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Community Building for Children's Health: Lessons From Community Partnerships for Healthy Children

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Key Points

- This article describes Community Partnerships for Healthy Children (CPHC), a 10-year, \$17 million initiative of the Sierra Health Foundation targeted at improving children's health in northern California by mobilizing communities to use their assets. Implementation grants were modest (\$50,000 annually), but technical assistance and communications support were also provided.
- The initiative rolled out in four phases. Overall, a total of 31 communities participated in the initiative. Twenty-six communities remained through phase three, with 18 engaging in the final fourth phase.
- Evidence indicates that CPHC improved the health of some children in some communities with regard to some outcomes, but did not improve the health of children at the population level. Community building appears to be well-suited to devising and implementing successful strategies to address straightforward health issues in the short term; more time, resources, and expertise are needed for more complex problems.
- The community collaboratives achieved many of the intermediate goals of the initiative. The evidence is strong that communities did identify and respond to needs.
- Most of the collaboratives on their own had access to few resources initially, but over time they were able to gather fiscal and human resources from a variety of sources and combine them to provide services such as recreation programs or family resource centers. Collaboratives involved in the final grant stage had been able to raise from other sources an amount nearly twice the foundation's investment in CPHC.
- The collaboratives were similar in role but differed in many other ways, such as the geographic scope and the existing assets. Collaboratives that had members with certain skills (such as grantwriting, public relations, and computer skills) had greater success.

Introduction

Sierra Health Foundation was created from the conversion of a health maintenance organization to for-profit status in 1984. By the early 1990's — after the foundation had experience operating a responsive grantmaking program and two three-year initiatives in AIDS and prenatal care access — the foundation had learned the value of investing in concentrated, longer term strategies and the importance of focusing on prevention. At that same time, the evidence related to “social determinants of health” (environment, lifestyle

choices, heredity, and health care) was growing. These factors influenced the foundation's decision to make its largest, longest investment ever, in an initiative that focused on the environment in which children (birth to age 8) develop.

In 1993, the foundation began a new initiative to see if community building could make a difference in children's health and well-being in northern California. The Community Partnerships for Healthy Children initiative (CPHC) had five goals:

1. To improve the health and well-being of children and their families in the Sierra Health Foundation region (inland northern California);
2. To assist the communities in the region to identify the needs of children and families and pursue new opportunities to address these needs;
3. To develop and strengthen the organizations and systems that respond to the needs of children and families;
4. To develop solutions to the needs of children and families by maximizing the use of existing financial resources and services through increased efficiencies and/or the reallocation of resources and, where necessary, by developing new resources; and
5. To achieve a lasting, positive impact on the ability of communities to respond to and organize around children's needs.

The overriding assumption was that community building is an effective approach for improving the health of young children. For CPHC, community building meant mobilizing residents to use the community's assets for the common good. A community's assets are the capacities, skills, and talents of its residents; the network of its local civic and voluntary associations; and the resources of its local agencies and institutions (Kreitzmann & McKnight, 1993). A phrase that is closely related to community building and that gained more widespread use as the initiative progressed is "social capital." In accordance with Robert Putnam's basic and generally accepted definition, "social capital is the glue that holds a community together." It consists of those specific processes among people and organizations working collaboratively in an atmosphere of trust that lead to accomplishing a goal of mutual shared benefit (Putnam, 1993). Communities where individuals and organizations work together for the common good are considered to have more social capital than communities where residents are isolated, uninvolved, or working in opposition.

CPHC was designed to build social capital and strengthen communities as a way to improve the health of children. Individuals and organizations were to work together to identify one or more

critical health-related issues for children in their communities, design solutions using community resources, and implement those solutions. Geographic communities, ranging from urban neighborhoods to entire rural counties, were provided both grants and intensive technical support over four phases of CPHC to achieve the goals of the initiative and to promote the development of local power and voice. Overall, a total of 31 communities participated in the initiative, covering a geographical area about the size of Washington state. Many of the funded collaboratives were informal in structure, requiring fiscal sponsors such as school districts or community-based nonprofit organizations. Twenty-six communities remained through phase three, with 18 engaging in the final fourth phase.

