The Community-Based Public Health Initiative (CBPH) is
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Survey of Individual Members and Member Organizations on the Costs and Benefits of Belonging to a Community-Based Public Health (CBPH) Consortium

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EXECUTIVE SUMMARY

Introduction

In the summer of 1994, as the second year of the Community-Based Public Health (CBPH) initiative was coming to a close, the Cluster Evaluation (CE) team conducted a two-part survey. All CBPH members listed in the CE data base received a questionnaire on the costs and benefits of the CBPH to themselves as individual members; 219 (76%) responded. Identified leaders from all CBPH organizations represented on consortium governing bodies received a questionnaire on the costs and benefits of the CBPH to their organizations; 63 (85%) responded. The results of both versions of the survey were analyzed for the total group in question (i.e., for all individual members, and for all member organizations). We also examined how Community, Public Health Practice, and Academic partners varied in their responses, as well as how the seven CBPH consortia differed. (Because of small numbers in the Organizational Survey, consortium differences were not investigated.)

The purpose of the survey, which will be repeated in Year Four of the initiative, is to compare the relative costs and benefits of CBPH membership for the different constituencies and to understand how perceptions of costs and benefit change over time. Prior research in the area (e.g., Prestby, et al., 1990; Norton, Wandersman, and Goldman, 1993; Knoke, 1988) suggests that incentives for membership in groups such as community coalitions may vary tremendously according to the kinds of individuals involved, as well as the goals of the group. It is also believed that members involved with group activities subconsciously, if not consciously make periodic assessments of the value of membership, and are likely to "opt out" of the group if the costs of membership get too high. Thus, the ratio of costs to benefits may be an important predictor of consortium sustainability. While some attrition of members is always to be expected, and recruitment of new members healthy, chronic attrition due to insufficient benefits, or insurmountable costs, places a consortium at risk.

For the purposes of this survey, "costs" and "benefits" are defined broadly and go beyond the strictly material. Other aspects of the overall concept include benefits and costs related to personal growth and development, social and political consequences, and goal attainment/mission support. For each area (including the material), there are potential gains (e.g., job promotion, increased status) as well as losses (e.g., time devoted to work that is not rewarded by the organization, negative backlash). Some of the more important findings and implications of the study are presented below. For more detail, please see the attached report.

The "Individual Survey"

Overall, individual members report numerous benefits of the CBPH, and for the most part, these benefits lie in the personal, social and political, and goal related areas. Only about one-third of the members receive any salary support for their work in CBPH. The costs for individuals are not material so much as interpersonal, stemming from internal group conflict and dissatisfaction with the consortium. Investment in the CBPH appears

high, in that three-quarters of all members report the time demands of CBPH to be "moderate" (39%), "high" (24%), or "extremely high" (11%).

Perceptions of the benefits of individual membership varied more by constituency group than they did by consortium, with more Community members reporting greater personal, social and political, and goal related benefits than either Public Health Practice or Academic members. While slightly more Academic members reported receiving salary support than the other two constituencies, Community members were more frequently on the receiving end for all other kinds of material benefits, including in-kind contributions (e.g., technical assistance).

In contrast to perceived benefits, the perceptions of the costs of individual membership varied greatly by consortium, and rarely by constituency. Morale is generally high across the initiative, with three-quarters of the members reporting that the benefits of membership outweigh the costs, and only 12% indicating they would decrease their time allotted to the CBPH if they could. But morale is highly variable, and depends greatly on which consortium a member belongs to. Throughout the survey, roughly one-quarter of the members report considerable internal conflict and lack of collaboration occurring within their consortium; a similar proportion expresses reservations about the consortium approach and a need to restructure their consortium model.

The "Organizational Survey"

Overall, a large proportion of leaders in CBPH organizations report numerous benefits. The Organizational Survey findings, however, are somewhat limited, in that two consortia account for 44% of the respondents. Nonetheless, the benefits reported encompass a range of in-kind material contributions that organizations gain from each other, as well as from the W. K. Kellogg Foundation (e.g., technical assistance, matching grants). Strongest benefits cited were those in the social, political, and mission related areas. The CBPH is seen by a large proportion of member organizations as having given them positive recognition in the broader community, increased their status with peer organizations or groups, enhanced their political collaborations, and helped their organization address its goals. On a seven-point scale, 97% of the respondents said the CBPH goals support to a "moderate" or "great" extent their organization's mission.

Material costs and benefits were difficult to weigh, partly because many respondents did not estimate the dollar value of in-kind contributions and the reporting of income was inconsistent. Direct support was definitely acknowledged, however; nearly half of all the responding organizations received computers, over one-third hired part-time staff, and one-quarter hired full-time staff as a result of the CBPH grant. One rough calculation of how material costs and benefits balance out is that nearly twice as many involved persons (4.4) per organization were reported to receive no salary support for their CBPH work as supported persons (2.2).

Morale among these leaders is high, even higher than individual member respondents: 86% of the leaders said that the benefits of membership outweigh the costs. The generally high commitment and support voiced by leaders, however, is tempered by the relatively high number of organizations -- nearly half -- that report that no core group of people from their organization works on the CBPH. Rather, only one or two persons are involved. This, coupled with greater reserve on the parts of Academic and Public Health leaders expressed in several areas of the survey (e.g., overall assessment of benefits and costs), casts a shadow on the potential for meaningful systems change in some institutions.

Conclusions and Recommendations

This survey is one of four broad strategies developed by the CE team to understand and assess the Community-Based Public Health initiative. As such, findings from this strategy can be compared to information gained from our site visits, the video documentary, and the indicators of consortium activity and outcomes. Of these other strategies, the site visit strategy currently offers the best opportunity to "triangulate" our survey data.

Generally speaking, the results of the Individual Survey confirm observations and findings gained from interviews on the site visits. Expected differences between constituencies and consortia were seen, with somewhat greater disparity than anticipated. The results of the Organizational Survey, however, were more positive than we had expected. This might be a result of the disproportionate representation of consortia across the initiative. It might also be because, in at least some cases, leaders are somewhat removed from the daily challenges of CBPH work and may not experience the costs as members on the front line do.

