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Reconciling Community-Based Versus Evidence-Based Philanthropy: A Case Study of The Colorado Trust's Early Initiatives

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Introduction

One of the fundamental philosophical tensions in philanthropy surrounds the question of whether local communities can be trusted to produce the right solutions to the problems they are addressing. Some foundations have a core belief that local residents are directly knowledgeable about the needs, assets, and values of their community and that community-based organizations understand what is required to do effective work within the local context. As such, community-level decisions should be respected and supported with grant funding. Other foundations have a less sanguine view of the capacity of communities to choose, design, and implement effective strategies. They point to the many poorly conceived grant proposals they receive from community-based organizations. Even if a proposed project reflects the wishes of community members, it doesn't necessarily warrant an investment of resources from either the funder or the community. These foundations are much more inclined to support programs that have empirical evidence of effectiveness.

For the sake of brevity, we refer to this contrast in philosophy as community-based philanthropy versus evidence-based philanthropy. (See Table 1.) The former seeks to engage community-based organizations and residents in problem solving, organizing, and advocacy work that will improve local conditions, with the proviso that the foundation is facilitating the change

> ### Key Points
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> - One of the dominant tensions in philanthropy involves the question of whether foundations should focus their grantmaking on projects that come from the community versus projects that have a base of scientific evidence. How a foundation answers this question leads to different strategic orientations.
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> - This article describes how this tension was expressed and resolved during The Colorado Trust's early years of initiative-based grantmaking. The community-based philosophy is illustrated through the Colorado Healthy Communities Initiative, while Home Visitation 2000 serves as an exemplar of the evidence-based approach. The Colorado School Health Education Initiative purposefully integrated the two philosophies.
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> - The community-based and evidence-based philosophies each have inherent limitations which can be overcome by incorporating the opposing philosophy. This finding is consistent with Barry Johnson's (1992) Polarity Management model and potentially at odds with the principle of strategic alignment.

process, not directing the content or shape of the solutions. The contrasting perspective aims for the adoption and implementation of effective programs and relies heavily on science and evaluation to identify effective programs and to determine which programs are effective.

These contrasting perspectives point foundations in different directions when it comes to strategy. A community-based orientation has led foundations such as the Annie E. Casey Foundation, the Skillman Foundation, and The California Endowment to create initiatives that encourage neighborhood organizing, grassroots leadership development, coalition-based problem solving, agenda setting, and policy advocacy. In contrast, foundations with an evidence-based orientation use their resources to promote the dissemination and uptake of programs and services that have evidence of effectiveness. This can be done by structuring grants to incentivize the adoption of a particular program model or by supporting a national or state office that promotes and trains around a particular model. Some foundations with an evidence-based orientation move further upstream and fund the development and testing of new program models. In a similar vein, the William T. Grant Foundation has a grants program designed to increase the willingness and capacity of agencies and policymakers to incorporate research evidence into their decisions about policy and practice.

In terms of assumptions, the community-based approach to philanthropy assumes that the choice of strategy should be left in the hands of local actors (including community-based organizations and, in some cases, residents who take part in a planning process). The evidence-based approach offers local actors an opportunity to adopt specific program models that have been shown to be effective. In terms of theories of change, the community-based approach calls for the foundation to support an expansive, locally driven process of problem identification, planning, decision-making, and implementation. The evidence-based approach conceives of a more bounded process of problem definition, program selection, and implementation. Under each approach, the foundation provides grants and other resources to implement programs, build capacity, and change policy and funding streams. However, foundations with a community-based philosophy employ very different grantmaking guidelines and seek very different types of relationships than do evidence-based foundations.

This contrast in philosophy has appeared in stark terms within the field of place-based grantmaking. The proceedings report from the "Towards a Better Place" conference, held in Aspen, Colorado, in September 2014, included the following summary:

> We heard a number of examples of funders following the lead of the community designing their own solutions or campaigns, where the funders saw their role as listening, resourcing, convening, and building capacity. Some national funders provided a contrast to this approach, arguing that underresourced communities can benefit from technical expertise that they may not otherwise have access to, or that foundations can leverage their expertise to advance community agendas at the state or national levels. Some argued that communities may not always know the solutions, and that foundations are expected to add value. (Aspen Institute & Neighborhood Funders Group, 2014, pp. 11–12)

It is important to point out that foundations with contrasting philosophies often seek to accomplish the same overall goals, such as improving community health, enhancing childhood development, or increasing the percentage of people who graduate from high school and find gainful employment. The foundation's philosophy comes into play when deciding how to achieve those goals. As noted above, foundations with a community-based lens tend to promote community development, while foundations with an evidence-based lens tend to promote the adoption of program models that have been shown to be effective. In either case, the strategy will have an underlying theory of change (either explicit or implicit), but those theories will focus on different pathways as a function of the foundation's philosophical orientation.[1]

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[1] A theory of change describes the conditions that need to be in place and the steps that need to be taken in order for a desired outcome to occur (Weiss, 1995). While known as a "theory of change," It is actually a "theory of the change process" that the intervention will stimulate in order to generate the desired outcomes. The particular theory of change that undergirds a foundation initiative (or a foundation's larger strategy) is an amalgamation and reflection of the foundation's beliefs and assumptions about how change happens and how its own resources and activities will influence the change process (Patrizi & Heid Thompson, 2011; Patton, Foote, & Radner, 2015). By definition, theories of change involve some degree of speculation as to what will happen when a foundation introduces its strategy. One function of evaluation is to test empirically the accuracy of the theory on which a strategy is built.