Over the 10 years the initiative was in place, Sierra Health Foundation provided over \$17 million in funding, including technical assistance to grantees and the evaluation. Grant amounts to CPHC collaboratives were kept purposely small to encourage community volunteer participation and to create sustainable activities and programs. Grant funds primarily supported community organizing and collaborative management. Activities of the collaboratives were generally volunteer-based or supported by other local resources.

In addition to the grants to communities, the foundation provided numerous supports to the grantees, including group training and individualized technical assistance. Several communication mechanisms were put in place, including support for electronic communication; a newsletter; a three-volume set of guidebooks providing tools for community planning, communication, and evaluation; and policy briefs (available at <http://www.sierrahealth.org/doc.aspx?57>).

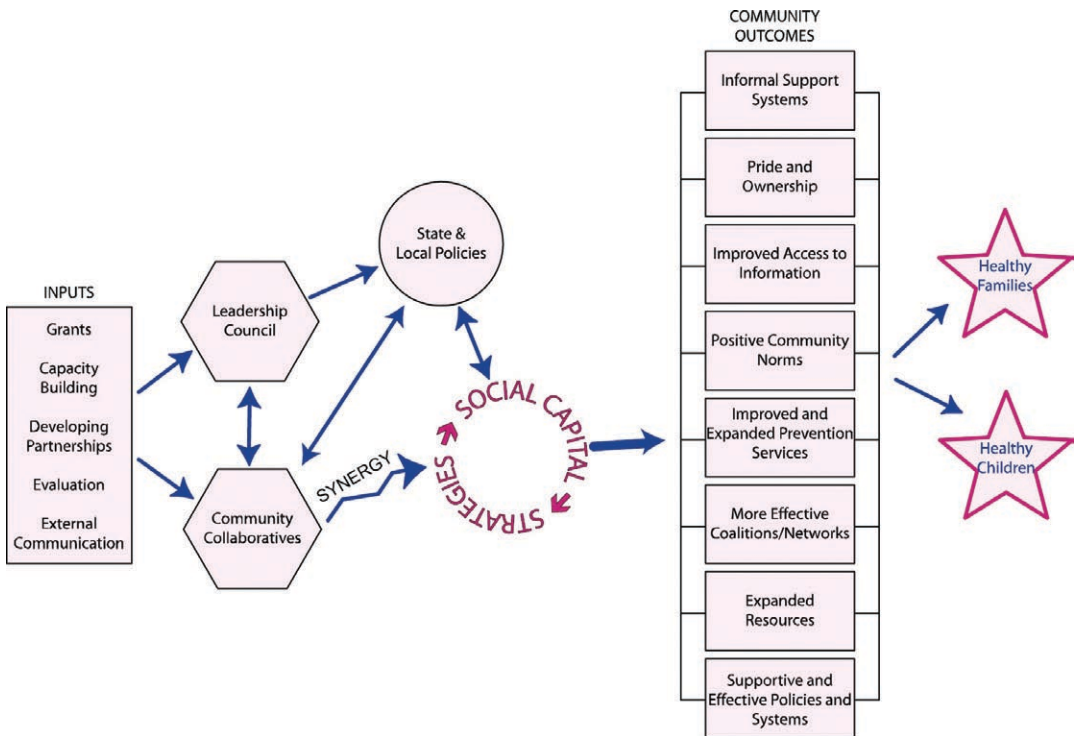
The CPHC Grantmaking Strategy

The four phases of the CPHC were community development, program planning, program implementation, and impact and sustainability.

Community Development

During this phase, communities were expected to establish a collaborative, conduct a community health assessment, reach conclusions about the

FIGURE Theory of Change for Community Partnerships for Healthy Children



health and well-being of children and families, select issues to be addressed, and submit a program planning proposal to the foundation. Nineteen community development grants were awarded in May 1994, two in October 1994, and eight more in January 1995. Initial grants were up to \$37,000 per collaborative.

