

The Partnership for the Public's Health

Findings from the Evaluation

Executive Summary

Prepared by the Center for Community Health and Evaluation
Group Health
Seattle, Washington

For The California Endowment

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Introduction

An Overview of the Partnership for the Public's Health (PPH)

The Partnership for the Public's Health (PPH) was a \$37 million, five-year initiative funded by the California Endowment (TCE) to develop partnerships between California communities and local health departments. Fourteen county and city health departments were funded under the PPH Initiative along with 39 local community groups (including established service agencies and resident-based organizations). The Initiative grantees are diverse in terms of ethnicity, geography, types of community groups, and experience in collaborating on community health improvement projects.

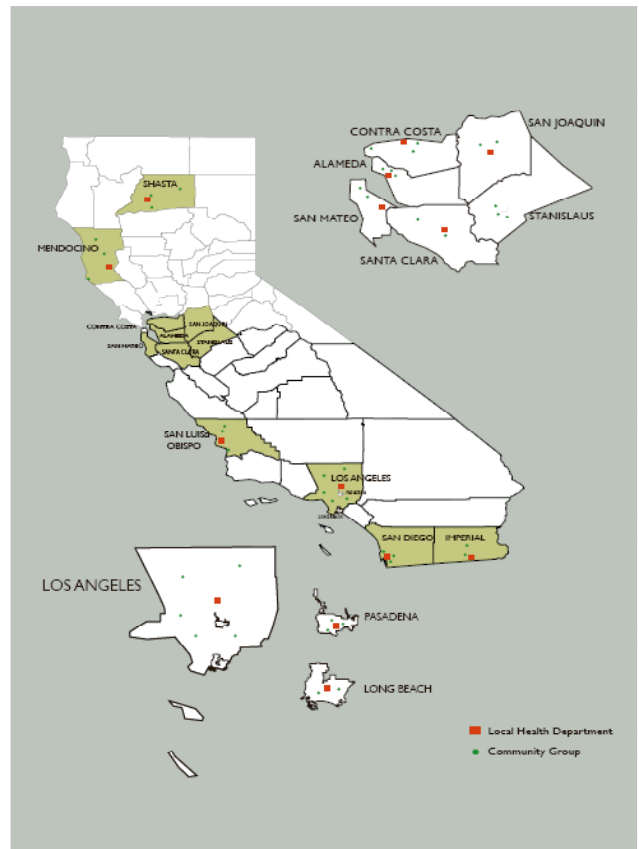
The design of the PPH Initiative included the creation of a central office to develop, implement, test, and disseminate model community-based public health approaches in California. The PPH Office was housed within the Public Health Institute and included personnel skilled in community-based programs, grants management, technical assistance, communication, policy change and evaluation. In 1999, the PPH Office developed a request for proposals for health departments and community groups resulting in the selection of 14 health departments and 39 communities groups. Each health department worked with 2-3 community groups. Funding was based on a number of criteria, including readiness to pursue community-based health activities, and geographic and demographic diversity. A strategic decision was made to include grantees with a broad range of expertise and readiness. The end result was an extremely diverse group of grantees.

PPH grantees were mandated to work in five separate, but interrelated, goal areas:

- Building the capacity of community groups;
- Building the capacity of local health departments;
- Building the capacity of partnerships between the two;
- Improving community health; and
- Achieving policy and systems change.

In support of these goals, grantees received guidance and support from the PPH Office. The first year of funding was a planning year during which grantees were required to develop an action plan that was updated on a yearly basis. Grantees also received numerous technical assistance opportunities and personal support and feedback from their program officers.

The PPH Initiative is a direct outcome of TCE's founding values and its vision for the future. TCE's mission statement emphasizes a commitment to promoting fundamental improvements in the health status of all Californians. To achieve this mission, TCE



has taken an approach that emphasizes cooperation between communities groups and the institutions that serve them.

This approach is consistent with a national movement that recognizes the importance of communities in fulfilling the mandate to improve health and reduce health disparities. The Turning Point Initiative, for example, can be viewed as a precursor to PPH. Funded by the Robert Wood Johnson and W.K. Kellogg Foundations, the Turning Point Initiative sought to strengthen and transform public health infrastructure through partnerships involving a variety of private organizations and public agencies, including but not restricted to those directly involved with public health.