TABLE 1 Contrasting Assumptions and Pathways for Community-Based Versus Evidence-Based Philanthropy

	Community-Based Philanthropy	**Evidence-Based Philanthropy**
ASSUMPTIONS		
Responsibility of local actors in selecting programs and setting strategy	"The community" (operationalized accordingly) is responsible for making its own decisions based on its own assessment of what is needed and what will work.	Local organizations are responsible for using their resources to carry out the programs and services that are most effective in achieving their mission.
Which programs are assumed to be most effective?	Programs that arise out of the collective wisdom of community-based organizations and residents who are focused on the issue and who have experience working within the local context	Programs that have been shown to produce outcomes within rigorous studies and that are appropriate to the local context
THEORY OF CHANGE PATHWAYS		
What are the key steps in achieving impact?	• Activate local actors to engage in new work to improve the community • Incorporate the wisdom of a broad range of stakeholders • Find innovative approaches to address critical underlying issues • Implement the strategies • Change policy and institutions to support the strategies • Evaluate and adapt the strategies on an ongoing basis to optimize impact and remain relevant	• Identify the specific problem(s) to be solved • Select an evidence-based program that addresses that problem and is appropriate to the local context • Ensure that the program is implemented with fidelity • Change policy and institutions to support the program • Evaluate the program and assess if additional or different programs are needed
What is the role of the foundation in fostering positive impact?	• Respect the community's authority and wisdom • Provide forums and resources that help activate local actors and that support community-based analysis and planning • Provide implementation grants for community-defined strategies • Provide technical assistance and other support for evaluation, learning, and adaptation • Offer training and other resources to build individual and organizational capacity • Assist in changing policy and institutions to support community-driven strategies	• Support research to develop and evaluate promising programs • Bring evidence-based models to the attention of organizations that could benefit from adopting them • Provide grant funding to implement evidence-based models • Help organizations build the capacity and infrastructure to implement evidence-based models (e.g., through staff training) • Provide support for implementation evaluation and learning • Assist in changing policy and funding streams to support the implementation of evidence-based models

REFLECTIVE PRACTICE

This tension between trusting the wisdom of communities versus trusting scientific evidence arises not only across foundations, but also within foundations. In many foundations there will be substantial diversity of opinion, perspective, and background among the board and staff. … One perspective may win out and rule the organization, but it is also possible that a foundation will allow both perspectives to operate simultaneously.

This tension between trusting the wisdom of communities versus trusting scientific evidence arises not only across foundations, but also within foundations. In many foundations there will be substantial diversity of opinion, perspective, and background among the board and staff. The principle of "trusting the community" appeals to some, while "moving evidence-based models into practice" appeals to others. One perspective may win out and rule the organization, but it is also possible that a foundation will allow both perspectives to operate simultaneously. This can happen more easily in foundations with multiple program directors, each of whom has autonomy over a particular grant portfolio or set of initiatives.

This article considers the question of how foundations should manage situations where two competing philosophies are generating divergent and even inconsistent strategies. We describe The Colorado Trust's early phase of initiative-based grantmaking

to illustrate how a foundation can reconcile two competing philosophies, and in the process create a more complete theory of change and more effective strategy. The Trust is a Denver-based health foundation established in 1985 with the proceeds of the sale of Presbyterian/St. Luke's Medical Center (PSL) to American Medical International Inc. (AMI). Because PSL was a nonprofit entity and AMI was a for-profit entity, the proceeds were channeled into a "health conversion" foundation.[2]

After five years as a responsive grantmaker, The Trust shifted to a proactive orientation. Foundation staff designed initiatives that provided organizations across the state with opportunities to engage in specific forms of work aimed at improving health through particular strategic pathways. Many of these initiatives were grounded in the philosophy of "trust the wisdom of the community," but others explicitly sought to promote the adoption of evidence-based programs. We describe how The Trust came to adopt these different theories of change, what it learned with regard to the shortcomings of each theory, and how the different theories were blended in an initiative designed to engage a wide range of local stakeholders in a process of selecting evidence-based health education curricula. To motivate this case study, we present two alternative theories of how a foundation (or any organization) should reconcile inconsistencies in philosophy.

Competing Perspectives on How to Reconcile Philosophical Inconsistencies

How should a foundation respond when it finds that it is pursuing different strategies that are based on competing philosophies? The natural inclination among those who advise on organizational strategy is to resolve the inconsistency

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[2]Health conversion foundations (sometimes referred to as "health legacy foundations") are created with the proceeds that accrue when a for-profit firm acquires a nonprofit health organization (e.g., hospital system, physician practice, health insurance plan), or alternatively when a nonprofit health organization converts its status to for-profit (e.g., Standish, 1998; Frost, 2002; Niggel & Brandon, 2014). The Colorado Trust was formed during the initial wave of conversions in the 1980s, when 57 foundations were established. There are now more than 300 conversion foundations in the U.S., some with endowments in the billions of dollars (Niggel & Brandon, 2014).

by committing to a particular philosophy. If two competing philosophies are guiding different bodies of work, then the organization is arguably out of alignment, and possibly even trying to move in two opposing directions. If those two different strategic directions require contrasting competencies and processes, then the organization will inherently find itself building competing structures and hiring employees with different mindsets. In other words, competing philosophies make it difficult or even impossible to create a coherent organization with a clear sense of direction.