More probably, however, the results are this positive because a large proportion of the Organizational Survey respondents are "hard core," committed individuals who played a major role in developing the initial concept paper or proposal, and have been with the initiative from the beginning. It is significant that 40 of the 74 potential respondents -- over half of all leaders and nearly two-thirds of the Organizational Survey respondents -- volunteered to fill out an Individual Survey in addition to the Organizational Survey, because they considered themselves more than an official leader or CEO representing a member organization. They considered themselves active, individual members, as well. This group has believed in the CBPH from the beginning and is "in it for the long haul;" it is not surprising that they see the glass as "half full." Whether their belief in the CBPH extends to other key leaders, "work horses," and gatekeepers in the organization, however, or even involves many other people in their organization, is another question.

Are these results "good?" In our assessment, "yes," the results are positive. Unless the responses were unconsciously biased by the desire of members to "say what they think a Foundation wants to here," they speak well for the potential of an initiative that is three years in the making and not an easy assignment to begin with. The strong response of Community respondents throughout both versions of the survey suggests that the goal of community capacity building, which has been integral to the initiative since its beginning, is being well served.

As for the liabilities of the initiative, the results point out that several consortia clearly have their work cut out for them, judging by the number of members who report a high degree of internal conflict, lack of collaboration, and concern for the consortium approach and structure. Virtually all consortia share one very important challenge, however, and that is the challenge of recruiting more members from Public Health Practice and incorporating a higher degree of relevance and purpose in the consortium's work to the field of public health. Only 19% of all CBPH members are currently from Public Health Practice. While a number of very committed Public Health Practice leaders are on board, agency involvement is comparatively low, as has been noted in virtually every report generated by this evaluation team since the Leadership and Model Development year. This initiative has always struggled to balance different needs and goals for three very different constituencies. To date, building community capacity-building has won out. If consortia don't find ways to highlight the areas in which community development and the practice of public health intersect, and find ways to meet the self-interest and needs of

Academic as well as Public Health Practice organizations, then the broader, long-term goals of this initiative will not be met.

These comments lead to three recommendations which consortia may wish to discuss as they move into Year Three:

1. Strengthen the involvement of all Public Health Practice partners. Do what needs to be done to better understand their perspective and current constraints. Build their capacity to engage in the effort. Work to provide the incentives necessary to gain their support. Find "new" people to represent the agency, if the current members are inactive.

2. Think strategically about membership. In which organizations is there a core group of people working on the CBPH? In which organizations is a core group missing, or needed? In which organizations is "systems change" most necessary or desirable for overall success? What barriers need to be removed, or incentives offered to organizations, so that they actively support a critical mass of personnel?

3. Although financial support may not be the driving incentive for membership, 40% of all members (50% of all Community members) say their continued involvement in the CBPH depends on financial support. The implications of this finding for sustainability are clear enough.

References

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SURVEY OF COSTS AND BENEFITS FOR INDIVIDUAL MEMBERS IN CBPH CONSORTIA

The "Individual Survey"

RESPONDENTS

- N = 219 (76% of all CBPH members). (See the Appendix, page 20, for the definition of "member" and method of calculating response rates.)
- All 7 consortia are fairly well represented. Consortium response rates varied from 64% to 87%. Because consortia are unequal in size, the larger consortia constitute a somewhat greater proportion of survey respondents. The results therefore reflect the opinions of members in North Carolina (19%), Maryland (18%), Massachusetts (18%), and Michigan (16%) to a greater extent than the members of Georgia (11%), Washington (11%), or California (7%).
- Academic and Community members comprise the larger constituencies in the CBPH; they also comprise the larger proportions of survey respondents (39% and 37%, respectively). The rates of response for constituency groups ranged from adequate (Community = 65%) to excellent (Academe = 91%).
- Demographically, respondents mirror the CBPH membership. About half the respondents are female, about 40% are African American, and another 40% are Caucasian. All ethnic groups are represented.
- About 40% of the respondents have been with the CBPH a long time -- since spring of 1991, when the initial concept paper was developed. About 1/3 of the respondents joined in the first year of the grant. The remaining third joined either during the LMD year, or during the second year of the grant.

FINDINGS

Level of CBPH Involvement

- Close to half (44%) of the respondents spend 5 hours per week or less on the CBPH. On average, members attend 3.6 CBPH meetings per month.
- A large majority of people (72%) spent 25% of their time or less on CBPH in the last 3 months. Community members were somewhat more likely to report spending more time than Public Health Practice or Academic members.
- 35% of the respondents perceive the time demands of the CBPH as "high" or "extremely high," whereas 39% perceive the time demands to be "moderate," and 26% perceive the demands to be "minimal."
- Morale at the end of Year 2 appears high, judging from members' response to a question about future time involvement. Only 12% of the respondents said that

they'd like to decrease their current time commitment; 60% said they would choose to maintain their current level, and 28% said they'd actually like to increase their time commitment, if they could.

- There were no differences in perceptions of time demands among the three constituent groups, and no difference in their responses regarding future time commitments. Minor variations across consortia were seen.

Material Costs and Benefits

- Not many people gain a lot from the CBPH in terms of material benefits. Of the six types of material benefits presented in the survey, only one ("full- or part-time salary") was reported by as many as a third of the respondents (33%). About 1/3 said they received additional personal support staff, such as graduate students or high school interns, as a result of the grant. Equipment (19%), release time (16%), per diem payments (10%), and improved work space or facilities (8%) were less frequently mentioned.

  Comparing the constituent groups on this question finds that Academic members are slightly more likely to have partial salary support (38%) than Community (29%) or Public Health Practice members (28%). Community members are more likely than others to receive per diem payments, computers, support staff, and improved facilities as a result of the CBPH grant.

- When respondents were asked to report the percentage of their regular salary being paid for through the Kellogg CBPH grant, 70% checked "zero." Of the three constituencies, Public Health Practice members were least likely (20%) to have salary support from the Kellogg grant. About one-third of Academic (38%) and Community (33%) partners reported some salary support from Kellogg.