The PPH Initiative has gone beyond its precursors by investing directly in partnerships between communities and local public health departments. The PPH Initiative has sought to support the capacity of community residents to act on their own, as well as to promote capacity within health departments to collaborate with communities. TCE has placed special emphasis on addressing public policy as it concerns the public's health, and to helping achieve sustainable partnerships among coalition members. Much of the material in this report focuses on the challenges and lessons learned in promoting capacity within communities, achieving sustainable partnerships, and addressing public policy.

TCE's newly launched Healthy Eating/Active Communities (HEAC) Initiative can be seen as a direct outgrowth of the PPH Initiative. The PPH Initiative was a broadly conceived undertaking, encouraging local creativity in identifying objectives and conducting experimentation. The HEAC Initiative has a similar aim of promoting community-based partnership for health improvement, but does so in a more focused manner, concentrating on obesity and physical activity, with an emphasis on children. The hope is to accelerate health improvement accomplishments while continuing to building

community networks and improving the systems that support public health in California.

The PPH Initiative has provided important groundwork for the HEAC Initiative, and helped staff at all levels anticipate and meet the challenges in the difficult work of community health improvement. This report provides information on the readiness of communities for forming coalitions, sustaining activity and relationships, and achieving measurable objectives. In addition, this report includes insights on evaluating initiatives concerned with coalition-building and sustainability — insights that may inform the evaluation of HEAC.

About the Evaluation Report and Executive Summary

This executive summary (and the longer report upon which it is based) explores the factors that led to progress in three types of capacity building (for community groups, health departments, and partnerships), community change outcomes (including community health improvement and policy/systems change), the sustainability of local partnership efforts, and initiative-wide outcomes (state-level policy changes and how well the PPH central office supported the grantees). It concludes with a summary of lessons learned from the PPH evaluation for local partners, philanthropists, and evaluators.

Evaluation Design and Methods

A logic model was developed to explain the sequence of activities and outcomes and to assess PPH's impact — both in local communities and statewide. Beginning with visioning and planning, the model moved to more specific actions stemming from the planning process, a combination of organizational and community changes, and finally long-term outcomes. These included sustainable, significant systems and policy changes, as well as improvements in community-level health outcomes. Since changes in health outcomes were not expected to occur during the initiative's five-year time frame, the evaluation focused instead on documenting the intermediate outcomes of organizational and community changes.

To capture progress at the **local community level**, local evaluators compiled case studies from a variety of data sources, including interviews, participant observation, and partnership records. For each community partnership, the case studies summarized community characteristics, the partnership's history, its accomplishments to date, factors associated with success (or lack thereof) in reaching partnership goals, resident involvement, sustainability, lessons learned, and recommendations. Case study results have been aggregated for this executive summary to provide an overview of partnership-level accomplishments.

The case studies also were used to develop standardized measures of progress. Local evaluators led a collaborative process in which partnership members assessed their own degree of progress. This was followed by a facilitated discussion among the local evaluator, PPH Program Officer, PPH Evaluation Coordinator, and Center for Community Health and Evaluation (CCHE) staff to determine the final progress assessment results.

Although the progress rating scales that emerged from this process vary slightly by goal, their general definitions are as follows:

- **High** degrees of progress are characterized by the implementation of activities that either substantially strengthened the organization or entity, or were likely to significantly improve long-term community health.
- **High/moderate** degrees of progress are characterized by activities that have potential to move into the “high” category described above with only a modest investment of additional resources
- **Moderate** progress indicates either a limited number of activities and/or activities of modest scope
- **Low** progress indicates little or no activity in the indicated area.

Two Initiative-level outcomes — statewide policy changes and the impact of having a central PPH office — were evaluated using a combination of key informant interviews, document review and participant observation.