Holistic Alignment

Michael Quinn Patton, Nathanial Foote, and James Radner (2015) adopt this logic in making the case that foundations should specify their "theory of philanthropy":

> A foundation's theory of philanthropy articulates how and why the foundation will use its resources to achieve its mission and values. The theory-of-philanthropy approach is designed to help foundations align their strategies, governance, operating and accountability procedures, and grantmaking profile and policies with their resources and mission. (p. 10)

Patton, Foote, and Radner draw on the thinking of two highly regarded systems theorists, Jamshid Gharajedaghi and Russell Ackoff (1985), in arguing that organizationwide alignment (what they call "holistic alignment") is essential for effectiveness:

> [I]f the elements of a foundation are not integrated, the foundation's overall effectiveness is potentially undermined and resources are potentially wasted. The stakes for effectiveness and efficiency, we want to suggest, can be quite high. If impact and accountability matter, then alignment matters. (Patton, et al., 2015, p. 9)

According to Patton, Foote, and Radner, one of the key steps in developing a theory of philanthropy is to critically examine whatever theories of change might be at work in the foundation's grantmaking.[3] If different strategies reflect

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[3] These theories of change might pertain either to the foundation's own strategies or to the programming that grantees carry out with foundation funding.

contradictory theories, then those strategies are trying to make incongruous things happen. Likewise, the program departments leading those competing strategies may be working at cross-purposes to one another. When this situation presents itself (or is uncovered through a theory-of-philanthropy process), remedial action is warranted to clarify which theories are consistent with the foundation's overall assumptions, beliefs, and philosophy about how change should happen. Once that clarification has occurred, the foundation would be expected to abandon or modify those strategies that are out of alignment with the accepted theories of change.

Polarity Management

Barry Johnson (1992) presents an alternative view on how organizations should seek to resolve competing philosophies and contrasting theories of change. Johnson points out that many contrasts in perspective are opposite ends of a "polarity." According to Johnson, a polarity is a "set of opposites which can't function well independently. Because the two sides of a polarity are interdependent, you cannot choose one as a 'solution' and neglect the other" (p. xviii).

For example, the community-based and evidence-based philosophies of grantmaking both speak to the issue of "What form of decision-making leads to the greatest and most meaningful impact?" The two perspectives emphasize different elements and often lead to different strategic orientations, but each perspective has its merits and logic. Just as importantly from Johnson's point of view, each perspective has its shortcomings and blind spots. (See Table 2.)

Rather than selecting one approach as "good" or "right," Polarity Management presumes that it is neither possible nor desirable to select one end of the polarity and set aside the other. When developing a particular strategy, the organization considers the upsides and downsides of each perspective, taking into account the specific context and organizational objectives. As such, some of the organization's strategies will be grounded in one perspective, some in the other, and some will reflect both perspectives. Polarity Management is designed to get "the best of both

TABLE 2 Arguments For and Against Community-Based and Evidence-Based Philanthropy

	Community-Based Philanthropy	Evidence-Based Philanthropy
Payoff (when successful)	• Solutions and strategies are informed by local wisdom. • Programs and services fit the local context. • Local buy-in sustains whatever programs are developed. • Innovation thrives. • Local residents gain experience analyzing problems and developing solutions. • Community-based organizations and residents feel respected by the foundation.	• Communities gain access to programs and services that have been shown to be effective. • Local organizations allocate their resources efficiently. • The foundation knows it is investing in effective programming. • The approach builds a greater appreciation for the value of evidence.
Downside Risks	• Community-based decision-making can be driven by emotion and politics rather than data. • Community-based organizations and residents may choose ineffective or even counterproductive strategies. • The community might come up with strategies that the foundation believes to be ineffective or inappropriate, leading to "bad" implementation grants. • Community-based processes can generate conflict, confusion and frustration for the foundation and for local actors.	• Local organizations may choose to adopt programs that have evidence but are inappropriate to the local context (e.g., required resources not available). • Foundations can incentivize adoption, but can't control fidelity of implementation. • Because the program was developed elsewhere, local actors may not feel committed to implementing and sustaining it. • Community-based organizations may resent the foundation for not trusting the community, and for honoring research more than local wisdom.

opposites while avoiding the limits of each" (Johnson, 1992, p. xviii). This philosophy is at odds with the idea of holistic alignment, which holds that strategies should be aligned around a coherent philosophy (and thus should be based on consistent theories of change).

Polarity Management also assumes that an organization's strategies will (and should) evolve according to a dynamic flow from one pole to the other and back again. The process begins by developing a strategy based on one end of the polarity. When that strategy is actually put into practice, a set of shortcomings will inevitably arise,

implying that at least some expectations won't be met. Rather than focusing on trying to improve the design and implementation of the strategy, Polarity Management calls for the organization to identify and understand the shortcomings that are inherent in the underlying philosophical foundation on which the strategy was built. The fundamental notion behind Polarity Management is that a strategy's most important shortcomings can be remedied by paying attention to the truths associated with the opposite end of the polarity.

Polarity Management also has implications for evaluation. In addition to evaluating how fully

the strategy is implemented and achieves its objectives (which all evaluations do regardless of orientation), Polarity Management emphasizes the importance of identifying the strategy's shortcomings. Even more specifically, evaluation should identify shortcomings that arise specifically because the strategy is operating from a particular philosophical orientation. This will guide the organization in deciding which features of the competing perspective need to be incorporated to improve the strategy's effectiveness.

Accommodating Both Philosophies at The Colorado Trust

Polarity Management suggests that a foundation can simultaneously accommodate a community-based philosophy and an evidence-based philosophy, rather than selecting one over the other. This is accomplished by affording respect and discretion to community-based organizations and residents, while at the same time bringing new knowledge and evidence into community settings.

We illustrate this inclusive approach to managing competing perspectives within the context of The Colorado Trust's early years as an initiative-based grantmaker. The community-based and evidence-based perspectives were both active within the foundation. Different members of the board and staff placed greater stock in one point of view over the other, but they generally had at least some respect for the contrary perspective. In practice, this arrangement meant that The Trust alternated between community-driven initiatives and efforts to promote the adoption of evidence-based programs.

