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Transformations in public health

In This Issue

Communication Matters

Improving Communication Among State and Local Public Health Agencies

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The Turning Point Initiative is in a unique position to share lessons learned, inform public policy, and provide insights to upcoming public health initiatives. An important step in assessing the contributions of Turning Point is to evaluate initiative processes and outcomes that will help decision makers determine whether changes in Turning Point states can be generalized to other states, and whether these changes can be sustained over time. Since 2001, The Robert Wood Johnson Foundation (RWJF) has worked with evaluators affiliated with the Public Health Institute in Oakland, California, to conduct a "light-touch" evaluation of the second phase of the Turning Point initiative. The goal of this evaluation is to examine the approaches being employed by Turning Point state partnerships, National Excellence Collaboratives (NEC), and the National Program Office (NPO) to achieve systems change in public health function and infrastructure.

Three key questions are being addressed in this evaluation: 1. How have public health systems changed in Turning Point states since the inception of the initiative? 3. What is the likelihood that these changes will be sustained over time? and 3. In what ways have these changes been replicated in other states? We have been collecting data through various methods, including: *review* of grantee reports and Turning Point products; *observations* at grantee and NEC meetings; *online surveys* of local public health representatives; and *structured telephone interviews* with state project directors, NEC leaders, and other key informants within and outside of the initiative.

As part of the evaluation, we are conducting a series of case studies to describe in detail selected key outcomes being pursued through Turning Point. The first case study seeks to answer the following primary research question: How have local infrastructure changes resulting from state Turning Point activities affected state and local public health entities and individuals? To address this question, we surveyed local and state public health representatives in six states in fall 2004. Three Turning Point-funded states that were known to have undergone significant changes in local public health infrastructure

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TurningPoint

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From the Turning Point National Program Office

Community Health Improvement Through Evaluation

Bobbie Berkowitz, Director

Evaluation, the theme of this issue, often carries a connotation of judgment. Maybe it is human nature that in the face of an evaluation, our enthusiasm for blossoming programs is clouded by apprehension. When a new program is designed to address a community need, incorporates a sound methodology, is developed by professionals, and implemented with adequate funding and energy, it is sure to be successful, isn't it? we ask ourselves. But, what if it isn't?

Program planning and implementation are often monumental tasks involving building partnerships, program design, and grant writing. The creation and implementation of a reliable evaluation process can become burdensome to overworked public health professionals. When something has to go, that something is often evaluation.

Neglecting to evaluate programs, however, is a mistake. By not evaluating programs, we deprive public health professionals and the communities we serve of knowledge and information that can only be gained through substantive examination of our interventions, processes, and outcomes. The different types of program evaluation are divided roughly into "formative" and "outcome" evaluation. Outcome evaluation usually happens at the end of a program and describes the effect of an intervention. Formative evaluation is ongoing during the life of the program and involves communication and feedback among evaluators and the program staff. The strength of formative evaluation is that it provides feedback for the program to improve along the way, offering the opportunity for midcourse planning corrections and adjustments that might lead to a greater positive effect for the program.

Turning Point relies on the involvement and participation of communities, individuals, and agencies. Our primary commitment is to these constituents. We ask ourselves throughout the program how Turning Point can best benefit the system and the people participating in Turning Point. The Turning Point National Program Office uses a formative evaluation process for several reasons. Formative evaluation gives immediate feedback that allows the initiative to:

- Make necessary modifications to the program early and often through technical assistance, site visits, and so on
- Share early and obvious lessons learned with the broader pubic health community, through publications and presentations
- Identify opportunities to maximize The Robert Wood Johnson Foundation's investment

Evaluation has been integrated into Turning Point since the beginning of the initiative. From evaluation of programs such as Missouri's voluntary accreditation system to a broader evaluation of improved state and local relationships within Turning Point states, evaluation processes have strengthened our programs. In addition, they point the way to our work in the future, as we continue to adapt and innovate to meet the needs of our communities, agencies, and the people we serve.

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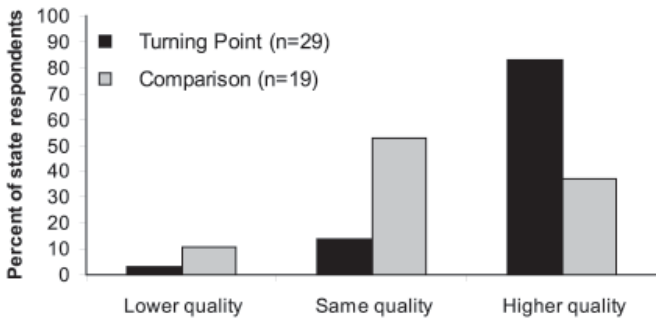
participated in the case study: Oklahoma, Nebraska, and New Hampshire. In addition, three states not funded by Turning Point but similar in demographics, political climate, and political infrastructure to the three Turning Point states served as a comparison group: Tennessee, Idaho, and Vermont. Local public health respondents completed an online survey, and state respondents participated in a 30-45 minute telephone interview.