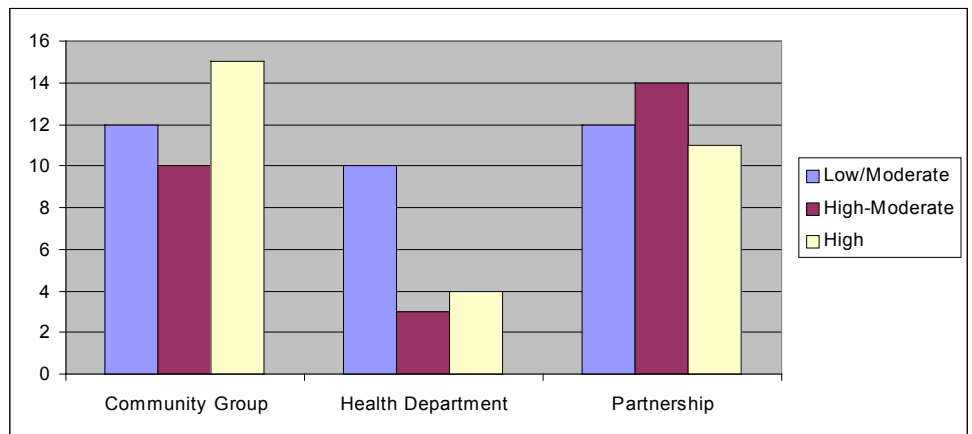
Evaluation Findings

The highlights below summarize findings for each major area, but it should be noted that these represent tremendous diversity among PPH communities. More details about variations and their implications can be found in the full report.

Progress in Capacity Building: Community Groups, Health Departments, and Partnerships

Figure 1 shows the distribution of ratings for progress in the three PPH capacity building goal areas: among community groups, health departments, and partnerships. Of these three, the community groups collectively showed the greatest improvements in capacity building, with 15 rated as “high” in terms of their progress in this area. (Because 2 of the original 39 community groups were de-funded, the 15 community groups ranked as “high” constitute 41% of the total.) Among health departments, far fewer — 4 of the 17, or 24%, earned a “high” rating in capacity building. For partnerships overall, 11 (or 30%) were rated “high.”

FIGURE 1: PARTNERSHIP PROGRESS IN THREE CAPACITY BUILDING GOAL AREAS



COMMUNITY GROUP CAPACITY BUILDING

What did the **high-functioning partnerships** have in common in terms of capacity building among community groups? In general, they had taken concrete steps to improve their internal organization or governance — for example, by strengthening their leadership, boards, or decision-making procedures. Another factor was improvements in infrastructure (such as adding office space or new personnel). Whether or not new personnel were added, upgrading the skill sets of staff was a factor, as was achieving independent 501(c)(3) status. A greater level of communication between these partnerships and the community at large led to greater recognition. They also paid attention to involving residents in leadership and planning, supporting these efforts with specific training and systems that made this possible. Finally, the high-functioning partnerships shared a commitment to sustaining current or new activities.

Factors identified by key informants as responsible for the success of high/high-moderate partnerships included leadership, staffing, size/definition of community, and relationships with residents. Among the partnerships that were rated as “high” or “high/moderate” in their success in capacity building, 80% noted strong leadership, 76% noted the talent and dedication of their staff, 84% pointed to the advantages of working in a small and/or well-defined community, and 84% had established relationships with residents.

AN EXAMPLE OF A COMMUNITY GROUP MAKING SUBSTANTIAL PROGRESS IN CAPACITY BUILDING:

Inglewood/Lennox/Hawthorne Community Health Council (ILH-CHC) in Los Angeles County increased networking and communication opportunities among the partner organizations, improved communication mechanisms with parent agencies, created a Neighborhood College curriculum and timeline for integrating five of the graduates into ILH-CHC’s Steering Committee, and designed and implemented a group governance structure.

In contrast, half of the partnerships rated as “low” or “low/moderate” suffered from recurring staffing problems (such as recruiting difficulties and/or turnover), communication challenges, and other problems with working in the community and building trust. Forty-two percent experienced leadership problems and the same percentage reported lack of resident engagement.

HEALTH DEPARTMENT CAPACITY BUILDING

The health departments that reported progress in capacity building had a number of factors in common. These included assessing community needs through some type of assessment, providing community-level data to communities, involving communities in a strategic planning process, training employees to improve their skills in working with community members, changing policies and organizational culture to make health departments more responsive to community input, and allocating additional financial resources to support community-based public health efforts. Among those with a “high” or “high/moderate” success rating, fully 80% reported that they had strong leadership committed to working with the community, and 75% had worked with community members on data collection and distribution.