Our case study describes one initiative that was grounded in the community-based philosophy (the Colorado Healthy Communities Initiative) and one that sought to increase the adoption of an evidence-based program (Home Visitation 2000). In addition to describing how each perspective was translated into specific initiatives, we present some of the key evaluation findings, especially as they pertain to the shortcomings of the initiative's underlying theory and philosophy. We then describe how the two initiatives were

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revised or augmented to address those shortcomings — by specifically incorporating key features of the competing perspective. The final section of the case study covers a later initiative, the Colorado School Health Education Initiative (CSHEI), which intentionally incorporated features of both philosophies, taking into account lessons learned from earlier initiatives.

Our intent with the case study is to illustrate what the Polarity Management approach can look like within a foundation, especially with regard to strategy design, evaluation, learning, and organizational alignment. It is important to point out that The Trust did not explicitly utilize the Polarity Management model. Instead, we view Polarity Management as a framework that helps to clarify the way in which The Trust was designing, evaluating, and refining its initiatives from 1992 to 1999.

This analysis should be regarded as a collective reflection on the part of two researchers who were deeply engaged in The Trust's strategy

development and evaluation during period in question. The first author served as director of research and evaluation during that period; the other served as an external evaluator for two initiatives, including CSHEI, and engaged regularly in The Trust's internal deliberations and organizational learning.

Background on The Colorado Trust

As noted earlier, The Trust was established in 1985 through the sale of PSL to AMI.[4] The Trust's initial endowment was just shy of $124 million, which made it the second-largest foundation in Colorado and the largest health funder.[5] The founding board had strong links to the presale medical center: six of the nine had been members of the PSL board (including the chair and vice chair) and three were physicians with the medical center (Moran, 2011).[6]

Typical of most new conversion foundations at that time, The Trust began with the intent of investing in worthy projects that had the potential to advance the health of residents. Talk of "strategic philanthropy" was still years away and The Trust was following the traditional model of grantmaking, where the foundation serves primarily as a resource to nonprofit organizations that do work in line with the foundation's mission.

John Moran, who served as The Trust's second chief executive officer from 1991 through 2005 (as well as The Trust's general counsel from 1985 through 1991), describes the early grantmaking:

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[4]See Moran (2011) for an in-depth historical account of The Colorado Trust's formation and first 20 years of grantmaking and organizational development.

[5]The philanthropic landscape in Colorado has changed considerably over the subsequent 30 years. Although The Trust's assets have grown to more than $400 million, it is no longer the largest health foundation in the state. Four more health conversion foundations have been established, one of which (The Colorado Health Foundation) is roughly five times the size of The Trust. Private foundations established by Bill Daniels and Phil Anschutz each have assets of over $1 billion. And community foundations across the state (e.g., Denver, Aspen, Boulder) have built their endowments and developed sophisticated grantmaking strategies.

[6]One of the three physicians had also been a member of the presale PSL board. The ninth trustee did not have a direct affiliation with PSL.

[The Trust] was flooded with grant requests from many different sources. It did what came most naturally, and that was to be a responsive grantmaker within certain predefined areas of interest, such as health and wellness, medical care and research, and health policy and human services. The scope of its interests broadened after a couple years to include health promotion, indigent health policy, children's issues, and Native American health. (Moran, 2011, p. 74)

Moving Toward Strategic Philanthropy

Although the board and staff of The Trust were active and visible in the local community during those initial five years, there was a growing sense among the board members that The Trust was not achieving its potential. Many nonprofits in the metropolitan Denver region had benefited from The Trust's funding, but the grant portfolio was diffuse and scattershot. This wasn't surprising, given that new funding areas were added each year, often in response to turnover in board chair. At a deeper level, the board and staff had not coalesced around a focused set of priorities and a coherent grantmaking philosophy.

A 1999 profile of The Trust written by Allen Otten for the Milbank Memorial Fund characterizes the situation:

During the early years, there was what Moran describes as "healthy discussion" (and what onlookers call "considerable skirmishing") among the staff and between the staff and the board over the future direction of The Trust. [The initial CEO, Bruce Rockwell] tended to favor more help for existing strong community-service organizations, the doctors on the board urged more for medical research, and several board members searched for programs that would make a bigger splash for The Trust. (Otten, 1999, p. 37)

The 1990 board retreat provided the venue for moving The Trust onto a more strategic path. One board member who had consistently argued for a sharper focus, Bob Alexander, raised the defining question: How do we know we are making any difference? The ensuing conversation led to the decision to conduct an environmental scan of the social, economic, political, and technological trends and forces at work in Colorado. The

premise was that by understanding the needs, opportunities, and threats facing the state, The Trust could determine what it should do to be most effective in promoting the health of residents. Walter LaMendola, The Trust's vice president for research, led the scan and enlisted the entire staff and a contingent of consultants to carry out interviews, focus groups, and secondary data analysis.[7] All grantmaking was suspended for the 18 months that the scan was underway.[8]

The scan provided a comprehensive view of the many factors affecting the health of Coloradans and also predicted how those factors could shift in the coming years (under three scenarios).[9] The analysis went well beyond the approach of a traditional health assessment; it emphasized the structural determinants of health, including the distribution of wealth and allocation of resources throughout society, as well as the ways in which institutions and communities function or fail to function. With this analysis as backdrop, LaMendola made the case that The Trust should stake out a more proactive role and explicitly address the deeply rooted issues that prevent Coloradans from achieving optimal health and developing their human potential.

The board agreed with LaMendola that The Trust should become more strategic with its resources and should seek to effect change on a statewide basis rather than focusing so much attention on the Denver metro region. These two principles led the board to shift from responsive grantmaking to foundation-defined initiatives.

[7]In committing to carry out the scan and develop a strategy based on the findings, the board was effectively moving away from philosophy of philanthropy that Rockwell had championed. Rockwell left The Trust in 1991 while the scan was underway. He was replaced by The Trust's general counsel, John Moran.

[8]The Trust was able to meet its payout obligations because the board had approved a $30 million grant in 1991 to support the "buy back" of the PSL health system from AMI, returning the system to nonprofit status. See Otten (1999) and Moran (2011) for detailed accounts of this controversial transaction.