- Although some individuals reported large amounts of unreimbursed expenses occurred on a monthly basis by virtue of their CBPH work, the most frequent amount of out-of-pocket expenses reported is "zero."

- Although only a third of the respondents' salaries were reported as having been supported by the WKKF grant, 40% of the members said they felt their continued involvement in CBPH was "somewhat" to "totally dependent" upon Kellogg's financial support. This suggests that while material gains may be limited and affect a minority of CBPH members directly, a considerable proportion of people feel their continued involvement depends on Kellogg's financial support.

  In comparing constituents on this question, more Community members (50%) said their continued participation was dependent on Kellogg's financial support than Academic members (38%) or Public Health Practice members (28%).

- The CBPH grant provided new means of employment for one-third (33%) of the Community respondents. This is a significant finding particularly in light of the fact that project directors and staff were not considered members, and were therefore excluded from this survey. Many of these people came from the Community. Had they been included, the number of new employment opportunities would probably be higher. The CBPH grant also resulted in higher pay for about 16% of Community and Public Health Practice members. The grant did not impact Academic members' means of employment or salary level.

- Responses to questions of material gain varied by consortium. In some consortia, significantly more members reported receiving salary support than members of other consortia. Significantly more members of some consortia reported being dependent upon Kellogg financial support in order to continue their involvement in CBPH. The importance of these differences is not known, as the potential relationship between material gains and satisfaction with the consortium, level of involvement, or other variables, is not yet understood.

Personal Development

- In addition to "new means of employment," and "higher pay," eight other kinds of personal development and advancement possibilities were presented in the survey. Overall, the most prevalent types of personal benefit cited were "new knowledge" (90%), "leadership opportunities and responsibilities" (67%), "opportunities to join task forces and policy groups (64%), and "access to technical training, education, and professional development" (48%). The least frequent type of personal gain reported was "job promotion" (5%).

- In every instance but one, more Community members reported experiencing the listed benefit than the other two groups (see chart below). (See note on page 10 for key to levels of statistical significance indicated by asteriks.)

Personal Benefits of CBPH	**Community Members**	**PH Practice Members**	**Academic Members**
	% of respondents who said "Yes"		
New means of employment***	33	11	11
Job Promotion	9	4	1
Resulted in higher pay**	16	17	2
Training, education, professional development***	65	53	31
Speaking engagements**	51	52	29
Opportunities to join task forces, policy groups*	74	62	54
Led to consulting work*	19	2	8
Enhanced ability to bring in other grant money	42	30	27
New leadership opportunities, responsibilities**	80	62	55
New knowledge, insights, understandings	96	89	82

- The frequency of reported personal benefits did not vary by consortium.

Potential Internal Conflicts

- In this survey, respondents answered questions about potential conflicts within their consortium around goals, resources, governance, philosophy, and personality clashes. About 25% of the respondents reported conflicts at either the "great" or

"moderate" level for each type of conflict except for personality clashes, which was reported less frequently (13%).

- Constituent groups did not vary in terms of their reporting of internal conflicts.

- Strong, statistically significant differences between consortia emerged on every type of potential conflict listed except "resources," which was experienced by every consortium to some extent. In some consortia, significantly more respondents reported "great" or "moderate" levels of conflict around goals, governance, philosophy, and personality clashes than respondents in other consortia. Across the seven consortia, the proportion of people reporting conflict ranged from the single digits to the 40% - 50% range (see below).

Conflicts with CBPH Members	**Consortia**						
Over . . .	**A**	**B**	**C**	**D**	**E**	**F**	**G**
	% reporting "Moderate" or "Great" amount of conflict						
Goals*	47	26	20	28	8	24	42
Resources	40	27	25	22	14	17	43
Governance, power, procedures***	53	23	23	36	8	28	50
Philosophical differences, values**	47	23	21	33	3	15	42
Personal, personality clashes**	7	18	8	15	6	12	25

Potential External Conflicts

- Four kinds of potential external conflicts were presented in the survey. None of the listed conflicts were reported at the "great" or "moderate" extent by very many people. In fact, 70% of more of the respondents said they experienced no conflict at all with non-CBPH colleagues or staff, bosses or other superiors, family, or other community groups as a result of their CBPH work.

- Reports of external conflicts did not vary across constituent groups or consortia.

Social/Political Costs and Benefits

- Four kinds of social/political benefits were presented in the survey, and three kinds of social/political costs. Overall, the benefits to which people said "Yes" were: "new friendships" (88%), "networking opportunities" (84%), "positive recognition from peers" (74%), and "support from new mentors or key leaders" (59%). Costs were cited by comparatively fewer people: "negative collaborative experiences (17%), "isolation due to personal conflicts with CBPH goals" (5%), and "excluded from policy arenas because of CBPH participation" (3%).

- In every instance but one, more Community members reported experiencing the listed benefit, or cost, than the other two groups (see chart below).

Social/Political Costs and Benefits	Community Members	PH Practice Members	Academic Members
	% Who "Agree" or "Strongly Agree"		
Received positive recognition from peers**	84	66	66
Negative collaborative experiences	12	15	22
New friendships	95	85	82
Isolation due to personal conflicts with goals	8	6	2
Excluded from policy arenas due to CBPH*	5	4	1
Support from new mentors, key leaders	69	62	49
Networking opportunities	93	79	77

- Reports of social/political costs and benefits did not vary across consortia.

CBPH Goals

- Eleven possible CBPH goals were presented in the survey. At least half the respondents said that they had focused "a lot" or "some" of their personal activity in the last year on each goal listed. The most frequently cited activities were "building community capacity" (81%), "building the consortium" (80%), and "assessing community capacity or health needs" (74%). The least frequently cited activity was "strengthening health department programs in health promotion or disease prevention" (51%).