AN EXAMPLE OF A HEALTH DEPARTMENT MAKING SUBSTANTIAL PROGRESS IN CAPACITY BUILDING:

Shasta County Department of Public Health established an Advisory Board and held Board trainings, established regional offices and made a conscientious effort to recruit and hire residents to work in these regional offices, and strengthened and formed new relationships between the regional office and other organizations. They also implemented a strategic planning process that has resulted in a revised mission statement and department values, supervisor and manager trainings, the new Public Health Advisory Board, and a reorganization of the health department. Community constituency (largely developed under PPH) advocated for retention of funding and community-based resources in the midst of massive budget cuts.

In contrast, the partnership with “low” or “low/moderate” ratings for health department capacity building had failed to make significant changes in terms of their ability to work with the communities around them. Over a third of the health departments in these categories — 35% — reported communication challenges. A significant percentage — 29% — reported lack of leadership or organizational support for community-based approaches to public health, bureaucratic obstacles that impede work with communities, and lack of resident engagement.

PARTNERSHIP DEVELOPMENT

Partnerships that had made progress during the study period had developed mutual respect and improved relationships among members. They were more familiar with each other and with partner organizations because they attended each other’s meetings and also held regular joint meetings. They also shared training and other resources, implementing joint activities, and acquired funding to sustain these activities. As a result, their knowledge of the health department and community structures for action and decision-making increased.

Partnerships with “high” and “high/moderate” success ratings were far more likely to report mutual understanding and trust between the health departments and community groups (80%), established relationships with residents (76%), working in small or well-defined communities (72%), open communication and sharing of information (60%) and working with a stable, knowledgeable group of core members (60%).

On the other hand, half of the partnerships with “low” or “low/moderate” ratings, who had failed to strengthen the connections between the health department and community groups, reported internal and external

AN EXAMPLE OF A HIGH FUNCTIONING HEALTH DEPARTMENT/ COMMUNITY PARTNERSHIP:

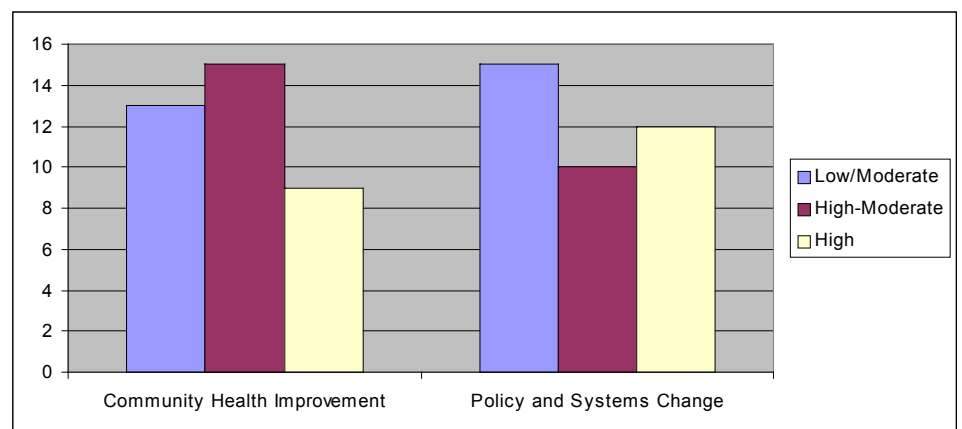
The Asian Pacific Self-Development and Residential Association/ Calaveras River Central Community Collaborative — San Joaquin County Public Health Services increased access and use of each partner's resources (staff and materials), developed clear governance structures and communication processes, involved high-level decision makers in partnership governance, increased trust and conflict resolution skills, engaged in a number of joint activities including a community health assessment and a program to promote dental health, built community-based research and evaluation skills, and jointly developed a sustainability plan.

communication challenges and a lack of resident engagement. They also reported other challenges of working in the community (42%); a third said they had been unable to develop or maintain a clear purpose or sense of vision.

Progress in Community Change Outcomes

Figure 2 shows progress in achieving community health and policy/systems change outcomes.