[9]A summary of findings from the scan, Choices for Colorado's Future: Executive Summary, was released in the summer of 1992 (Colorado Trust, 1992). The full 769-page report was released the following year (LaMendola, Martin, Snowberger, Zimmerman, & Easterling, 1993).

The essential idea behind initiative-based grantmaking was that the board would identify specific health issues where it wanted to have an impact and then the staff would determine how The Trust could actually achieve impact on those issues.

Grantmaking Through Initiatives

The essential idea behind initiative-based grantmaking was that the board would identify specific health issues where it wanted to have an impact and then the staff would determine how The Trust could actually achieve impact on those issues. Based on background research, advisory committees, and expertise provided by consultants, the program staff would design an initiative that would combine grants and other forms of support (e.g., technical assistance, convening, research) within a theoretical framework. Initiatives would generally support multiple organizations or communities across the state, with each grantee carrying out parallel work and coming together in periodic networking meetings to learn from one another.

Competing Theories of Change

As The Trust set out on the task of developing initiatives, some members of the board and staff were interested in supporting community-driven problem solving, others wanted to disseminate evidence-based programming, and some wanted to do both.[10]

[10]There was also an interest in increasing the availability of health care providers and access to health care services, but no firm notion on how to advance those goals. At this point in its history, The Trust deliberately avoided venturing into work that might be interpreted as policy advocacy.

The countervailing idea of promoting evidence-based practice originated not from the environmental scan, but from the personal beliefs and training of individual board members.

The environmental scan provided the impetus for supporting community-driven problem solving. In interviews, focus groups, and regional forums, residents across the state had described a profound sense of disenfranchisement and inability to control their own destiny. The following two passages from the Choices for Colorado executive summary (Colorado Trust, 1992) summarize this finding:

> Many participants in this study report that Coloradans are not participating in decisions that affect and determine their future. … Lack of participation or the perception of exclusion appears to threaten democratic values more than any other underlying dynamic identified in this study. … Study members see participation as the single most important remedy to the problems discussed in this report. (p. 13)

> [Coloradans] speak widely of needing a sense of community, a measure of control over their own destiny, and a feeling of being connected with family, neighborhood, and government. They want to meet these needs through a new covenant between themselves and others that respects multicultural diversity and works to further the common good. (p. 15)

Building on this sentiment, the staff and board articulated a philosophy that explicitly endorsed the wisdom of "the community." This was reflected in The Trust's vision statement, which was developed at the 1993 board retreat and approved by the board in 1994. That statement, "Vision 2000," contained the following passages:

> The Trust works in partnership with its grantees, building on their strengths, spirit, efforts, talent,

and conviction to achieve goals. … The Colorado Trust believes in the intrinsic capacity of local communities to define and solve their own problems. (Colorado Trust, 1995, p. 22)

The countervailing idea of promoting evidence-based practice originated not from the environmental scan, but from the personal beliefs and training of individual board members. Three of the nine members were physicians who personally relied upon scientific findings as a means of choosing the right course of action. Another five of the board members had strong business backgrounds and a keen mind for monitoring investment portfolios. They talked regularly at board meetings about data-driven decision-making and evaluating impact.

The board's interest in metrics and evidence led to the hiring of Walter LaMendola as the vice president for research and information in 1990. The board also allocated funds to hire two research associates in 1991–92. In addition to orchestrating the environmental scan, LaMendola commissioned evaluation studies of some of The Trust's largest grant-funded programs and organizations. These studies assessed program outcomes with the intent of guiding The Trust's future grantmaking decisions. Programs with positive outcomes would be re-funded and possibly disseminated either across the state or nationally. Programs that were not achieving their objectives would not warrant further investment.

Contrasting Initiatives

Building on these two distinct philosophical frameworks, The Trust followed two parallel paths in developing its initial round of initiatives. The first path involved creating community-level forums and processes that would allow a broad range of community stakeholders to come together to explore local issues and generate locally relevant strategies. These community-based planning and problem-solving efforts generally required participation from a broad range of local stakeholders. The Trust hired professional facilitators from outside the community to help the groups carry out the planning steps and to find consensus on

solutions and action plans. The first initiative to follow this approach was the Colorado Healthy Communities Initiative (CHCI).[11]

The second line of initiatives focused on disseminating specific program models with at least some research evidence. The first initiative under this approach was Home Visitation 2000 (HV2000), which was designed to encourage agencies across Colorado to adopt David Olds' model of home visitation for pregnant and parenting mothers. (This program is now called the Nurse-Family Partnership program, but at the time it was generally referred to as "the Olds model of home visitation.") HV2000 funded an experimental study comparing the nurse model against a model of home visitation that used paraprofessionals as visitors. The initiative was based on the theory that agency directors and policymakers would move toward the Olds model if a definitive test showed that it was superior to the approaches they were currently using.[12]

The following sections provide a deeper examination of one initiative reflecting the community-based orientation, CHCI, and one reflecting the evidence-based orientation, Home Visitation 2000. These were the two most expensive and longest-running initiatives launched by The Trust in the 1990s. For the purposes of this article, each initiative is instructive in illustrating how The Trust adapted its strategies and theories of change to address shortcomings in the

initial design.[13] For each initiative, those adaptations involved acknowledging the validity of the contrasting perspective (i.e., the one that was not considered when formulating the original theory of change).

Colorado Healthy Communities Initiative

The Colorado Healthy Communities Initiative was the first initiative launched by The Trust when grantmaking resumed in 1992. Under CHCI, The Trust offered communities across the state an opportunity to engage in an inclusive process of assessment, visioning, and planning that would lead to an action plan to improve community health. CHCI was initially conceived as a $4.5 million, five-year initiative, but grew in scope to eventually become an $8.8 million, eight-year investment that supported health-improvement planning and implementation in 29 communities across Colorado (Conner & Easterling, 2009).