Program Planning

This second phase focused on the development of a Strategic Action Plan to address the health issues identified earlier. Collaboratives involved community members in identifying solutions to the issues and in selecting corresponding indicators that would track the impact of implemented strategies. Grants of up to \$70,000 for 18 months were awarded, with \$5000 augmentation grants being awarded to carry out specific short-term strategies during the planning stage.

Program Implementation

Collaboratives carried out their strategies and activities during implementation. Grants of up to

\$150,000 each for 34 to 36 months were awarded in this phase. Twenty-six communities remained in the initiative during the implementation phase.

Impact and Sustainability

This phase, added in year seven, was designed to increase the effectiveness of the collaboratives and help them sustain their efforts beyond 2003. In this final phase, 15 received full funding, and three participated with technical assistance only. Grants of up to \$100,000 were awarded for the final phase.

Funds were available for all communities should they succeed with each phase. If grantees did not proceed to further initiative stages, it was because either their self-assessments or those of the foundation indicated they had not progressed sufficiently to be successful in the next phase.

CPHC Theory of Change

The Figure illustrates the logic and hypothesized effects of CPHC. As is common with comprehen-

sive community initiatives (CCI), the Theory of Change evolved over the course of the initiative (Connell, Kubisch, Schorr, & Weiss, 1995), with the final change being the addition of the CPHC Leadership Council and the impact on policy, which were added in phase four. The left side of the Figure shows the activities carried out by the foundation that served as inputs to the initiative. The middle of the Figure shows some of the interim outcomes that were expected to result from these inputs, with the primary one being a functioning collaborative in each community (Goal 3). By the end of phase four, the work of the Leadership Council and of the collaboratives was expected to have an impact on state and local policy.

The evaluator compiled data on a common set of child and family health indicators, for example, the percentage of babies born prematurely and the percentage of children placed in foster care, that were tracked across all CPHC communities.

A series of outcomes was hypothesized to occur in the CPHC communities through the collaboratives' efforts. After developing a plan, the collaboratives were to carry out the activities in the plan (Goal 2). Through implementation of the plan, social capital would be enhanced. As social capital increased, more resources would become available to successfully carry out more activities in the plan (Goals 4 and 5). Thus, the framework shows a synergistic relationship among the strategies being carried out and also the development of social capital, with the hypothesized result being an improvement in one or more community outcomes. The right side of the Figure shows examples of the kind of community-level outcomes that were expected to result from the implemen-

tation of the strategies. Ultimately, these strategies and their impact on the community were predicted to improve the health and well-being of children and families in the community (Goal 1).

The CPHC Theory of Change reflected the principles and assumptions underlying the initiative and incorporated numerous features of CCIs (Connell et al., 1995):

1. CPHC was grounded in the belief that the solution to health problems required the active and substantial involvement of members of the community. The initiative provided support to empower community members to identify child health issues of greatest concern to them and to develop and implement solutions.
2. Cross-sector collaboratives were encouraged to engage many different voices in identifying and implementing solutions.
3. CPHC sought to bring about change at multiple levels: changes in the community such as community engagement, activism, and the kinds and quality of services available, as well as changes in families and children.
4. The time frame for CPHC was 10 years, acknowledging the many years needed to bring about and sustain change at the community level.

Evaluation Methodology

The evaluation of CPHC conducted by SRI International had two components: a cross-site component and a site-specific component. The cross-site component included common information collected from all sites; data came from annual interviews with the coordinators for each collaborative, surveys of collaborative members conducted several times over the course of the initiative, and data collected on child and family outcomes. The evaluator compiled data on a common set of child and family health indicators, for example, the percentage of babies born prematurely and the percentage of children placed in foster care, that were tracked across all CPHC communities. The cross-site component also included case studies of ten collaboratives.