- Some expected role differentiation between partners was seen in the reporting of activity on particular goals (see table on next page). For example, Public Health Practice and Community partners were significantly more likely to say they had been involved with "delivering health services to underserved populations" than Academic partners. Community partners were significantly more likely to be active in "assessing community capacity" and "providing opportunities for youth" than other partners. Academic partners were significantly more likely to be involved with "preparing a new generation of practitioners and researchers."

  At the same time, collaboration appears to be occurring in at least some areas which previously might have been considered the domain of one partner alone. For example, about half of each group reported involvement in "addressing policies at the institutional, local, state, or national level." About half of each group reported involvement in "building the body of knowledge about CBPH by gathering data, conducting research, or evaluations."

Time Committed to CBPH Goals	Community Members	PH Practice Members	Academic Members
	% reporting "Some" or "A Lot of Activity"		
Building community capacity	86	89	71
Delivering health services to underserved***	66	75	36
Strengthening promotion and prevention*	54	56	44
Assessing community capacity, needs**	86	68	64
Recruiting people of color*	48	49	64
Providing opportunities for youth**	75	52	47
Building the consortium	80	76	82
Addressing policies that affect health of people	53	54	49
Building body of knowledge about public health	55	54	57
Preparing public health practitioners, researchers***	53	41	76
Building trust among CBPH partners	81	78	65

- Consortia varied somewhat in the reporting of activity in community capacity building, community assessment, recruitment of people of color in institutions, and teaching. No differences across consortia were seen in the amount of attention being paid to service delivery, health promotion and disease prevention, youth opportunities, building the consortium, policy, research, or building trust among partners.

Satisfaction with the Consortium

- In the last section of the survey, respondents were asked about the extent to which they agreed or disagreed with five positive and three negative statements about their consortium. Again, morale seemed generally high, in that 86% of the respondents said they would "recommend that others join their CBPH consortium;" 85% feel that the consortium model is the "right approach to take in strengthening community-based research, teaching, and practice;" and 85% feel their consortium is "heading in the right direction." About 70% of the respondents feel that "other partners have been helpful," and that members "tend to agree (rather than disagree) on how to do things." These results suggest a fairly positive amount of collaboration occurring within a number of consortia in the CBPH initiative.

- At the same time, 37% of the respondents said that partners in their consortium tend to work in parallel, without much collaboration, on the goals listed in the previous section of the survey. 36% said they feel their consortium needs to be restructured, and 25% said it is not clear what the consortium's goals should be.

- In every instance, Community members were more positive about their experience in their consortium than either Public Health Practice or Academic partners.

Satisfaction with the Consortium	Community Members	PH Practice Members	Academic Members
	% who "Agree" or "Strongly Agree"		
Other partners helpful in working on goals**	85	76	71
Partners work in parallel, without collaboration	31	39	40
Not clear in my consortium what goals should be	16	28	30
Consortium is headed in right direction	93	79	80
Members tend to agree, not disagree*	74	66	67
Consortium model is right approach to take	92	78	82
Would recommend to others to join consortium**	90	89	79
Consortium needs restructuring	25	42	41

- Consortia tended to respond similarly to each other on three of the eight satisfaction items listed above. They responded similarly about the helpfulness of other partners, the consortium being the right model or approach, and their willingness to recommend their consortium to other people. Strong differences between consortia were noted on the remaining five satisfaction items (see below).

Satisfaction with the Consortium	Consortia						
	A	B	C	D	E	F	G
	% "Agree" or "Strongly Agree"						
Partners work in parallel, without collaboration**	36	30	53	46	22	18	54
Not clear in my consortium what goals should be**	29	19	31	38	8	7	46
Consortium is headed in right direction	87	73	73	86	97	95	75
Members tend to agree, not disagree**	64	55	60	65	97	83	46
Consortium needs restructuring**	57	57	51	36	14	16	45

Cost/Benefit Ratio

- Morale seems generally high in the CBPH, judging from people's responses to the global question, "How would you rate the benefits of belonging to your CBPH consortium?" 74% of the members feel there are more benefits than costs. Over half (55%) the respondents checked the most positive response option on the five-point scale, "Many more benefits than costs." 12% said that costs and benefits were about equal, and only 13% said there were either "a few" or "many" more costs than benefits.

- Community people (80%) were most likely to say that benefits outweighed the costs. By comparison, 74% of the Academic partners, and 64% of the Public Health Practice partners said that benefits outweighed the costs. The difference between the Public Health Practice partners' response and the other two groups was statistically significant.

- Consortia also varied significantly from each other in estimating costs and benefits. In one consortium, 88% of the members said benefits outweighed the costs. At the other end of the spectrum, only 57% of the members in another consortium said the benefits outweighed the costs.

DISCUSSION

A Community-Based Initiative.

A strong community-based flavor can be seen in the results of this survey. At the end of Year 2, it appears that a great majority of Community members have experienced personal and social/political benefits by virtue of their involvement with the CBPH. Of the three constituent groups, a greater proportion of Community respondents reported higher degrees of satisfaction with their consortium and the most positive benefit-to-cost ratio. Although material gains were generally not reported by a lot of people, Community members were the most likely recipient of most of the benefits listed, outside of direct salary support (e.g., Community members were more likely to receive per diem stipends, computers, support staff, improved facilities, new means of employment, higher pay). If empowerment can be defined as the broadening of networking opportunities and access to leadership roles, policy arenas, as well as material benefits (including new grants), then the responses of the Community members confirms a philosophy that has guided this initiative from the beginning.

Morale.

Morale among members is generally strong across the initiative: 74% said the benefits of membership in the CBPH outweigh the costs, and only 12% wish they could decrease their time commitment. But morale seems to depend strongly on which consortium a member belongs to. Strong variation across consortia was seen in the sections pertaining to internal conflict, satisfaction with the consortium, and the overall ratio of benefits to costs. These variations were congruent with observations and interview data gained from annual site visit reports (see the Cluster Evaluation report, "Site Visiting the Seven Consortia in the CBPH: Reflections on Year Two). These findings would appear to put some consortia at risk.

The Role of Individual Public Health Practice Members.