Initiative Design and Theory of Change

CHCI's design was based on the theory that communitywide improvements in health could be stimulated by bringing together a large group of stakeholders who represented the different sectors and perspectives that make up the community, and then taking them through an in-depth process of assessment, planning, and consensus decision-making. CHCI operationalized these principles into an initiative by incorporating the Healthy Cities model developed by the World Health Organization (1986) in the mid 1980s. Healthy Cities is premised on a broad definition of health (extending beyond the absence of disease) and broadly participatory decision-making and priority setting (Hancock & Duhl, 1986). A number of cities in Europe and Canada pursued the Healthy Cities approach during the 1980s, each in their own way (Kickbusch, 1989). With CHCI, The Trust worked closely with the National Civic League (NCL) to create a more structured model of planning and stakeholder engagement. NCL was the natural partner

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[11]A second initiative that followed this general design was the Teen Pregnancy Prevention 2000 Initiative, which brought together representative stakeholder groups in six Colorado communities to explore the factors leading to teen pregnancy in their community and to find high-leverage strategies to address the underlying determinants (Gallagher & Drisko, 2003).

[12]Shortly after the introduction of Home Visitation 2000, The Trust introduced a second initiative designed to promote the adoption of a model program. The Preconception Health Promotion Initiative used grantmaking to incentivize three institutions located in cities along Colorado's Front Range region (Colorado Springs, Fort Collins, and Greeley) to adopt a specific health-education program aimed at reducing the risk of low birth weight and poor birth outcomes. Rather than educating women early in pregnancy, the preconception program aimed at young women before they conceived and even before they were planning to get pregnant. The preconception program had a much less extensive research base than did the Olds model of home visitation.

[13]Carol Weiss introduced the term "theory of change" in her seminal 1995 article, but the basic idea was incorporated within The Trust's strategic planning and evaluation years earlier. For example, the requests for evaluation proposals issued in 1993 used path-oriented figures to lay out the theory underlying the initiatives.

CHCI's theory of change presumed that a diverse group of local residents could, with the assistance of expert facilitators, reach a deeper understanding of the health-related issues facing the community, set a common vision for becoming healthy, identify strategic leverage points that would move the community in that direction, and design and carry out concrete projects that would initiate the change process.

because it had played a lead role in bringing the Healthy Cities concept to the United States and had access to an extensive network of expert facilitators who could guide local groups of residents through the CHCI process.

CHCI's theory of change presumed that a diverse group of local residents could, with the assistance of expert facilitators, reach a deeper understanding of the health-related issues facing the community, set a common vision for becoming healthy, identify strategic leverage points that would move the community in that direction, and design and carry out concrete projects that would initiate the change process.

Results

In many ways the CHCI stakeholder groups were highly successful in meeting the expectations of the planning model, with 28 of 29 groups completing the process and submitting an implementation proposal to The Trust (all of which were funded). Across these communities,

between 14 and 130 individuals participated in the process, with the majority attending at least most of the monthly meetings over a 15-month process (Conner, Tanjasiri, et al., 2003; Conner & Easterling, 2009). Stakeholders committed a remarkable degree of time and attention to the many steps that the model required and produced action projects in line with the agreed-upon goals. The nature of those action projects, however, did not match what the board and staff of The Trust had in mind when designing CHCI.

The board in particular had expected that each action plan would contain multiple projects aimed directly at improving access to health care, improving health behaviors, and/or addressing risk factors that directly influence health status. Indeed, The Trust presented each stakeholder group with guidelines indicating that implementation grants would be available for projects that advanced the Healthy People 2000 objectives. Instead of readily identifiable efforts to prevent disease and promote health, the vast majority of the CHCI stakeholder groups proposed projects that would build social capital, increase civic participation, develop new leaders, and continue the process of collaborative planning and problem-solving that had begun with the planning phase (Conner & Easterling, 2009).

The theory of change for the CHCI also included the expectation that stakeholder groups would choose and design their action projects based on existing knowledge and would seek out best practices. To support informed decision-making, The Trust allowed each stakeholder group an $8,000 line item to hire consultants with expertise on the issues that came out as priorities from the planning process. In practice, none of the groups took advantage of these funds. Perhaps not surprisingly, the projects described in the proposals for implementation grants were of uneven quality and rigor. But honoring its stated commitment to community-based decision-making, the board approved $100,000 implementation grants for all 28 of the communities that completed the planning phase.

Although many of the implementation plans did not measure up to what the board and staff

had envisioned during the design of CHCI, the initiative actually produced a variety of meaningful outcomes during and after the two-year implementation phase. The CHCI communities launched a host of important projects, programs, and initiatives, including health clinics, family resource centers, recreation facilities, a mobile van, leadership training programs, civic forums, and even a new community foundation. Moreover, most of the organizations that were established to extend the CHCI planning process became vehicles for regional planning and problem solving, which in turn fostered new transportation systems, health centers, and low-income housing units (Conner & Easterling, 2009; Easterling, Conner, & Larson, 2012). These longer-term, larger-scale projects generally weren't included in the initial action plan, but rather emerged as the CHCI process continued to unfold (Easterling, 2014).

