build on past achievements.

Grantmakers can help grantees by discussing, providing training and offering resources for sustainability planning early in the funding cycle

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# Epilogue

In the period between the end of the PPH initiative and the publication of this lessons learned document, there were many important developments that alter some of this report's conclusions about policy change. Still, the premise of persistence paying off over time must be underscored as one of the overriding lessons of this initiative.

## **NEW FOCUS ON COLLABORATION**

The public health policy environment in California has changed significantly over the past three years, gaining a new focus on collaborative approaches for addressing the social and environmental determinants of chronic disease. Although bioterrorism-preparedness efforts drove legislation creating a new Department of Public Health, the department, once created, along with the organizations that promoted it, embraced a larger vision for its mandate, given the growing acknowledgment of obesity as an actual (as opposed to potential) risk. Foundation initiatives were already demonstrating the contributions of state and local health departments, community partners, public and private agencies and policy advocacy as important means to achieve environmental changes to improve health.

A governor's summit on obesity and comprehensive state obesity prevention plan provided new openings for state leadership and fostered a greater convergence between state health department work and foundation initiatives. A California Health Strategy Summit also highlighted the importance of both communicable and chronic disease as threats to the health of the population, further legitimizing the expanded vision for public health.

A key lesson of this initiative is that persistence pays off over time

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## PPHS was an important catalyst, building capacity in local health departments and statewide momentum for CBPH

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Finally, and not least importantly, many local health departments, in spite of the funding and organizational challenges, were developing strategies to confront the challenges of chronic disease.<sup>4</sup> As a result of these combined forces, there is considerably less friction today over the priorities for public health in California, and there are many promising examples of agencies and organizations working together.

While it is unreasonable to ascribe these changes to PPH, it is fair to say that the initiative served as an important catalyst, fostering capacity in local health departments and building a statewide momentum for community-based approaches to public health. A new vision, buoyed by evolving models, can be important even when it is initially marginalized; and it can pay off immensely once it has had time to flourish. Many promising practices of local health departments that are working with communities on broad determinants of health were influenced by the Partnership for the Public's Health, and to the extent there is a constituency for this work, it reflects the legacy of PPH.

Today, there is growing acknowledgement of the initiative's role. The strongest indicator of its influence, however, is the transition of its vision from controversial to commonplace.

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<sup>4</sup> See, for example, Prentice B, Flores G, "Local health departments and the challenge of chronic disease: lessons from California," *Prev Chronic Dis* [serial online], Jan., 2007 ([http://www.cdc.gov/pcd/issues/2007/jan/07\\_0081](http://www.cdc.gov/pcd/issues/2007/jan/07_0081))



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