A persistent concern since the LMD has been the relatively diminished role that Public Health Practice partners play in this initiative. In this survey, "strengthening health department programs in health promotion and disease prevention" was the least frequently cited goal being worked on of 11 goals presented. Of the three constituent groups, Public Health Practice partners were least positive in summing up the costs and benefits of CBPH membership. Several items pertaining to satisfaction with their consortium were comparatively low. Public Health Practice partners were the also the least likely group to report salary support for their participation in the CBPH.

Coincidentally, our current membership data base shows that Public Health Practice partners comprise the smallest constituency in the total CBPH membership -- only 19%, or less than 1/5 of the members. Academic (31%) and Community (48%) partners are comparatively more numerous.

Response Patterns.

Academic partners tended to agree with their public health practice partners on many items, such as the amount of personal and social/benefits experienced and degree of satisfaction with their consortium. In response to many items of the survey, however, proportionally fewer Academic partners reported experiencing personal, social, or political benefits than either of the other two groups. Still, 74% of the Academic members said benefits outweigh the costs.

Results from earlier surveys of CBPH members, such as the "Evaluation of the CBPH Leadership and Model Development Program" (spring, 1992), and "Follow-Up of Participants in the CBPH Leadership and Model Development Program" (spring, 1993), registered a tendency for Community partners to respond more favorably to survey questions than either Public Health Practice or Academic partners. This general pattern may indicate a response pattern is at work, in addition to real differences between the groups.

Incentives for Participating in CBPH Consortia.

Generally speaking, the primary benefits reported by CBPH members lie in the personal, social, and political areas, rather than the material. Material benefits are higher than material costs, but none of the listed benefits are experienced by more than a third of the people in CBPH consortia. Kellogg's financial support, however, appears to be making an important difference, in that 40% of the respondents (50% of Community members) reported their involvement in CBPH depended on it.

The costs of CBPH membership lie in internal group conflict and dissatisfaction with the consortium, rather than conflict with external sources. This latter finding is important, in that we've generally given great weight to the organization or external environment's ability to influence the commitment among members (especially Academic members). Perhaps our survey failed to capture the power of the environment adequately in the items presented. Or, perhaps environments are more favorable than we had understood from some site visits. Responses from leaders of CBPH member organizations, for example, reported a high degree of congruence between CBPH goals and the missions of their organizations (see Organization Survey Summary, which follows).

Further Study.

The relationship of perceived costs and benefits to other variables (e.g., history of involvement, time commitment, satisfaction with the consortium, and overall cost-to-benefit ratio) will be explored for each constituency in further analyses by the Cluster Evaluation Team. It may well be that different constituent groups need different barriers removed, or different incentives offered to remain committed to CBPH. On the basis of this questionnaire's results, it appears that the items we presented well represent many of the kinds of benefits that attract Community people and keep them involved. It is less clear whether the survey was able to pin point the incentives for Academic or Public Health Practice partners in that generally lower frequencies (of benefits) were reported by these groups. The generally high retention rate (78%) of original CBPH members from Academe and Public Health Practice, however, suggests that incentives for involvement do exist. The survey did not explore the more purely altruistic reasons for involvement, such as "it's the right thing to do," or "I believe in CBPH principles." Perhaps items of this nature should be added in future surveys.

Note: Asteriks were used to designate levels of statistical significance on the tables in this report in the followring manner:

* = significant at the .05 level
** = significant at the .01 level
*** = significant at the .001 level

SURVEY OF COSTS AND BENEFITS FOR ORGANIZATIONAL MEMBERS IN CBPH CONSORTIA

The "Organizational Survey"

RESPONDENTS

- N = 63 (85% of all CBPH organizations).
- Respondents were <u>not</u> well distributed across consortia. This was due partly to uneven response rates, but mostly because the process of selecting respondents for the study was based on the number of organizations belonging to each consortium. Some consortia have many more organizations involved than others. Thus, organizational leaders in Michigan and North Carolina comprised 44% of the total respondents -- more than California, Georgia, Maryland, and Massachusetts combined. The results therefore reflect disproportionately the opinions of leaders in Michigan and North Carolina.
- The respondents were fairly well distributed across the three constituency groups: Community leaders comprised 35%, Public Health Practice 29%, and Academe 32% of the total group. The rates of response for the three constituencies were all very good, ranging from 79% (Community) to 90% (Public Health Practice).
- A majority of the respondents had been with the CBPH for a long time -- since the spring of 1991, when the initial concept paper was developed. As with the Individual Survey, about 1/4 of the respondents joined in the first year of the grant; the remainder joined either during the LMD or the second year of the grant.

FINDINGS

Level of CBPH Involvement

- Close to half the respondents (43%) indicated that no core group of people from their organization works on the CBPH -- only 1 or 2 members are involved. At the other end of the spectrum, however, 1/3 (38%) said that a core group from their organization does exist and commits significant time to CBPH.
- When asked to describe their organization's investment in the CBPH (e.g., commitment of time, resources, personnel), 40% of the respondents indicated "extensive," 48% reported "moderate," and 11% said "minimal investment."
- There was a slight tendency for fewer CBO leaders to report having a core group of members involved with the CBPH than other partners. At the same time, more CBO leaders described their investment in the CBPH as "extensive." One interpretation of this finding is that having fewer people devoted to the CBPH

leads to more work. A second interpretation is that even a few people may represent a significant contribution for a small organization to make.

- 80% of organizational leaders said that they are taking steps to sustain the CBPH. Many of the write-in examples supplied detailed project activities they are involved in, or relationships they are pursuing within the consortium, rather than external or institutional funds-seeking per se.

Material Aspects

- The amount of money that organizations received for this second year of operation from the CBPH grant varied widely (see below), but may not have been reported reliably. Some respondents (e.g., the outlier at $704,570) may have answered this question as a fiscal agent, and reported what their organization took in for the entire consortium, rather than what was allotted their particular organization as a partner in the consortium. Eliminating the low (zero) and high ($704,570) responses, the average amount reported per organization was $70,440.