Shortcomings

Despite the fact that CHCI ultimately produced large-scale projects that advanced community health, a number of shortcomings in the CHCI model came to light early in the implementation process. While the stakeholder groups stuck together and carried out the prescribed planning work, they didn't always identify factors that could truly provide strategic leverage (what the NCL facilitators called "trend benders"). Focus areas and projects were sometimes selected as a function of the specific interests of individual stakeholders rather than a logical analysis. The requirement that stakeholders reach consensus (defined as a decision that "everyone would agree to live with, even if they did not fully support") sometimes discouraged groups from choosing bold, innovative projects with high potential for impact (Conner & Easterling, 2009).[14]

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[14]The requirement for consensus had even more of a dampening effect within the Teen Pregnancy Prevention 2000 Initiative because of the controversial nature of teen pregnancy. This initiative required each participating group to reach out to and include stakeholders who represented all perspectives and to reach agreement on a comprehensive strategy for addressing teen pregnancy within their community. Not surprisingly, the groups developed plans that paid little if any attention to contraception, abortion, and sexuality education, despite the fact that nearly all evidence-based programs fell into these categories (Gallagher & Drisko, 2003).

At a more general level, The Trust's experience with CHCI (especially during the first two years of implementation) called into question the core assumption that communities have the capacity to define and solve their own problems. Communities might have the capacity, but they often needed to develop specific skills and to gain specific knowledge, especially when it comes to assessing the merits of alternative solutions.

These shortcomings were partially due to imperfect design and implementation of the CHCI model, but also reflected some wishful thinking and theorizing within CHCI's theory of change. The Trust and NCL presumed that local residents can capably engage in a complex strategic-planning process and make informed choices all along the way. Even agency heads find this work challenging. The theory also assumed that people without specialized training or experience could design effective projects and determine what would be needed to implement them. CHCI also was grounded in a belief that diverse groups of residents can find common ground and agree on what needs to happen to produce fundamental improvements in community health and well-being. These assumptions were confirmed within some CHCI communities but refuted in others.

At a more general level, The Trust's experience with CHCI (especially during the first two years of implementation) called into question the core assumption that communities have the

The second initiative approved by the board following the resumption of grantmaking in 1992 was a stark contrast to CHCI. Home Visitation 2000 was launched in 1993 as a means of demonstrating to social-service providers across the state that a nurse-based model of home visitation for young pregnant and parenting mothers was more effective than using less formally trained peer counselors to deliver these services — which was then the predominant approach across Colorado.

capacity to define and solve their own problems. Communities might have the capacity, but they often needed to develop specific skills and to gain specific knowledge, especially when it comes to assessing the merits of alternative solutions. The Trust also learned that capacity by itself wasn't sufficient to ensure that effective programs and projects would be developed and implemented. Personal interests, political considerations, and contextual factors often distract people from pursuing the most effective path.

Augmentation

Recognizing these shortcomings and nuances, The Trust augmented CHCI with a special funding opportunity in 1995 that allowed 15 of the funded communities to develop a set of community indicators for assessing and monitoring health. The basic idea behind the Community

Indicators Project (CIP) was that the new CHCI organizations formed out of the planning process would each translate their vision statement into a set of quantitative indicators and compile the data necessary to measure how the community was doing along each dimension. By repeating the assessment at regular intervals, local organizations and elected officials would be able to focus resources on critical issues and track the progress of their efforts (Conner, Easterling, Tanjasiri, & Adams-Berger, 2003).

This strategy drew directly from the other end of the community-based versus evidence-based polarity. While local groups would still be encouraged to make their own decisions about which indicators to include in their index, the net result would be more emphasis on metrics and a more bottom-line orientation to selecting strategies and developing programs. The CIP approach produced this result in at least some of the participating communities, where the published reports were disseminated to local decision-makers and incorporated directly into community and regional planning efforts (Conner, Easterling, et al., 2003). Some groups were able to continue publishing indicators reports even after The Trust's funding ended, including Yampa Valley Partners (2015), which recently published a 2014–15 report.

Home Visitation 2000

The second initiative approved by the board following the resumption of grantmaking in 1992 was a stark contrast to CHCI. Home Visitation 2000 was launched in 1993 as a means of demonstrating to social-service providers across the state that a nurse-based model of home visitation for young pregnant and parenting mothers was more effective than using less formally trained peer counselors to deliver these services — which was then the predominant approach across Colorado. This $7.1 million initiative used a randomized controlled experiment to directly test the nurse model that David Olds had developed in his research in Elmyra, New York, and Memphis, Tennessee, against a comparable approach that substituted "paraprofessional" home visitors for bachelors-trained nurses. It was hoped that a rigorous study would conclusively establish the

superiority of using nurses, which in turn would persuade providers to alter their practice.

Developing an Initiative to Promote Evidence-Based Practice

The board began exploring Olds' home-visitor model in 1992, when the program staff identified this as one of only a handful of programs that showed actual evidence of improving birth outcomes. In his original study in Elmyra, Olds had shown impressive reductions in childhood injuries and improvements in cognitive development, as well as increased employment and education among mothers. These effects were particularly pronounced when the mother was poor (Olds, Henderson, Chamberlain, & Tatelbaum, 1986; Olds, Henderson, Tatelbaum, & Chamberlain, 1986). A follow-up study in Memphis was beginning to show consistent findings among an African American population, extending the generalizability of the model's effectiveness beyond the white, rural mothers who participated in Elmyra (Olds, Kitzman, et al., 2004). The board was especially impressed that both of these studies had used randomized controlled designs. Most evaluation findings on home-visitor programs came from single-group pre-post assessments.

After hearing about the program's outcomes, the board invited Olds to visit The Trust and describe his research in more depth, as well as to discuss future directions. At that point, Olds was on faculty at the University of Rochester in upstate New York. His visit to Denver in late 1992 stimulated considerable interest among the board members, as well as speculation about how The Trust could play a leadership role in disseminating the nurse model throughout Colorado. Olds suggested a head-to-head experimental test between the nurse model and the paraprofessional model. The board was intrigued with this idea, but also cautious because of the high cost of such a study. Over the next few months, the staff provided the board with analysis and options, including the possibility of co-funding the study in conjunction with other foundations. The Memphis study had been funded in this way, with Olds obtaining grants

from eight private and federal funders. But this approach had, according to Olds, delayed the start of the study by at least three years. The Trust's board was interested in proceeding with the nurse-paraprofessional study as quickly as possible, and began looking at the high price tag as a test of its commitment to the strategy.