The site-specific component included unique data each collaborative collected about its activities and outcomes. Collaborative coordinators and volunteers collected the site-level data, including data on the implementation of their selected strategies and data on the status of their child and family outcomes. The evaluator provided technical assistance to collaboratives to assist them with their evaluation designs and data collection. The evaluator compiled and synthesized these data to reach conclusions about the overall effectiveness of the initiative.

Findings From the Evaluation

This section contains a summary of the findings from the evaluation. Due to space limitations, this discussion includes only a small sample of the supporting data upon which these conclusions are based. The supporting data are included in the reports that were prepared annually on the evaluation, including an overall synthesis in the final evaluation report (Hebbeler, Cherner, & Petersen, 2003). One additional report, which was developed from the evaluation reports and other information, was developed by the foundation for distribution to a general audience at the end of the initiative (Sierra Health Foundation, 2004).

The findings are organized around the five goals, with Goals 2 through 5 discussed first followed by the findings related to Goal 1, improving the health and well-being of children, the ultimate goal as represented in the Theory of Change.

Goal 2: To Assist the Communities in the Region in Identifying the Needs of Children and Families and in Pursuing New Opportunities to Address These Needs

The community-assessment process in phase one was the first step in assisting communities in identifying needs, and it was followed by many more steps. The evidence is strong that communities did identify and respond to needs. The creation and evolution of the collaborative was the mechanism that allowed needs to be identified.

The foundation's substantial investment in capacity building proved essential to the successful development of the collaboratives as well as to

every other accomplishment in the initiative. For nearly each grant dollar awarded to the community collaborative, another dollar was provided for technical assistance and capacity building and support.¹ The investment in capacity building resulted in considerable skill development among the coordinators and other collaborative members: in leadership, advocacy, networking, report writing, budgeting, planning, and evaluation, as well as in gaining access to agencies and information. Regular convening of the coordinators over the years built a network of people engaged in similar work and provided a source of information and a much needed source of social support. Throughout the initiative, coordinators repeatedly identified the technical assistance received as one of the key factors responsible for the collaboratives' success.

Allowing collaboratives to identify issues of most concern to them generated strong support for the work to be done but at times resulted in broad efforts that were not targeted enough to be effective. One of the unique characteristics of CPHC was that the initiative was not focused on a preselected issue. In keeping with the spirit of a resident-driven agenda, by the end of the first phase each community selected its own issue(s). Some communities selected one issue, such as recreation, on which to focus their efforts. Others selected several issues, some of which were very broad and only indirectly connected to each other or to children from birth to age 8. Over time, it became clear that collaboratives would have benefited from parameters that allowed them leeway but still assisted them in identifying issues that were manageable enough to be impacted by community-based strategies.

Although the collaboratives were able to develop action plans, the planning process proved challenging. The process was difficult to carry out because it was lengthy, complicated, and focused on getting ideas down on paper rather than on taking action. This was frustrating for collaborative members who wanted to get busy and make

¹ Sacramento's Center for Collaborative Planning served as lead technical assistance provider throughout the initiative.

a difference in the community. The foundation responded with a program of mini-grants that allowed communities to implement small projects during planning.

One additional challenge was the quality of some of the action plans. Many collaboratives did not have the expertise to research what was already known about effective strategies. Although the guiding principle that “communities know best” had value in terms of community mobilization, the role of expertise and knowledge of proven best practices is important, especially when designing solutions for complex issues like child neglect or drug abuse.

On the other hand, the process of working together to identify needs and to design and eventually implement activities was an important community-building tool. It provided an opportunity for people to work on a common problem, get to know each other, give of their time for the good of their community, acquire new skills, and build connections.

Goal 3: To Develop and Strengthen the Organizations and Systems That Respond to the Needs of Children and Families

In each CPHC community, the major organization that was developed and strengthened was the collaborative itself. The creation of these community-based collaboratives was an important contribution of CPHC.