Reported Amount of Money Organizations Received from the CBPH Grant During the Second Year of Operation

$ Amounts Reported	N	Percent (N = 63)	Adjusted Percent (N = 58)
0	11	18	19
250 - 30,000	17	27	29
34,007 - 72,000	15	24	26
74,014 - 250,000	13	21	22
340,300	1	1	2
704,510	1	1	2
missing	5	8	100%
	63	100%	

- Many people (about 1/3) did not know the percentage of the overall CBPH budget allotted to their organization, or chose to skip this question (see table next page). Of the 42 responses, about 1/4 said the money received constituted zero percent of the overall budget. Another quarter said it constituted 10% or less. Two leaders said they had received 100% of the CBPH budget. (This may reflect fiscal agent status, as explained above, rather than the actual share for the organization.) Eliminating the low (zero) and high (100%) responses, the average percentage of the total CBPH budget reported per organization was 20%. (Note that 20% of $500,000 -- an average annual budget for a CBPH consortium -- is $100,000, somewhat higher than the average annual amount of $70,440 calculated above.)

Reported Percent of Total CBPH Grant Allotted to Organizations During the Second Year of Operations

Percentages Reported	N	Percent (N = 63)	Adjusted Percent (N = 42)
0	10	16	24
1 - 10	11	18	26
11 - 28	13	21	31
35 - 45	2	3	5
50	2	3	5
85	1	2	2
100	3	5	7
don't know	14	22	100%
missing	7	11	
	63	100%	

- Almost 1/3 of the organizational leaders said none of their members received any financial (salary) support from the CBPH grant. The range reported was zero to 20 people, with an average of 2.4. supported people per organization. (Zeroes included with means.)

- When asked how many additional people in the organization are committing significant time to the CBPH without Kellogg funding, 11% said "zero." The range reported was zero to 25, with an average of 4.4. unsupported people per organization. (Zeroes included with means.)

- The survey presented five additional types of material benefit that organizations may have received by virtue of their participation in CBPH. Of the five, the most frequently cited was "equipment" (e.g., computers, office supplies) (44%). "Additional part-time staff" (35%), "Additional full-time staff" (25%), "rental of office or other space" (16%), and "costs of building or buying a building" (3%) were mentioned less often.

- About half the leaders wrote in additional kinds of material benefits *gained* as a result of CBPH, and some of these examples could be categorized under the five options listed above. Many examples were noteworthy, however. They included such things as technical assistance in evaluation, faculty release programs, matching funds and grants, computer training, student stipends, volunteers, newsletters, honoraria for community instructors, transportation. The most prevalent type of in-kind benefit was personnel -- e.g., assistance from staff, faculty, students, and others.

- To some extent, the write-in list above mirrors the types of contributions that organizations reported *giving* to the CBPH. Space, equipment, clerical support, professional personnel time, technical support to other CBPH partners, supplies, and food were listed as contributions. It was difficult to analyze the responses to this question, however, because a lot of people did not answer it -- probably

because we asked respondents to estimate the dollar value of these contributions. Only one type of contribution was listed by over half the respondents: "professional personnel time." The dollar amount estimated for this contribution ranged from $800 to $60,000 per organization; the average amount reported was $15,326. In terms of dollar amounts, "professional personnel time" was also the most costly kind of contribution reported.

- Very few (n = 6) organizations found it necessary, or feasible to replace any professional staff whose time had been shifted to the CBPH. For those organizations, the average replacement cost was $30,000 per year.

- Throughout this section on material costs and benefits, there were no strong differences between Community, Public Health Practice, and Academic organizations. Small numbers make it difficult to judge these results, but it seemed there was a slight tendency for Community organizations to have fewer leaders reporting income at the lowest interval (e.g., zero to $30,000), and a slight tendency for Community leaders to report receiving equipment and rental of office space. In general, however, the constituent responses were quite similar.

Social and Political Consequences of Membership

- A significant proportion of leaders agreed, or agreed strongly, that their organizations received positive social and political consequences of their CBPH membership. The four possible benefits presented in the survey were cited by the following percentages of respondents: "positive recognition in the broader community" (90%), "positive public relations with constituents and consumers" (84%), "enhanced political collaboration" (69%), and "support from key leaders" (62%). The two possible negative consequences, "negative effect on staff or faculty morale" (12%) and "exclusion from policy arenas" (2%) were mentioned by a much lower proportion of respondents.

- Differences between constituent leaders were modest in this section, and none were statistically significant. Still, a comparison of findings is informative (see below).

Social and Political Consequences	Community Members	PH Practice Members	Academic Members
	% "Agree" or "Strongly Agree"		
Positive recognition in the broader community	96	89	85
Increased status of organization with other departments, programs, organizations	82	83	71
Enhanced political collaborations	59	70	67
Negative staff and faculty morale	9	13	15
Organization excluded from policy arenas	0	6	0
Support for organization from key leaders	55	61	63
More positive public relations with consumers	91	83	65

These results suggest that benefits are not as clearly present for Academic organizations as they are for other organizations -- although benefits in the recognition, increased status, and enhanced political collaborations are still strongly felt. The greatest proportional difference is seen with the last item, concerning public relations with consumers.

CBPH Goals

- Leaders reported in fairly high proportions a large or very strong degree of correspondence between CBPH goals and their organization's primary missions. Of the 11 possible CBPH goals listed, none were considered "not applicable" to the organization's mission by more than 11 (18%) leaders. The most frequently cited goals were: "building linkages between partners" (75%), "assess community capacity" (70%), and "building community capacity" (65%). The least frequently cited goal was "building knowledge about community-based public health" (54%).