This article presents findings from one section of the survey that asked participants about communication between state and local public health. Development of broad-based partnerships has been central to the Turning Point initiative, and research has shown communication to be an important factor contributing to the success of interorganizational partnerships. In the online survey, local respondents answered questions about communication quality between state and local public health leaders within the last twelve months and over the past four years. Communication issues were also addressed in the interviews with state representatives.

Local survey findings

Across all six states, fifty-four local public health officials responded to the online survey, with an average state response rate of 75 percent. Overall, Turning Point-funded states were rated as having more highly improved communication than the comparison states. However, only quality of communication over the past four years (as opposed to over the past twelve months) was statistically significantly different (*see figure 1*). When compared to non-funded states, Turning Point state respondents reported a significantly greater improvement in the quality of communication between local and state leaders over the previous four years (χ^2=10.60, p<.001).

Figure 1: Change in Quality of Communication Between State and Local Public Health Leaders Over Past Four Years



State interview findings

Interviews with state public health officials in each of the six states provided helpful insights into the local-level findings presented above. Although differences between Turning Point and non-Turning Point states on a number of issues were often quite subtle, one notable difference was the way in which respondents described improvements in local-state communication. Turning Point state respondents more often referred to improved relationships and direct communication between specific people at state and local levels. For example, a respondent reported that "real camaraderie" has developed between state and local health officials, as well as among local health officials. Another respondent noted, "It's almost like one happy family. People get along. Communication lines are strong." Local health officials also have reached out to other community partners. Moreover, these relationships have led to systematic processes to gather local input for new initiatives. As one state-level respondent said, "The state can turn around now, in areas where there was no local public health, and at least there's someone to go to and say, 'Hey, what's going on in your area? And how might this impact you?'"

In contrast, when comparison states discussed the relational aspect of communications, they often referred to problems that hindered efforts at improved

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communication. One comparison state made an attempt to improve communication among state and local health officials, including a facilitated retreat. However, "people just didn't like each other." Local level leaders felt they knew more; but people at the state had "control of the money, the power…" At the retreat, the participants developed a strategy for improved communication but "it kind of fell apart after that." Another comparison state respondent pointed to the importance of leadership and identifying individuals who "really do understand what public health and public health systems are about" and "are able to value each other in terms of a local perspective and a state perspective, and that it's not just one way or one means to get it accomplished."

Conclusions

Overall, Turning Point-funded states appear to have invested in more extensive relationship-building and personal connections than the comparison states. Both Turning Point and comparison states referenced extensive physical communication infrastructure improvements, such as improved information technology. It is important to note that all six states have undergone major improvements in their communication systems and epidemiological surveillance capacity in the last four years as a result of bioterrorism, emergency preparedness, and other funding that became available after the terrorists attacks of September 11, 2001.

These case study results suggest that state-local communication may be improved through two avenues: relationship-building and physical infrastructure. Physical infrastructure changes, such as improved information technology, may improve *communication capacity* between state and local entities. On the other hand, relationship-building efforts may improve the *quality of communication* between state and local public health leaders.

Although recent national emphasis has been on building physical infrastructure for the purposes of emergency preparedness, the Turning Point initiative has focused efforts on (among other goals) building the relationships required to support high-quality communication necessary for public health improvement. Successful relationship-building may be a distinguishing contribution Turning Point has made to the improvement of public health systems. The central role played by high-quality communication in improved public health functioning cannot be overstated. Although technology improvements and preparation for emergency response is important, meaningful, long-term collaboration between state and local health officials to set overall public health priorities and to modify health outcomes will likely be enhanced with better relationships and higher quality interpersonal communication. Future work will need to explore the strength and character of the relationship between communication quality, collaboration, and where possible, population health outcomes of the Turning Point initiative.

The findings presented in this article are an example of how Turning Point's relationship-building efforts have improved communication between state and local public health. We are currently analyzing the remaining data from this first case study and exploring other questions related to how local infrastructure changes have affected state and local public health outcomes. In future case studies, we will be exploring other ways in which Turning Point has had an effect on public health systems and infrastructure.