FIGURE 2: PARTNERSHIP PROGRESS IN COMMUNITY CHANGE OUTCOMES



COMMUNITY HEALTH IMPROVEMENT

Partnerships that reported progress in community health improvement had conducted needs assessment, supplied health-related information and/or resources, and increased social and health services. Among the partnerships with “high” and “high/moderate” success rates, 83% reported that they had stayed flexible and taken advantage of opportunities. The vast majority — 75% — had established relationships with residents, and 67% said they communicated openly and shared information. Fifty-eight percent said they worked in small and/or well-defined communities.

AN EXAMPLE OF A PARTNERSHIP MAKING SUBSTANTIAL PROGRESS IN COMMUNITY HEALTH IMPROVEMENT:

Shingletown Activities Council — Shasta Public Health Partnership

increased the availability of food for seniors by securing Meals on Wheels frozen meals, built relationships with the distributors of Brown Bag and commodity packages, and creating an emergency food closet. This partnership also enhanced preventive services for seniors, decreased traffic related fatalities, and increased awareness of traffic safety through data collection, public education, and advocacy. Other accomplishments were the creation of a network of partnerships and the organization of a youth council.

The partnerships with “low” or “low/moderate” community health improvements faced internal and external communication challenges (46%), lack of resident engagement and other challenges in working in the community (46%), an inability to develop or maintain a clear purpose or vision (38%), and inadequate funding or resources (23%).

POLICY AND SYSTEMS CHANGE

Partnerships that had achieved policy and systems change reported that they had begun a dialogue with the community regarding policy change and developed awareness of a need to identify a clear policy focus (i.e., a particular policy issue) — using community assessments to do so. The process of selecting a policy issue led to increased community and stakeholder interaction with policymaking bodies and to changes in policies within communities.

Of those reporting “high” and “high/moderate” success rates, 82% reported that they had the ability to network effectively, 77% had established relationships with residents, 72% had access to community leaders and worked in small and/or well-defined communities, and 68% had open communication and sharing of information.

The “low” and “low/moderate” partnerships had not strengthened connections between health departments and community groups. They were more likely to report internal and external communication challenges (60%), a lack of time and skills for planning and implementing policy change activities (46%), a lack of resident engagement (33%), an inability to develop or maintain a clear purpose or vision (33%), and inadequate funding or resources (26%).

Sustainability of Local Partnership Efforts

Improvement in long-term health outcomes will require that the PPH activities are sustained beyond the period of grant funding. Initial results are encouraging. At the end of PPH funding, almost 70% (25 out of 37) of health department and community groups had specific plans to continue working together, including six partnerships that had signed MOUs specifically outlining key elements of their continuing relationship and 13 partnerships that had specific projects they were continuing work on (most of which

had funding). In most cases it did not appear that the specific partnership structures that were developed under PPH would continue, but several partnerships did state that they would use the same committees and procedures to continue their partnerships.

All but three of the 37 partnerships had plans to continue at least one of the major activities begun under PPH. Twenty six partnerships (70%) had activities for which they already had secured continuation funding. As for funding to support continued activities: in the Grant Year 4, nearly 80% (29 out of 37) of partnerships applied for funding to sustain the work that was started under PPH. As of August 2004, PPH partnerships had applied for over \$18 million worth of funding (over \$4.5 million worth of funding had been received). An additional \$4.7 million was pending.

Initiative-Level Outcomes: State-level Policy Change

Promoting changes in public health policy to support the creation of a public health system that are more open to community-based approaches to public health was an integral part of the PPH Initiative. Significant resources were invested in developing and implementing the policy work, including two staff members specifically dedicated to policy work; the regular contribution of other PPH and senior PHI staff time; volunteer time from key stakeholders; resources for publications; trainings and forums; and the efforts of grantees working on local policy change. A small group of staff members (the policy workgroup) from the PPH Office and PHI was organized to guide the policy effort.