Degree to which CBPH Goals Complement Organization's Primary Mission(s)	Community Members	PH Practice Members	Academic Members
	% indicating "Large" or "Strong Degree"		
Building community capacity	60	72	60
Delivering health services to underserved	47	68	50
Strengthening promotion and prevention	50	61	55
Assessing community capacity, needs	70	89	58
Recruiting people of color	50	61	68
Providing opportunities for youth	50	61	63
Building the consortium	70	83	69
Addressing policies that affect health of people	40	83	53
Building body of knowledge about public health	40	67	58
Preparing public health practitioners, researchers	40	67	74

- Fairly strong differences between constituencies were seen in this section, although none was statistically significant. Strong endorsement came from Public Health Practice leaders for "delivering health services" and "assessing community capacity." Several surprising findings: fewer CBO leaders indicated that the CBPH goals of "recruiting people of color" and "providing opportunities for youth" complemented their primary missions. It is interesting to note that more Public Health Practice leaders feel responsible for "building the body of knowledge about community-based public health" and "building the consortium" than leaders from the other groups.

- On a 7-point scale, 97% said the CBPH goals support to a "moderate" or "great" extent their organization's goals.

Satisfaction with Consortium

- Overall, CBPH leaders seem well satisfied with their consortia and the consortium model as an approach for strengthening community-based public health practice, education, and research. 90% agreed or agreed strongly that the "consortium approach" was the right approach to use; 88% said the consortium has "helped their organization address its own missions and goals." 85% would "recommend the consortium approach to other organizations." On the less positive side, 20% of the leaders said that the "goals of the CBPH are not clear in our consortium," and over 1/3 said that "organizations in this consortium tend to work in parallel, without much collaboration." 34% of the leaders had "serious doubts about our ability to sustain this effort" after the Kellogg grant period is over, and another 30% said their consortium "needs restructuring."

- Differences in satisfaction with the consortium were expressed by the three constituencies (see below). None of the differences were statistically significant.

Satisfaction with the Consortium	Community Members	PH Practice Members	Academic Members
	% "Agree" or "Strongly Agree"		
Has helped consortium address mission, goals.	91	89	80
Partners work in parallel, without collaboration	42	22	36
Not clear in my consortium what goals should be	0	28	35
Consortium is headed in right direction	100	95	90
Members tend to agree, not disagree	84	72	74
Consortium model is right approach to take	95	95	75
Would recommend consortium approach to others	90	100	65
Consortium needs restructuring	15	33	47

The results indicate that fewer Academic leaders than others feel that goals are clear in their consortium; or that the consortium model is the right approach to use; or would recommend the consortium approach to other organizations. Proportionally more Academic leaders feel the structure of operation of their consortium needs recasting or restructuring.

Cost/Benefit Ratio

- Overall, a large majority (86%) of the organizational leaders responding to this survey said there were more benefits than costs in belonging to their consortium, and only 8% said there were more costs than benefits. This is an even more positive response than the individual members gave in the Individual Survey. Over half the total group (52%) responded at the highest ("many more benefits") level, and 34% at the next highest ("few more benefits") level.

- When constituency groups were compared on this question, it appears that fewer Public Health Practice leaders (33%), compared to Academic (50%) and Community (62%) leaders feel that there are "many more benefits than costs." More Academic leaders (15%) than Community (5%) or Public Health Practice (6%) leaders, however, feel that the costs outweigh the benefits.

- Write-in comments tended to emphasize the positive: additional benefits were cited three times as often as costs. In terms of the content of these responses, several areas emerged:

Write-in Benefits

* Networking both within the community and within the organization.

* A focusing of organizational efforts.

* Several people said CBPH provided a forum, linkage, or avenue of communication between community and institutions, with better understandings of each other as the result.

* The benefits to students of being able to train in the community.

* Increased awareness and involvement and development of faculty.

* Interdisciplinary activity.

* Support for various organizational goals and objectives.

* Additional building security, maintenance, and stipends for consultants were reported by one respondent.

* More positive public relations for their organization.

Write-in Costs

* Financial costs were reiterated, especially by institutions.

* Stress and conflicts resulting from unclear objectives, inadequate representation on the governing board.

* Tremendous in-kind contributions of faculty and staff.

* The difficulty of working collaboratively, rather than in parallel.

* The time consuming, labor intensive aspect of CBPH work was restated.

* The sense that in-kind contributions were not acknowledged or appreciated by the consortium as a whole.

DISCUSSION

Limitations of the Survey.

The survey of organizational members in the CBPH is limited in several ways. Despite a high overall response rate of 85%, unequal consortia size and our strategy for defining the survey population produced an aggregate response which over represents two CBPH consortia. Thus, it is difficult to say whether the results reflect the whole initiative very well.

The survey was not as successful at improving our understanding of the material costs and benefits for organizations as was hoped. Respondents had difficulty estimating expenses and the value of in-kind contributions; some undoubtedly misunderstood some of the questions or simply didn't know how to get the information we requested. Without looking directly at budgets and clarifying terms with project managers, we probably will not be able to get reliable estimates of such things as income and expenses per organization via mailed questionnaires.

Some of the findings related to material costs and benefits do not correspond with impressions we've gained from site visits. For example, we frequently heard that when the CBPH budget was distributed within consortia, community organizations typically received the lion's share. This pattern was not particularly evident from these data, which found no significant differences between constituent groups in reported income or percentage of the CBPH grant. It is still entirely likely, however, that if all the separate budgets for separate community organizations within a consortium were added together, they would surpass budgets allocated to the institutions. Just as there are more Community *individuals* in this initiative than either Public Health Practice or Academic individuals, there are more Community *organizations* (n = 31) than either Public Health Practice (n = 19) or Academic organizations (n = 24).

Material Costs and Benefits.

One useful finding from the Material Costs and Benefits section is that on average, there are twice as many unsupported people in an organization (4.4) working on the CBPH as there are supported people (2.4) While the exact number may be more or less accurate, the ratio between the two figures does coincide with other information we have gained, both from this survey and our annual Cluster Evaluation site visits. We know that the primary cost for organizations lies in donating personnel and time.