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Turning Point Member Profile

Kathleen Wojciehowski

As the daughter of a military family, Kathleen Wojciehowski spent her childhood traveling, learning new systems in new cultures, and adjusting and thriving through change. It is no surprise then that her career path has led her through a few professions before she reached her current one as a public health systems change agent.

Like most teenagers, upon graduating from high school Kathleen wasn't sure what she wanted to be. After receiving a bachelor's degree in Economics and Math, Kathleen changed course and pursued a master's in Library and Information Science. A dozen years later, Kathleen decided to pursue a law degree from the University of Missouri, with an emphasis on negotiation and governmental law.

At the onset of her law career, more than a decade ago, Kathleen worked for the Department of Social Services. In time, Kathleen's management experience and her ability to assess legal matters led her to become general counsel for the Department of Health. She readily admits that despite her work in the Department of Social Services, she was among those who thought first of immunizations when she heard the words *public health*. That was to change.

At the Department of Health, Kathleen received an on-the-job education in public health, and before long she was hooked. Her career was about to take another turn as she transitioned to work for the Center for Local Public Health Services. Her policy assignments expanded into quality-management consulting and then into direct work with local agencies on their quality issues. When Missouri received Turning Point grant in the late 1990s, Kathleen was part of the team that decided to start a nonprofit institute, separate from government, to work on voluntary accreditation. The original group from the planning phase of the state's first Turning Point grant included seven local agencies, as well as the state Department of Health and other nontraditional partners.

Kathleen is now fully focused on continuous quality improvement through the Missouri Institute for Community Health (MICH). She believes the success of MICH and its voluntary accreditation system for local public health agencies came mainly from including on the standards creation work-team people from the agencies that were going to be evaluated.

Kathleen and MICH are such believers in the power of evaluation and accreditation that they have a subcommittee that evaluates their accreditation system on a regular basis. Continuous improvement through evaluation is the next extension of the law, as far as Kathleen is concerned. Every day MICH asks the questions, "Does accreditation make a difference to the community in terms of long-term health status indicators? In the short run, if an agency is accredited, do more people know about that agency and make greater use of the services offered?" Knowing we have Kathleen Wojciehowski heading up this inquiry, we are sure Missouri Turning Point will continue to improve quality and help us all learn how accreditation can be used to improve public health.

Arizona's Academy Without Walls

Jennie Mullins, Aleena Hernandez, and Catharine (Kiki) Riley

Arizona, set in a complex geopolitical region on the US-Mexican border and with many sovereign tribal nations, faces some of the highest health disparities in the nation. Adding to the challenge of eliminating health disparities, Arizona's public health system has only 69 public health professionals per 100,000 people, in contrast to the national average of 158 per 100,000. Besides having fewer professionals, the average age of public health professionals in the county and state public health systems is between 41 and 50 years. Conversely, 60 percent of the tribal public health workers are under the age of 30. In addition, 46 percent of public health workers in Arizona have less than a bachelor's degree, and many have no formal training at all in public health.

In 2002 the Arizona Turning Point Project, administered by the Maricopa County Department of Public Health, contracted with the University of Arizona Mel and Enid Zuckerman College of Public Health to develop, deliver, and evaluate public health curricula in three priority areas: basic public health sciences, community dimensions of practice, and cultural competency. The project, known as the Academy Without Walls, aimed to strengthen competencies and capacity of frontline public health professionals so they are better able to address their local public health concerns.

Project objectives

- Deliver competency-based training at four sites (two county and two tribal health departments) to frontline public health professionals who may have received little or no formal training or education in public health in the three priority areas
- Pilot and refine curricula for continuing education for frontline public health workers throughout the state
- Evaluate the effectiveness of the trainings for Arizona's diverse public health workforce and settings

More than twenty faculty and academic professionals from the college participated in the project. After pilot sites were chosen, pre-training site visits were conducted to elicit key local public health system strengths and concerns, inform curriculum content, and identify training expectations. Three four-hour instructional modules were delivered in local communities, and on completion of the series, a follow-up site visit was conducted with each pilot site to assess the effects of the training.