Progress in the statewide policy work of the PPH Initiative included:

- Developing a policy agenda
- Supporting Mobilizing for Action through Planning and Partnerships (MAPP)
- Cultivating regional public health collaboratives
- Identifying models of effective community-based public health practice among local health departments
- Alliance building to support policy agendas
- Participating in the Little Hoover Commission
- Facilitating Health Department Peer Learning
- Providing Grantee Policy Advocacy Training

Initiative-Level Outcomes: PPH Office/Initiative Support

The PPH Office was established before community grants were awarded. The responsibilities of the PPH Office included management of the community-level grants, oversight of evaluation efforts, development of technical assistance resources, support of contractors, and development, and advocacy for statewide policy efforts. Findings from an assessment of the PPH office role included:

- The overall selection process for both the health departments and community groups was well-organized and consistent.
- Grant management was effective, especially considering the large number of grantees located throughout the State of California, including relatively inexperienced community organizations, well-established community organizations, and local public health departments, all with varying degrees of resident involvement.

Technical assistance to grantees provided by both PPH staff and outside contractors was well-organized and useful.

Summary and Implications of Findings

The Partnership for the Public's Health was a large (over 50 grantee organizations), complex initiative with ambitious goals for community changes promoting long-term improvements in population health. In particular, of the 37 partnerships funded throughout the initiative, between 25% and 40% were able to make a high level of progress in the five goal areas of the initiative. Progress was also made toward statewide policy changes to promote community-based approaches to public health. The PPH office was able to manage the complexity effectively and produce a number of substantial achievements.

Substantial, and likely enduring, accomplishments of PPH were:

- Ongoing work in partnership communities. A wide array of capacity building activities ranging from increased resident involvement, enhanced community leadership and better relationships between health departments and community organizations led to substantial community changes. Many of these changes are being sustained beyond the period of PPH funding through foundation and local funding and in-kind contributions. While it is uncertain what the effect of these changes will be, many are of sufficient scope and intensity to produce long-term improvements in community health status.
- A model of health department/community collaboration. PPH showed that given the right circumstances and support, that health departments can be effective partners with community groups in broader health improvement efforts. In many cases, these efforts were in areas far removed from traditional public health activities.

- The potential models of health department/community collaboration may offer the most important PPH legacy for other, future initiatives. Health departments are often left out of community partnerships for a variety of reasons, but PPH demonstrated that they can be effective partners given the right circumstances and resources. The following section provides further details on specific lessons/changes that health departments need to make to be effective community partners, as well as other lessons relevant for funders and communities.

Lessons Learned

This section summarizes the lessons learned over the course of the initiative, grouped into those with particular implications for the practice community, funders, and evaluators.

Lessons Learned: Practice Community

COMMUNITY ORGANIZATIONS

- A range of capacities is required for community groups to partner effectively and be successful in policy work. Figure 3 lists capacities required for community groups to build a stable organization, work with health departments and advocate for policy and systems change. Creating a stable organization requires trust among members, effective leadership and adequate resources. When partnering with health departments, resident engagement and understanding how to use and collect data help facilitate collaboration. Advocating for policy and systems change requires new alliances and the ability to mobilize residents.

FIGURE 3

CAPACITIES NEEDED FOR A STABLE ORGANIZATION:

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

CAPACITIES FACILITATING WORK WITH HEALTH DEPARTMENT:

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

CAPACITIES FACILITATING POLICY AND SYSTEMS CHANGE:

- Mobilize residents
- Create new alliances
- Promote community self-empowerment

- Success often can be traced back to key leaders and staff members who were committed, enthusiastic and effective. There were numerous examples of key staff members or leaders making a major difference in the ability of the organization to stay focused and accomplish its goals. In some cases, this role was concentrated in one person, while in other cases it was distributed across a number of individuals.
- Community groups are most effective when they are able to critically reflect on their strengths and weaknesses. Many of the most successful partnerships were also the most self-critical (e.g., more likely to give themselves assessment scores lower than those of the Initiative Evaluation Team). A certain amount of self-criticism and reflection seemed crucial to effective goal setting and ongoing improvement.