The collaboratives were similar in role but differed in many other ways. Eight identified their target “community” as an entire county; nine were smaller than a county, but included several towns; four were towns; and 10 were neighborhoods within an urban area. When a large number of square miles were included in a “community,” there were significant logistical barriers (e.g., driving distance, lack of public transit) to full participation. Smaller communities could easily bring people together. On the other hand, county-wide collaboratives had easier access to county-level resources.

Collaboratives also differed with regard to human capital, which turned out to be critical to success.

Although a central theme of community building is that all residents bring assets to the table, it is also true that some assets (e.g., writing skills, public relations knowledge, computer expertise, grant writing experience, etc.) are more valuable than others for a collaborative’s day-to-day work and eventual sustainability. Collaboratives that possessed these specialized assets had distinct advantages over those that did not.

Finding and retaining capable leadership also turned out to be a critical success factor. Successful collaboratives had a core number of “weight-bearers” who could step up their involvement during times of coordinator transition. Finding the right balance in collaborative membership between agency representatives and community residents proved to be challenging. The foundation actively promoted having more resident members in the collaboratives, fearing that having too many agency representatives would lead them to drive the agenda; however, agencies can bring needed resources to the collaborative.

By the end of the initiative, the effects had begun to extend beyond the collaborative into other organizations and institutions in some CPHC communities. One of the most significant was agencies and organizations being more open to community input and viewing residents as having assets.

Goal 4: To Develop Solutions to the Needs of Children and Families by Maximizing the Use of Existing Financial Resources and Services Through Increased Efficiencies and/or the Reallocation of Some Resources, and, When Necessary, by Developing New Resources

The list of what collaboratives were able to accomplish in their communities was lengthy and impressive. It included new services such as recreation and education programs; new facilities such as clinics, shelters, and family resource centers; community events; newsletters; resource directories; community gardens; neighborhood beautification programs; and many other community improvements. The most common activities implemented were related to health, family support, collaborative promotion/enhancement,

recreation, school readiness/achievement, parenting, and child behavior/development.

In addition to activities included in action plans, many of the collaboratives reacted to needs and opportunities as they unfolded. Many collaboratives used their new skills to apply for grants using information they had gathered for CPHC. One rural collaborative took the training it had received and formalized a network to pass that training on to other communities that were not part of CPHC.

The concept of achieving a set of prespecified, long-term outcomes did not exert much influence on the day-to-day work of some collaboratives, resulting in many deviations from the action plans. However, this way of doing business was very effective for the collaboratives. It provided high levels of satisfaction for the members, garnered respect from the community, contributed to community building, and resulted in numerous concrete benefits to children and families.

The accomplishments are all the more remarkable given that collaboratives received only a \$50,000 annual implementation grant, supplemented by an investment in capacity building. The terminology in the goal statement about “increased efficiencies” and “reallocation of resources” does not accurately reflect how the collaboratives operated; “mobilization of resources” would be a more appropriate descriptor. Most of the collaboratives on their own had access to few resources initially, but over time they were able to gather fiscal and human resources from a variety of sources and combine them to provide services such as recreation programs or family resource centers. The collaboratives were also successful in acquiring new resources. CPHC collaboratives in phase four became very attractive to other public and private funders for program service funding. Collectively, the 15 phase four collaboratives obtained nearly \$32 million over the course of CPHC to improve conditions for children and families.

The small grant size necessitated recruiting volunteers for implementing strategies that could be staffed by volunteers and seeking additional

funding for activities that required financial resources (e.g., staffing dental screenings, outreach programs). Some services, such as youth athletic leagues, can be entirely operated by volunteers, but many require at least some level of paid staff. To support staff for these kinds of activities, the collaboratives received grants that funded the activities on a short-term basis, but that left the collaborative in the position of having to find the next grant to keep the service operating. In only a few examples were collaboratives successful in securing permanent public or private funding to support the services and other needs identified. One example was a city where the collaborative's issue was recreation, and the city created a recreation coordinator position. Another was a collaborative that brought a clinic to the community to make those services permanently available.