Project evaluation

An evaluation team designed and implemented an evaluation of the effectiveness of the training and project as a whole. Aleena Hernandez, a Master in Public Health student intern, worked with the evaluation team to develop the evaluation framework, design data collection tools, assist with implementation, collect and analyze data, and report the evaluation findings. The evaluation framework consisted of a three-pronged approach:

- **Formative Evaluation**: pre-training site visits to decide project priorities and goals
- **Process Evaluation**: the extent to which the curriculum was implemented as planned, as well as student attendance
- **Impact Evaluation**: a post-training participant survey to refine curricula and instructional methods; a retrospective pre-test and a post-test several weeks after all three trainings were completed; and a follow-up site visit using the Nominal Group Technique to determine the most significant effects

Project results

In a six-month period, three competency-based curricula, along with comprehensive training tools, were developed, delivered, and evaluated in three core public health domains at four local public health sites with two distinct audiences—county and tribal public health professionals. Trainings were delivered to a total of 326 participants across all four pilot training sites, with 137 individuals attending at least one or more trainings and 79 participants attending all three trainings. There was a 96 percent response rate to the participant training surveys.

Using a 5-point Likert scale, 90 percent of participants across domains and sites rated the trainings as effective to very effective. Both county and tribal participants demonstrated an increase in confidence levels to perform the skills addressed in the three domains and expressed a better understanding of their importance. A greater percentage of participants with less formal education indicated an increase in perceived importance and confidence levels of the core competencies. The greatest increase in importance and confidence occurred among participants from tribal agencies in the domain of community dimensions of practice. In addition to gaining new knowledge and abilities to better perform key functions, many participants reported acquiring new appreciation for the purpose of their role in the agency and a deeper respect for their colleagues' roles. Some individuals reported specific individual gains, over and above the knowledge and skills acquired. These included recognizing their leadership skills and role within their community, becoming less judgmental and more tolerant of co-workers and community members, identifying personal areas of strength and weakness, and deciding to pursue more education in public health.

Overall the effect of the trainings at the agency level revealed that the trainings:

- Allowed for team building and the exchange of information and removed some barriers to collaboration and integration of services among public health programs
- Promoted the importance of an ecological model of public health to address the health concerns of the community
- Facilitated the identification of a common vision and mission across the organization and between organizations
- Validated strengths and expertise of the local public health system

For the tribal programs, the trainings particularly reinforced the importance of self-determination and the need to develop their own tribal health professionals to ensure that public health and health care services integrate native culture and traditions.

The Academy Without Walls demonstrated how workforce development can successfully strengthen both skills and capacity of the local public health workforce. This project was an excellent learning experience for students and faculty alike at the newly accredited UA Zuckerman College of Public Health. A closer relationship was forged between academia and local public health, for which the college received a special recognition from the Council on Linkages, and Aleena Hernandez was selected by the Association of Schools of Public Health for the 2004 Student Excellence in Public Health Practice Award for her work on the evaluation. Through the collaboration among the Arizona Turning Point Project, the UA Zuckerman College of Public Health, and local public health agencies, a foundation of trust and success has been established on which we can build as we continue to expand workforce development programs in Arizona.

Jennie Mullins, MPH, is principal investigator and project director of the Academy Without Walls Project.
Evaluation Team Members:
Aleena Hernandez, MPH, student intern
Catharine (Kiki) Riley, MPH, director of Arizona Turning Point Project
Mark Veazie, DrPH, evaluation principal investigator
Stuart Cohen, EdD, evaluation advisor
Rhonda Johnson, DrPH, evaluation advisor

Why Should We Evaluate?

Beverly Tremain

Monitoring the public's health is an overwhelming feat for any size of community and requires reflection at a system level. We cannot go blindly year after year, doing the work of public health in our communities without asking the questions: Does that program work? Are we doing what we said we were going to do? Are my objectives being met? Are the rates for this disease declining? Do the citizens of this county know about us and what we do? Are my staff trained for the mission of this organization?

Most would probably agree that Local Public Health Agencies (LPHA) would prefer to function through planning and long-range thinking rather than in a reactionary mode. The only way to accomplish this is for the key decision makers in an organization to ponder three questions:

1. What does success for an LPHA look like?
2. How do we look compared to that image?
3. What do we need to do differently or keep doing to achieve this success?

Evaluation should be seen not as some overbearing set of rules and stringent guidelines, but as an undercurrent in an organization.

For the Missouri Institute for Community Health (MICH), a voluntary accreditation program was the first step in forming a system-level approach to public health. But it did not stop there. The evaluation of that program, from both process and impact perspectives, was part of the plan. Evaluation safeguards an administrator from tunnel vision by providing a framework by which the organization can operate and progress and actually see itself.

Evaluation at MICH

Evaluation should be seen not as some overbearing set of rules and stringent guidelines, but as an undercurrent in the organization. It's what pushes the agency to be more than it is right now. Evaluation shouldn't be thought of as something we do last, but as a continual process, from beginning to end, on all programs and on the infrastructure as a whole.