PUBLIC HEALTH

- Effective partnering requires health department leadership that understands and clearly communicates the value of working with communities. It is critical that health department leadership be able to persuasively articulate the benefits of working with the community. Health departments with the strongest mechanisms for working with communities have support from key leaders within the health department who have the power to influence decision-making and organizational culture.
- Health departments should consider creative financing to fund work with communities. One of the biggest challenges that health departments face is finding funds to support work in partnership with communities. Health departments involved in PPH have explored strategies for finding funds that are flexible enough to use for community-based public health efforts. These strategies include using local general fund or state realignment monies, using administrative waivers to streamline administration of funding streams, flexible use of categorical funding, and creative use of bioterrorism preparedness funding.
- Health departments must commit to sharing data with community groups. The epidemiology departments in most health departments can be a valuable link to communities. Data collected by health departments can assist community groups with grant writing, advocacy, and identification of community health issues that need to be addressed. The ability to provide community level data is critical in support of these efforts.

PARTNERSHIPS

- Partnerships are difficult to sustain without organizational infrastructure and governance. While volunteer residents may be important to community-based partnership, it is difficult to sustain without organizational infrastructure (staffing, office, communication systems) and a clear mission and governance structure.
- Partnerships need to include key decision-makers and gatekeepers. Partnerships need persons who represent, can speak for, make decisions on behalf of, and commit resources of partnering organizations and constituencies.

COMMUNITIES

- Leadership development training is an effective means to empower community members and create strong community programs. The PPH experience demonstrated the importance of training residents in leadership skills. A number of partnerships used this technique, effectively bolstering social capital in their local communities and providing local leadership for community health improvement.
- Cultural diversity within communities poses challenges that need to be respected and addressed. Cultural diversity in communities and partnerships poses logistical and ideological challenges for partnerships. Findings from this evaluation suggest that it is easier to make progress in ethnically homogenous groups. Given that diverse communities often have significant economic, social, and health needs, it is imperative to find ways to address cultural diversity. One approach is to acknowledge and address these challenges with increased awareness of cultural differences, additional time for assessment, outreach, leadership development and trust building, and supplemental resources (money and technical assistance) to address language and cultural barriers.

Lessons Learned: Funders/Philanthropy

DESIGN AND PLANNING OF A COMMUNITY HEALTH INITIATIVE

- Community partnerships choose health improvement goals that address the “broader determinants of health.” When partnerships were encouraged to define their own health improvement goals, almost 90% partnerships (33 of 37) identified a broader range of health determinants than those traditionally undertaken by local health department and health services agencies. These broader goals, including housing, transportation, traffic safety, environmental justice, and public safety, were reflected in goals that residents viewed as more important (therefore encouraging resident involvement) and gave the flexibility for residents to work in multiple areas and appeal to the varied interests in a community.
- Criteria for selecting and funding community health improvement efforts should be well thought out, especially around community group readiness. Limiting selection to the highest performers may neglect groups with great potential; however, expectation and strategies for technical assistance and implementation need to accommodate lack of readiness.
- Capacity building requires a long-term commitment (5-10 years) to be successful. Four years was not enough time for partnerships to effectively plan, build capacity, implement and sustain major community health programs. Many grantees at the end of the four-year funding cycle were just beginning to have the capacities they needed to carry out their plans efficiently and effectively. This was especially true in the policy arena.

IMPLEMENTATION OF A COMMUNITY HEALTH INITIATIVE

- Baseline capacity assessments should be conducted with each grantee. These assessments are needed to facilitate development of an appropriate TA plan for each grantee and the identification of common TA needs. These plans should be updated annually.
- Technical assistance should be tailored to individual community needs. PPH used a hybrid TA model. For example, when media advocacy training was identified as a widespread need, the TA provider adapted the training to the capacity of each grantee. This approach was much more effective than the standard training package that was offered to other PPH grantees. When individualized training is not feasible and grantees are at very different skill levels, cluster trainings or training modules should be organized to respond to groups of grantees at similar capacity levels. The program office has to be adequately staffed in order to organize these trainings over the course of the Initiative.
- A strategic communication plan should be developed for dissemination of Initiative information. Information about Initiative efforts needs to be disseminated quickly to a wide range of audiences. A strategic communication plan should be developed that identifies key messages, audiences, and opportunities for delivering these messages. The plan should be developed early on, using a participatory process that includes funders, Initiative staff and grantees. The plan should be reviewed and updated regularly.
- A variety of methods/media for communicating results is needed. Since printed documents have a limited audience, communication regarding the Initiative could have had a more extended reach if a wider range of media and communication methods been used, such as television, radio, and community presentations