Although the guiding principle that “communities know best” had value in terms of community mobilization, the role of expertise and knowledge of proven best practices is important.

Goal 5: To Achieve a Lasting, Positive Impact on the Ability of Communities to Respond to and Organize Around Children's Needs

The most significant impacts on the community included the establishment of organizations focused on improving children's health, the increased capacities of individuals in the communities to respond to children's needs, and the increased recognition of the importance of community voice in local decision making.

The collaboratives evolved over the years of the initiative into strong, well-respected organizations in their communities. Obtaining financial support for the coordinating functions and the core community organizing activities was critical for sustaining community impact. Securing such funding proved challenging, but all of the phase four collaboratives obtained enough support to

maintain operations for at least another year after their CPHC funding ended (which was the last year data were collected).

Even if a collaborative ultimately dissolved, the individual and collective capacities of those who participated remained. The leadership and technical skills (e.g., budget development, proposal writing, evaluation) of the collaborative members, especially the coordinator, constituted new assets for the community. Central to the CPHC Theory of Change was the reported increase in social capital. Given the dedication of the collaborative members, it is highly likely these assets will continue to be put to use in the service of children.

Evidence indicates that CPHC improved the health of some children in some communities with regard to some outcomes, but did not improve the health of children at the population level.

The recognition of the importance of community voice was another lasting impact. When interviewed, almost half of the coordinators said that CPHC had changed the ways members engaged in community life because the initiative had shown them that their voices mattered and that they had assets that could be put to good use. Many collaboratives had successfully implemented policy-change strategies in their communities even before the final phase began. These strategies included improved lighting, highway safety projects, and banning alcohol at local public events. In the final phase a common theme was that local policymakers were now taking time to listen to residents' opinions and seek their input before making decisions. Other examples of later policy success included instituting new nonsmoking policies. Again, even without the collaborative, community members will retain the sense

that their community has assets and that their input is needed and valuable.

By the end of the initiative, a CPHC Leadership Council, with representatives from each of the community collaboratives, had formed to provide training and technical assistance to other collaboratives and communities in northern California, as well as networking support for collaborative and community leadership. The council also agreed to work toward influencing policies at the local, regional, state, and national levels and spreading the community-building approach to improving health outcomes. While the council did not formally exist much after the end of the initiative, at the time of this writing one key member continues to communicate with the prior CPHC coordinators to keep them informed of statewide policy activities and to share opportunities in which community voices can impact state health- and child-related policy.

Goal 1: To Improve the Health and Well-Being of Children and Their Families in the Sierra Health Foundation Region (Inland Northern California)

This is the most complicated and far-reaching of the CPHC goals and the most difficult to measure. Data from the site-specific indicators and data from the common indicators both pointed to improvement in health outcomes in the CPHC communities. To see if this improvement could be attributed to CPHC, the evaluation examined the common indicators for the state as a whole and found improvement for the state as well. Outcomes in the CPHC communities did not improve as much as in the state as a whole, making it difficult to argue the improvements were due to CPHC. The case study analysis indicated a few outcome areas where it appeared likely that the collaboratives did make a difference, but there were also many for which there was no evidence that outcomes improved.

The evaluation's ability to answer the question about changes in health outcomes was severely hampered by lack of good data on the health and well-being of young children. This same lack of data hampered the collaboratives' abil-

ity to use outcome data to monitor their own work. Few data are publicly available at the neighborhood level, and neither the collaboratives nor the evaluators had the resources to collect the kinds of outcome data needed year after year. The conclusions reached in the evaluation with regard to changes in outcomes are based on extensive analyses of the evidence available, but that evidence was far from ideal and better data may well have resulted in different conclusions.