Here is where MICH is breaking new ground. The accreditation program not only acts as an evaluation of the LPHAs' performance, but has a built-in evaluation of MICH as an organization. The evaluation program consists of process and impact phases and benefits MICH, the LPHAs, and the Missouri public health infrastructure in that it:

- Provides an opportunity for public recognition and celebration of excellence
- Enhances an agency's standing when working with other community agencies that are accredited
- Fosters the best use of available personnel and a climate for ongoing self-study and improvement
- Supports and enhances potential for increased local support and grant funding
- Identifies areas where improvement is needed
- Builds an evidence-based practice

Perhaps the last reason is the best reason of all. In public health, the collection of evidence-based practices across the state is a major goal of MICH. Counties in Missouri come in all sizes; however, there are commonalities among the counties, including similar problems for which solutions are not easily found. With one central

system collecting this information through a formal evaluation process, common problems can be identified and possible solutions more easily shared.

Process and impact evaluations

The purpose of process evaluation is to provide an ongoing assessment of the quality and effectiveness of the programs being delivered by the organization. A process evaluation question would be, for example, "Is MICH administering the accreditation program according to its stated objectives?" The purpose of impact evaluation is to measure the change in knowledge, attitudes, and behavior. In this case, changes in how the LPHA performs its daily function and services are documented. The process and impact evaluations work in tandem; one without the other would not give the whole story. We would hope that after one year of conducting a self-assessment, the LPHA shows positive systematic changes in how it functions.

The table below provides an overview of the accreditation program. Steps A through E represent specific interviews with the accreditation manager and the type of evaluation (process or impact) that will be performed at that time.

The LPHAs that have participated in this program have told MICH that changes occurred almost immediately after completing the self-assessment and before their on-site visit by the accreditation review team (i.e., staff sought more education and training, changes in policy were made, staff morale improved, and so on).

MICH is currently creating a database to hold all evaluation data on each LPHA and expects its database of evidence-based practices and solutions will benefit all local public health departments in Missouri.

Beverly Tremain, PhD, CHES, is a member of and technical consultant for the Missouri Institute for Community Heath.

For more information on the MICH LPHA Accreditation Program, visit www.michweb org.

The MICH Evaluation Structure

Evaluation Step	Purpose and Description
A. Agreement to Participate in Evaluation for the Accreditation Program	To obtain a signed letter from the LPHA (at the time of application) agreeing to participate and cooperate in a four-step evaluation of the Accreditation Program.
B. Applying for Accreditation Evaluation (process)	To assess the following components of applying for accreditation: Usability of the Web page, clarity and use of accreditation manual, technical assistance, and, communicating with MICH.
C. Self-Assessment Evaluation (process)	To assess the following components of the Self-Assessment: Timeliness and value of technical assistance, standards feedback, completing and submitting the Self-Assessment, and communicating with MICH during self-assessment process.
D. Accreditation Evaluation (process and impact)	To assess the interaction with the Onsite Review Team from MICH and immediate changes documented by LPHA after self-assessment. Self-assessment used as a pre-test instrument.
E. Individual LPHA one-year Evaluation (impact)	To assess change one year after accreditation, including an analysis of the factors supporting change and barriers to change, methods for LPHA improvement, and best practices. Self-assessment used as a post-test instrument.

Challenges in Evaluating Systems Change Efforts

The Group Health Community Foundation's Center for Community Health and Evaluation

Evaluating community-based initiatives is challenging, even when they have a single health target and a limited range of intervention options. Only a few communities can typically be included in an experimental design, limiting statistical power. And, since some form of health promotion activity is occurring in all communities, there are really no true "control" communities. Finally, it is difficult to achieve a measurable effect since interventions are typically small relative to other factors that affect health outcomes.

The recent trend toward community-driven systems change initiatives brings additional and greater challenges for evaluation. (In this context, *systems change initiatives* refers to initiatives that have goals related to policy, systems change, community capacity building, and infrastructure development.) In particular, the evaluation gold standard of a randomized control trial is very difficult, and often inadvisable, to implement in systems change initiatives. The focus of such initiatives is usually broader than a few specific health targets, making it difficult to narrow the list of health outcomes to be tracked. Even if there are targeted health outcomes (for example, asthma, diabetes, obesity), the community-driven nature of the programs makes it challenging to standardize the interventions to conduct a credible multi-community trial.

The process of defining and measuring success in a collaborative way can also benefit the effort directly by clarifying goals and the process for achieving them.