It is not clear whether the purely material costs outweigh the material gains. A considerable list of material benefits was mentioned by respondents (both cash and in-kind, e.g., faculty release time, matching grants, student stipends, and honoraria). In addition, nearly half the organizations got computers, one-third hired part-time staff, and one-quarter hired full-time staff as a result of membership. In terms of direct financial support, an average gain of $70,440 per organization may cover the salaries and fringe benefits of one, perhaps two professionals, or some combination of students and lay personnel. The ratio of supported to unsupported members reported suggests that the financial costs probably outweigh the financial gains, if all organizations were equal -- which they are not. Organizations varied in the amount of their estimated investments in CBPH, from "minimal" to "extensive." Some organizations may be operating "at a loss" -- others may actually come out ahead. For

the one-third of organizations whose members received no salary support, the balance is more clearly on the side of financial costs, rather than gain.

Material and Other Costs Are Offset by Intangible Benefits.

In arriving at their own assessment of the final cost/benefit ratio, 86% of the leaders were clearly positive. One interpretation of this finding is that the costs are real: they lie in personnel and time. These costs are mostly offset by benefits which are largely intangible, but nonetheless important. As with the Individual Survey, the intangibles lie in the social and political arenas: "positive recognition in the community," "increased political and social status," enhanced political collaboration, and increased support for activities that are considered complementary to the organization's primary missions.

Community Certainty vs. Institutional Uncertainty.

While results generally affirm CBPH directions and indicate strong institutional commitment to CBPH goals and the consortium approach, leaders in Academe were less certain about the consortium model and less apt to recommend the consortium approach to others. Almost half felt their consortium needed restructuring, over one-third said their consortium's goals were unclear. By comparison, 100% of the Community leaders feel their consortium is headed in the right direction, and zero Community leaders feel the consortium's goals were unclear. While Public Health Practice leaders responded very positively in many areas of this questionnaire (especially in the areas indicating the complementary nature of the CBPH with their goals and mission), they were much less likely than other groups to say that membership entailed "many more benefits than costs." This suggests that there are important doubts or barriers remaining for at least some agencies and institutions in the CBPH.

Potential for Systems Change.

The generally enthusiastic response of leaders to the survey and the high level of reported organizational investment in the CBPH raises hopes for institutional change. This optimism is tempered not only by the hesitancy noted in some institutitional partners, but also in the number of people within an organization working on the CBPH. Barely half (57%) of the organizations involved reported the existence of a core group of people active in the CBPH. The absence of a core group may have serious implications for the larger organizations, or for any organization for which change is considered desirable. The absence of a core group may not be as significant a finding for small, grass-roots groups, except that it places a larger burden on the individuals to carry. As the initiative heads into Year 3, organizations hoping to make headway in institutional change and policy need to consider how they will replenish their membership and expand beyond a few individuals, if the effort is going to be sustained.

Survey of Costs and Benefits to Individual Members and Organizational Members in CBPH Consortia

APPENDIX TO 1994 SURVEY RESULTS

Respondents

Respondent lists for both the Individual and Organizational Survey were drawn from the Cluster Evaluation Membership Data Base, a comprehensive mailing and demographic data base which was created in winter of 1992-93 and is updated every six months. Confirmation of membership and assignment to the "Individual" or "Organizational" survey was done with assistance of project evaluators and staff.

Individual Member Survey

All consortium members listed in the Cluster Evaluation Data Base were sent a copy of the Individual Survey. This included former members (unless they had left the consortium before the first year of the grant). Although "membership" status varies by consortium, we defined "members" as:

> People from academic, public health practice, and community groups who participate in organizing, prioritizing, selecting, designing, developing, or implementing CBPH consortium missions, goals, and activities.
>
> CEOs and political contacts who serve on advisory boards were not considered members, unless they are active decision makers with voting authority, or other responsibilities that directly engage them with the work of CBPH.
>
> Members are also distinguished from videographers, evaluators, and logistical support staff who do not participate in decision making, or who do not represent academic, public health practice, or community constituencies.
>
> Students who participate in the governing body as voting members, or as participants in decision making, are counted as consortium members. Students who are enrolled in CBPH classes, or who receive stipends for graduate assistantships, were not sent a survey, unless the above statement applied.
>
> Project directors, site coordinators, other administrators, and support staff who represent a constituency (e.g., faculty body, health department staff, community-based organization or coalition) in the consortium were counted as members. Those who do not represent a constituency were not sent a questionnaire.

Organizational Survey

To survey organizations, 74 member organizations were identified, and a key leader was identified for each organization. In cases where several leaders were identified, one was selected as the primary respondent, and this person was encouraged to consult with other leaders in preparing the response for the organization. 74 individuals representing 31

Community, 19 Public Health Practice, and 24 Academic organizations received an Organizational Survey.

Each mailing also contained an Individual Survey that organizational respondents could fill out if they wished. We anticipated that some organizational leaders would also consider themselves individual members of a consortium; others would not (see above definition). We could not predict how they would classify themselves. Therefore, we gave every organizational leader a chance to complete an Individual Survey. If they returned it completed, we interpreted that as a sign of member status. To show the difference that the addition of organizational leaders' responses made to the Individual Survey, several response rates were calculated (see Figure 1).

Figure 1

Overall Response Rates	**Number of Surveys Sent**	**Number of People Responding**	**Response Rate**
Individual member responses to the Individual Survey	**248**	179	72%
Organizational member responses to the Individual Survey	**74**	**40**	54%
Total responses to the Individual Survey (based on a denominator of **248 + 40**)	288	219	76%
Total responses to the Individual Survey (based on denominator of **248 + 74**)	322	219	68%
Organizational member responses to the Organizational Survey	74	63	85%

Presented next are the response rates for each of the seven consortia (see Figure 2) and the response rates for the three constituent groups (see Figure 3).

Figure 2

Response Rates by Consortium	**Percent Responding** (by consortium code number)						
	1	**2**	**3**	**4**	**5**	**6**	**7**
	%	%	%	%	%	%	%
Individual Survey (all respondents)	65	64	74	87	80	78	77
Organizational Survey	80	71	67	90	90	83	100

Figure 3

Response Rates by Constituency	Percent Responding		
	Community	PH Practice	Academic
	%	%	%
Individual Survey (N = 288 respondents)	65	77	91
Organizational Survey	79	90	87