SUSTAINABILITY

- Sustainability planning should begin early in the funding cycle. Grantees need to be introduced to the idea of sustainability planning early on and provided technical assistance to begin this planning several years before funding ends.
- Key stakeholders (including grantees) need to participate in discussions regarding what should be sustained. Sustainability can take many forms; therefore some discussion is needed regarding the specific sustainability goals of funders and other stakeholders. There needs to be some consensus if grantees are to engage in appropriate sustainability planning.
- Health departments can foster sustainability of community health improvement programs by building the capacity of community groups. Although health departments have not traditionally seen it as their role to assist community groups in building basic organizational and community engagement capacities, such efforts were often a successful strategy for ensuring sustainability of programs. In a number of partnerships the community organization was able to develop and procure multiyear funding for health improvement programs done in collaboration with the health department. This type of sustainability has benefits for the community group, the health department, and the community in general.

Lessons Learned: Evaluation

- The design of a participatory evaluation should be developed during the planning phase of the initiative/project and then further negotiated with grantees at the beginning of the initiative. In addition to training on participatory evaluation and basic evaluation skills, grantees should be given the chance to review the evaluation design and provide input on data collection and indicators.
- Multiple strategies should be used for involving communities in the evaluation. Readiness and receptivity to evaluation varies greatly across communities. Evaluators need to develop a toolbox of strategies for involving grantees in the evaluation, including ways to provide useful feedback.
- The evaluation should balance the need for detailed local information with the resources required to collect the data. Collection of local data can be very resource intensive and demands on local evaluators can quickly exceed the funding allocated. Local evaluators must work with the initiative-level evaluators to design instruments and tools, collect uniform, detailed information on their partnership, work in a participatory way with the community groups and health departments, and at the same time build local evaluation capacity. Accomplishing all of these tasks requires significant skills and a significant investment of resources.
- The relationship between the local- and initiative-level evaluators should follow participatory principles. One of the unique aspects of the PPH Initiative evaluation is the extent to which participatory principles guided the initiative-level evaluator's approach to working with local evaluators. This participatory philosophy meant that local evaluators were included in the design process, empowered to participate in

decision-making, and there was an on-going commitment to capacity building for all evaluators. This process resulted in better data quality and evaluation processes that accommodated the diversity of PPH partnerships.

- Resources should be allocated for emerging evaluation questions. During the course of the PPH Initiative, areas emerged for which stakeholders felt they would benefit from a more in-depth examination of local partnership characteristics and activities (e.g., community capacities, health department capacities, resident involvement). These newly identified data needs can put a strain on the resources available for evaluation.
- Local evaluators should be employed for initiatives involving multiple communities and should report to the Initiative level evaluators. The local evaluators served a key role in this Initiative. They provided a consistent local presence, ensured that evaluation activities met the needs of individual partnerships, and provided important insights for the initiative-level evaluation. Finally, skilled local evaluators are able to establish trust and build evaluation capacity, both of which are critical to the success of the local- and initiative-level evaluations. At the same time, local evaluators needed the guidance and oversight of the Initiative-level evaluators to ensure consistency of products and comparability of data across communities.
- The evaluation design should include a combination of qualitative and quantitative indicators to ensure that a full range of accomplishments is documented. The combination of both qualitative and quantitative data ensures that the evaluation captures the most accurate and complete information about the project outcomes.

In summary, we submit the following as recommendation to the foundation as it continues to improve and build on strategies and initiatives that involve community partnerships.

- A significant investment of time and other resources must be allocated to determine the readiness of potential grantees. Expectations, technical assistance, timing, and indicators of progress and success must match the level of readiness.
- The foundation should draw on the PPH experience to build capacities in communities and public health departments that are necessary for successful partnerships.
- Involvement of and leadership development in local public health are critical to any strategy to build sustainable community health partnerships.
- Sustained action and improvement should be an explicit expectation of all initiative stakeholders. Resources for and indicators of progress in sustainability must be present from the beginning of initiatives.
- Community-based initiatives require a participatory approach to evaluation — an approach that provides timely feedback to all stakeholders for improvement.

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- The California Endowment
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