The logic of logic models

The challenges involved in conducting randomized trials of systems change initiatives have led to alternative evaluation methods, including a case study logic model approach. Logic models lay out the steps by which a program is designed to achieve its objectives, including inputs, activities, and short-term, intermediate, and long-term outcomes. Indicators, both quantitative and qualitative, can be created for each stage in the logic model to determine whether and to what extent the program has been successful in achieving that step.

Attributing systems changes and other outcomes to a particular community-based effort can be accomplished in two ways using a logic model. First, the logic model specifies a series of steps and a timeline for achieving them. If the longer-term outcomes are achieved and they are preceded in the specified order by the sequence of process and intermediate outcomes, it is plausible that the effort was responsible for the change. This method of attribution—looking for patterns over time and checking to see if they fit with what was expected—is similar to the "pattern matching" suggested by Yin in *Case Study Research: Design and Methods* (1994) for case study research.

A second approach to attribution within a logic model framework is to use key informant interviews and other data to examine directly whether the accomplishments documented by the logic model indicators are the result of program efforts. For example, suppose a key policy change occurs in a school district around dietary standards. The health partnership being evaluated was active in the coalition to bring about the policy change so a conventional pattern-matching approach would give at least some credit to the partnership. However, key informant interviews with key players in policy circles (district staff, other organizations lobbying for the change) may give the partnership more or less credit than simple pattern matching might suggest.

In evaluating systems change efforts, this second, direct approach often yields more credible and useful information. Timing and indicators alone provide only a superficial picture of the complex dynamics of changing health systems. By gathering data from a range of sources, including stakeholders with different perspectives and interests, a richer picture can be developed for why changes occurred.

In addition to attribution, specifying and measuring the outcomes of interest is another challenge in evaluating systems change efforts. Systems change outcomes are often not quantifiable and therefore must be described qualitatively. As a result, it is difficult to compare the degree of change across communities. Assessing the effect of the systems changes on health outcomes—the ultimate goal—is particularly challenging; for example, how can one measure whether improved coordination between agencies improves health outcomes?

Two stages of evaluation

In measuring and assessing the effects of systems change efforts, the evaluation team has adopted a two-stage approach. The first stage is primarily descriptive—listing all of the changes in systems, policies, community capacity, or infrastructure that might have occurred in whole or in part as a result of a partnership or program effort. The second stage attempts to attribute the degree to which a partnership was responsible for the change and to gauge the likely effect on long-term health outcomes. This necessarily involves subjective judgments about complicated and often incomplete data. Attribution ratings are generally limited to a few broad categories: 1. change would not have happened without the partnership, 2. partnership played a key role, and 3. partnership played a minor role. For impact, there might be only two categories: 1. likely to have a significant effect on long-term health outcomes and 2. not likely to have a significant effect.

Once systems changes have been rated, summary statistics can be created for the overall initiative and for each site; for example, number of systems changes likely to have a significant effect on long-term health that would not have occurred without the initiative.

As might be imagined, there can be disagreements among evaluators, initiative staff, partnership members, and other stakeholders about the significance of a particular accomplishment or the role a partnership played in bringing it about. We have found that a participatory process involving a multi-sided conversation among stakeholders works best for reaching agreement about the ratings. It is important to begin the process early so that all participants have a clear understanding of how they will be evaluated and what the criteria for success are.

In summary, the best approach we have found for evaluating partnership efforts in bringing about community-level systems change is:

- A case study design built around a logic model
- Detailed qualitative descriptions of systems changes and the process by which the changes occurred (for determining attribution)
- A participatory process for rating the significance of the systems changes as well as the role of the partnership in bringing them about

The benefits of evaluating systems change initiatives include a richer understanding of what has been accomplished and why, as well as judgments about the potential long-term significance of the changes for community health. The process of defining and measuring success in a collaborative way can also benefit the effort directly by clarifying goals and the process for achieving them.

Resources

See references related to this article on the Turning Point Web site at www.turningpoint.org/publications.html.

The Center for Community Health and Evaluation at the Group Health Community Foundation includes Allen Cheadle, William Beery, Dave Pearson, Clarissa Hsu, Sandra Senter, Pamela Schwartz, Howard Greenwald, Emily Bourcier, and Antoinette Angulo.

Reflections on Evaluating the Partnership for the Public's Health

Rhonda Sarnoff, Clarissa Hsu, and Maria Casey

The Partnership for the Public's Health (PPH) recently completed a statewide initiative with the goal of building a foundation for local public health departments and community groups to become allies in the improvement of community health. The PPH initiative was funded by The California Endowment (TCE) through a six-year, $40 million grant to the Public Health Institute (PHI). By establishing 39 local partnerships encompassing 14 public health departments and 39 community groups throughout California, PPH grantees began to create a roadmap on how communities and public health departments can work together to build effective public health systems to reduce health disparities and improve community health.