The answer to the question of whether CPHC brought about improvement in health outcomes is not a simple "yes" or "no." Evidence indicates that CPHC improved the health of some children in some communities with regard to some outcomes, but did not improve the health of children at the population level. One of the most important considerations is the difference in complexity in the various health issues faced by children and families. Some children's health issues are considerably more complex and difficult to address than others. It is far easier to have children immunized than it is to reduce drug abuse and child abuse. Community building appears to be well suited to devising and implementing a successful strategy to address straightforward health issues. Examples of such activities included service-oriented solutions (particularly preventive health services) such as clinics to increase immunization rates, dental screenings, fluoride treatments, recreation programs to provide safe and healthy environments, parent support groups to provide information to new mothers, community cleanups to eliminate health hazards and impart a sense of pride, and health fairs to provide information and decrease isolation.

Other child health problems, such as parental drug abuse, child abuse, domestic violence, gang violence, or children beginning school not ready to learn, are more complicated because they arise from multiple causes, such as poverty and limited education, and require multipronged solutions (e.g., individual treatment, policy changes, community norm changes, social support). It was probably unrealistic to expect that a small

group of community residents with no or limited expertise in these extremely challenging problems could be expected to (1) correctly identify root causes; (2) partner successfully with relevant agencies; (3) devise effective strategies; (4) implement a variety of strategies, programs, and policy changes that would target the entire population at risk with extremely limited resources; and (5) sustain themselves. Seat belt use and no-smoking laws were held up to the collaboratives as examples of the potential of policy to produce sweeping health changes, but sweeping policy solutions to child abuse and drug abuse are not obvious. Collaboratives accurately identified these serious health issues as problems in their communities, but they needed more support in the way of technical assistance and financial resources to be able to address them effectively. An important lesson about community building and health outcomes is that some outcomes are far easier to address than others.

In addition to the complexity of the problem, the nature of the health problem also contributed to whether it could be successfully addressed by community building. For some problems, community building in and of itself has the potential to improve health. Community building produces improved health outcomes directly for outcomes such as "increasing social support" or "reducing isolation." Because lack of community is the problem, building community is the solution. However, the role of community building differs for outcomes addressed through implementing a particular type of strategy or service. Community building results in residents who seek to implement a strategy such as a new service. Widespread use of the service then results in improved health. This chain of events is more complicated than building community to reduce isolation.

An issue that is closely related to the complexity of the problem is the amount of time required to positively affect different health issues through community building. Although the initiative lasted a decade, that time probably was not long enough for the collaboratives to achieve some of the outcomes they sought. It took years for

the collaboratives to be seen as credible organizations in their communities. They derived their credibility from a track record of providing tangible benefits (the strategies and activities) in the community. These successful activities were valuable to a collaborative in establishing its credibility, although some had limited impact on improving children's health because they were small in scope or reached a small number of children, or both. The limited scope and therefore limited potential impact of the strategies was part of the motivation to conduct phase four. The assumption for the final phase of CPHC was that policy and systems change would affect more children. The basis for the assumption may be sound, but the time span between a policy change and a change in health outcomes is far longer than the two years of phase four. Furthermore, many policy changes are incremental and have their impact only when combined with other changes. For example, moving alcohol sales away from the teen activities at the county fair is only one small step in addressing teen drinking. It is a sensible policy change, but it could take years before the combined impact of this and many such small changes actually reduce teen drinking. Of course, as long as the collaboratives sustain themselves, the potential for future impact remains.

Lessons for CCIs

As one of the longest and largest community health initiatives during its time, CPHC offered numerous lessons for all the parties involved: the funders, the grantees, the technical assistance providers, the evaluators, and the communities. Following are some of the most significant.

Duration of the investment. Ten years is just the beginning of the needed investment period for efforts that expect sustainable community change.

Number and dispersion of grantees. Start with a manageable number of grantees when implementing a new grantmaking approach. Consider the potential geographical dispersion of grantees when planning for individualized technical assistance.

Collaborative membership. Balancing collaborative membership between agency representatives and community residents is important; both offer important contributions to the process, and neither should be ignored.