How PPH differs from other community health initiatives

The PPH initiative was *open-ended* and encouraged partnerships to identify and respond to the health issues most important to their communities. An assumption of the initiative was that when the community helps define the agenda, it is more likely to participate in creating a solution.

Second, the initiative was *place-based*. PPH funded local collaboratives working in a defined geographical area. An underlying premise was that residents would become engaged when the goal was improving the quality of life in their community.

Third, the initiative viewed *local health departments as key players* in community-based public health work, in the belief that local public health departments, as the public agencies charged with protecting the health of the public in the community, had to be able to work with communities to improve local health conditions.

Finally, The California Endowment requested a *participatory evaluation* design.

Evaluation design and infrastructure

The size and complexity of the initiative called for a multi-level evaluation design. The evaluation field has considerable experience with participatory evaluation but limited experience with the participatory approach applied to such a large-scale, multi-site, open-ended, community health initiative. 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 a team experienced in evaluation of community health initiatives.

PPH also hired an evaluation coordinator to work with CCHE to ensure coordination of program and evaluation activities. The initiative-level evaluation staff was linked to the grantees through a team of local evaluators, who were hired to monitor and document the progress of the partnerships and support the development of local evaluation capacity. An evaluation advisory sub-committee was established to support PPH by sharing insights from the experiences of other community-based health improvement initiatives.

Creating an evaluation community

The participatory nature of an evaluation is commonly envisioned as a democratic relationship between evaluators and grantees. Although this is a key component,

participation also must be built into many other relationships. The close working relationship that developed between the staffs of CCHE and PPH was unusual for an external evaluator and program office. Regular meetings and communication facilitated sharing of information from the grantees and coordination of the program and evaluation activities. The active participation of the local evaluators in the design of the evaluation process, methods, and instruments was critical for ensuring these were appropriate to the grantees' needs. Coordination was achieved through monthly local evaluator conference calls. These calls also provided opportunities to share ideas and tools that local evaluators had developed with their partnerships.

Participatory evaluation was new to most of the PPH grantees. They required 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 of the stakeholders (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.* Striking a balance between participation and the time constraints of participants presents an unresolved challenge for participatory evaluation. The linking of evaluation findings to sustainability efforts, particularly grant writing, was the most effective strategy for stimulating grantee interest in evaluation.

Lessons on Participatory Evaluation of Community Health Initiatives

1. ***Addressing the interests of multiple stakeholders through a participatory evaluation is likely to yield multiple perspectives on the initiative accomplishments.*** Grantees want to know how to improve their programs and grantmakers want to understand the outcomes of their investment. The participatory nature of the evaluation argues for the presentation of each perspective, particularly when significant differences emerge.
2. ***Progress in building local evaluation capacity depends on the willingness of the grantees to assume an active role in evaluation.*** Adequate funds for evaluation training are essential. Stipends for residents who organize and conduct local evaluation activities should be seriously considered.
3. ***Creating opportunities for learning among the members of the evaluation team at all levels of the initiative is essential.*** This learning occurs through the exchange among the local evaluators, the community, and the initiative-level evaluation staff. It also applies to creating a mechanism for ongoing dialogue between the evaluation team and the funder. Periodic discussion and reflection help ensure that the interests and questions of the funder are addressed in the evolving evaluation design and that the rationale for key evaluation decisions is fully understood. The dialogue also creates a deeper understanding of the unique potential, limitations, and costs of the participatory design.

Evaluation findings of the PPH initiative

Community groups developed key capacities for community health work.

PPH's support was focused on building the capacity of the community groups to work effectively with the health department and the local community and to sustain their work into the future. Most of the community groups made substantial progress in developing these capacities. The evaluation identified several capacities that were crucial for working with health departments. Many of these are core capacities that all organizations need to function effectively: maintaining a common goal, acquiring resources, providing effective leadership, and cultivating trust and open communication. Other capacities were particularly critical for collaboration with health departments: collecting and using data for strategic planning, identifying and training new leaders, serving as the legitimate voice for the community, and leveraging power and creating new alliances.

One of the more difficult goals of PPH was changing health department systems and culture to support working with communities.

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Health departments have limited flexibility to make significant changes in programming and organizational structures. The PPH experience identified three instrumental factors for enabling health departments to make changes that supported a sustained community-based focus. These include:

1. *Health department leadership that understands and clearly and consistently communicates the value of working with communities.* It is crucial that health department leadership be 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.
2. *Creative financing that prioritizes work with communities.* PPH-supported health departments have adopted a number of different strategies to identify funding that is flexible enough to support community-based public health, including: using local general fund or state realignment monies (revenues that were allocated from the state to the local level as corresponding responsibilities were shifted), flexible use of categorical funding, and creative use of bioterrorism preparedness funding.
3. *Institutionalized mechanisms for including community input in health department program planning and implementation.* Examples of input mechanisms include community advisory boards, direct involvement of community members in assessment and planning processes, hiring of community residents as staff, and regular public forums.

Successful Community Action

An example of what a mobilized partnership can achieve is seen in the accomplishments of the partnership between a community group—the Intermountain Action Growth and Education—and the Shasta County Department of Public Health. These accomplishments included the following policy and systems changes in conjunction with the PPH Initiative:

- Brought "5 a Day" and "Nutrition Olympics" to area schools
- Successfully advocated for the removal of sodas and the provision of healthier food options in a local school district
- Collaborated with local schools to establish a community park that included a toddler park, a fitness course for older children, and a skate park.

Partnerships made significant progress in policy and systems change.

Significant gains were made in the development of advocacy skills and policy awareness. The majority of partnerships were able to achieve at least one significant policy change in their local community. These policy changes were in direct support of community health improvement goals.

Numerous factors contributed to progress in achieving local policy and systems change. Those that were particularly important included addressing issues that were critical for the community, maximizing alliances, the presence of a group of residents who were energized around local issues and understood local decision-making processes, and the perseverance to continue to advocate even when decision-making processes were slow.

Local health departments and communities can partner effectively to improve community health. Their success will depend on a willingness to get to know one another, recognition of their shared mission as well as their operational differences, their capacity to change structures and procedures over time, and a shared understanding and respect for the assets that each brings to the challenge of improving community health.

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Making Sense of Dollars: RWJF's Perspective on Evaluation

Nancy Fishman and Carol Chang

The Robert Wood Johnson Foundation uses a variety of funding efforts aimed at improving health and health care in this country. One of the most important methods is funding evaluations of our large demonstration programs. We undertake evaluation in order to learn from our work and from the work of our grantees. Making the greatest impact in health and health care requires continual appraisal of priorities, populations, resources, methods, and outcomes in order to determine what and where to invest. We leverage our current investments in programs by translating current activity into valuable information to make informed decisions about future investments. The process of evaluation of our grants is a critical bridge spanning our past and current attempts to improve health and health care to applied knowledge and to improved outcomes in the future.

At RWJF, we employ many methods of evaluation; most fall into the two traditional categories of formative/process evaluation and outcome-oriented evaluation. The formative evaluation method assesses grants as they proceed and is valuable in allowing staff to make mid-course corrections where necessary. For example, the development of the Turning Point National Excellence Collaboratives came about, in part, from the formative evaluation process. Outcome evaluations, on the other hand, help describe what grantees ultimately have achieved, which promotes learning and progress in the field. At RWJF, information from evaluations is shared with grantees, other funders, policy makers, and professionals in the field, in addition to reporting results of our grants to our own Board of Directors.

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About three percent of RWJF's annual budget is dedicated to evaluation, and we employ both internal staff evaluators and outside consultants. In order to maximize the effect of programs and their evaluations, evaluators often are involved in the design of programs. If a program is designed from its inception with evaluation in mind, we stand a much better chance of generating information that is valuable to the grantees, the Foundation, the public, and the scientific community.

Evaluations of RWJF's programs are used extensively in determining the future directions for funding. One of our current challenges is finding ways to evaluate our impact on issue areas or groups of grants, rather than single grants. The effect of our evaluations and our programs trickle throughout the health and health care system, as RWJF, and its programs influence other foundations, academia, public health and health care practice, policy makers, and individuals.

The most important aspect of evaluation, however is not determining the value of investment of money, but rather the generation of knowledge that can inform progress in health, health care, and philanthropy. There are challenges inherent in evaluation, but they are well worth the gains.

Nancy Fishman and Carol Chang are program officers in the Research and Evaluation Unit at The Robert Wood Johnson Foundation.

Transformations in Public Health is a publication of the *Turning Point: Collaborating for a New Century in Public Health* initiative. The goal of this initiative is to transform and strengthen the public health infrastructure in the United States so that states, local communities, and their public health agencies can respond to the challenge to protect and improve the public's health in the 21st century. The University of Washington School of Public Health and Community Medicine serves as National Program Office for the initiative.

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