Timeline. Build flexibility into the initiative's timeline. Keeping all of the grantees on the same schedule makes an initiative easier to manage but forces grantees to rigidly adhere to an artificial timeline that is incompatible with the unique development of each collaborative.

Use of fiscal sponsors. CCIs often fund informal groups and require fiscal sponsors and expenditure responsibility grantmaking. The best sponsors have strong budgeting and accounting skills and policies and procedures that allow the collaboratives to put resources where and when they need them. Include a thorough examination of the fiscal sponsors as part of the grantee selection.

Grantee choice of issue to address. Giving collaboratives freedom to pick their own issues creates buy-in — but it also makes it difficult to keep choices reasonable and objectives achievable. Allow grantees to choose from a set of preselected issues.

Planning grants. Community residents often did not have skills or interest in extended planning. Provide them background research on promising practices and assistance with community data collection to help them move through the planning phase.

Importance of technical assistance. Investing in building the capacity of residents is critical to CCI success and can have lasting impact on a community. Allocate a significant portion of the overall budget to technical assistance.

Convening grantees. Regular meetings of the grantee leadership and annual "Sharing Conferences" can be useful in building momentum, sharing lessons learned, and bringing attention to the grantees and the initiative.

Evaluation and capacity building. Evaluation is technically difficult and rarely a popular use of a volunteer's time — but well-executed evaluation can improve the collaborative's strategies and open the door to other opportunities.

Grant requirements. Simplify grant-reporting requirements whenever possible. This allows grantees to focus most on what they do best. Also, be clear at the beginning about what parameters are nonnegotiable and must be adhered to by all grantees.

Grantee focus. As time goes on, a maturing collaborative will become involved in activities not originally envisioned. This is both a source of strength and a distraction. Closely monitor grantee activities beyond the planned scope of activities.

Intervening when problems arise. Be careful not to intervene too soon with struggling collaboratives. Working through the conflict can strengthen the collaborative.

Policy work. Introduce the concept of policy and advocacy early in the initiative so that looking for policy solutions becomes second nature to the grantees. Additionally, linking community residents to established advocacy groups can strengthen both bodies.

Sierra Health Foundation applied many of these lessons to its subsequent initiative, REACH: Connecting Communities and Youth for a Healthy Future. With REACH,

- only seven grantee communities were initially selected, all within about one hour of each other, making management and the provision of technical assistance much easier;
- information regarding promising youth development strategies was collected and shared early with the REACH communities, making it easier and quicker for them to move into strategy development;
- training and technical assistance is a large component, as it was in CPHC;
- grantee communities are brought together regularly to share lessons and strategies;

- the importance of policy change and the incorporation of policy strategies in the REACH communities were emphasized earlier, increasing the likelihood of effecting policy change; and
- the evaluation is more qualitative in nature, capturing more stories along with data.

Conclusions

Was a 10-year commitment and \$17 million enough to make a difference in the health of children in more than two dozen northern California communities? The evidence suggests most of the goals were achieved and many components and relationships suggested by the Theory of Change occurred as predicted. CPHC demonstrated that community building can make communities better places to live. The activities carried out through CPHC increased connections among community members and gave community members a sense of their own power to make change.

Given the right circumstances, it appears that community building can also improve some health outcomes. One of the lessons of CPHC is that community building appears to be well suited for devising and implementing effective strategies to address straightforward health issues such as immunization clinics, dental screenings, fluoride treatments, recreation programs, community cleanups, etc. CPHC was not as successful in addressing more complex health problems, such as drug abuse, child abuse, domestic violence, and school readiness, and was not long enough to produce policy change that would impact health at a population level.

CPHC left a legacy in the communities that has the potential to continue to improve health after the end of the initiative — in the continuation of the collaboratives and the programs or services they developed and by their influence on the policy and practices of other community organizations. It has shown that using community building as a health improvement strategy is a slow but potentially powerful process. Harnessing that power effectively will take further work and investment.

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