In the end the board agreed to fund the entire cost of the study, partly because this would expedite the process, partly because it would allow The Trust to have more control over how the study would be integrated into a larger strategy, and partly because investing $7 million made it clear that The Trust was staking out a leadership position in promoting the dissemination of evidence-based program models. The board recognized the risk inherent in this approach, especially the possibility that the nurse model might not emerge as statistically superior to the paraprofessional model. However, the board also saw upsides if the study did turn out as hoped, especially with regard to gaining a national reputation among health foundations. A number of board members referred to HV2000 as The Trust's "moon shot" — an expensive investment but with a huge potential payoff.

The Trust's investment paid off in ways that went well beyond carrying out an experimental test of nurses versus home visitors. The grant provided an opportunity for the University of Colorado Health Sciences Center to recruit Olds into a faculty position. Once in Denver, Olds established the National Center for Children and Families, which was dedicated to disseminating the "nurse family visitor" model and providing training to local sites. Subsequently the program model was standardized and branded as the Nurse-Family Partnership program. The National Center evolved into the Nurse-Family Partnership National Service Office, which has supported communities across the country in implementing the program, as well as advocating for federal policy and funding streams in support of it.

Initiative Design

While The Trust's investment in HV2000 eventually contributed to the national dissemination of Olds' model, this occurred through a different

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It is important to point out that the HV2000 strategy included more than funding an experimental study. The Trust also convened a large advisory committee that included local agency directors, health scientists, elected officials, and representatives from state agencies. This committee had a dual mission: (1) to advise the study team on research design, carrying out the study, and interpreting the findings; and (2) to serve as a vehicle for disseminating findings from the study and translating those findings into policy and practice.

pathway than the board and staff had in mind in 1993. The original HV2000 strategy involved collecting evidence that would persuade agency directors and policymakers to adopt and fund the nurse model in place of the less rigorous home-visitor models that were then in widespread practice.

It is important to point out that the HV2000 strategy included more than funding an experimental study. The Trust also convened a large advisory committee that included local agency directors, health scientists, elected officials, and representatives from state agencies. This committee had a dual mission: (1) to advise the study team on research design, carrying out the study, and interpreting the findings; and (2) to serve as a vehicle for disseminating findings from the study and

translating those findings into policy and practice. The advisory committee was specifically constructed to include some of the best-known leaders of paraprofessional home-visitor programs operating across Colorado. These leaders were in many ways the primary audience that The Trust hoped to reach with study findings, because they would be the ones who would need to change their program design if and when the nurse model was shown to be superior. The board and staff of The Trust believed that by engaging agency leaders in up-front discussions about the intent and design of the study, the study would be viewed as a legitimate method to arbitrate the relative merits of the nurse model versus the prevailing models. This acceptance in turn would, at least according to the theory of change, facilitate the adoption of the most effective model.

Designing the study to achieve The Trust's objectives raised a dilemma with regard to the specific interventions that would be received by the treatment and comparison groups. It was clear that one group would receive the nurse home-visitor program that Olds had defined based on his research in Elmyra and Memphis. It was also clear that there would be a second treatment group that would receive home visits from a paraprofessional, as well as a control group that would not receive home visits. For the paraprofessional treatment group, Trust staff initially proposed that Olds create a protocol for the home visits that would approximate the prevailing practice of the home-visitor programs that were operating in Colorado. Olds pointed out a number of shortcomings to this design, including the difficulty of finding a "prevailing program" when so many different variants were in practice. More fundamentally, Olds believed that the critical research question that needed to be answered had to do with who delivered the services, either a nurse or paraprofessional. He wanted to equate the program content so that the analyses could isolate the effect of visitor type. The Trust agreed that this experimental comparison was important, especially from a long-term and global perspective. Thus the study compared two different types of home visitor (nurse and paraprofessional), each of whom carried out the standard Olds protocol for home visits. These two

treatment groups were each compared against a control group, where mothers were provided with free developmental screening and referral to treatment (Olds, Robinson, et al., 2004).

Results

The Denver trial ran from 1994 through 1999 and produced ambiguous findings (Olds, Robinson, et al., 2004). On some outcome measures, the group visited by nurses had significantly better outcomes than the control group; on other measures, the paraprofessional group had better outcomes than the control group. Nurse-visited mothers had a longer time interval until the birth of the second child and also reported less domestic violence than the control group. In contrast, the mothers served by paraprofessional visitors were less likely than the control group to have a low-birth-weight baby in subsequent pregnancies. They also reported a greater sense of mastery and better mental health than the control group.

The HV2000 study failed to generate the evidence that The Trust had hoped would make a convincing case for Olds' nurse home-visitor model. Long before the findings were published in 2004, however, other shortcomings in the HV2000 strategy had presented themselves. When the advisory committee first convened in 1994 it was apparent that there was a deep philosophical divide between the scientists and the local agency leaders, with the policymakers and state agency representatives occupying more of a middle ground. The local agency directors came with a strong belief that their home-visitor programs had value and were well suited to the local context. They pointed out that the Olds model was much more expensive and that it required bachelors-trained nurses to serve as home visitors. Both factors made it difficult to establish and sustain the program, especially in rural communities where bachelors-trained nurses are in short supply. In addition, some committee members questioned whether the experimental study would actually provide a relevant comparison because the paraprofessional model being tested was different from the service they were providing. Perhaps most fundamentally, the agency directors on the committee found it difficult to accept that The Trust had invested $7 million in

academic research rather than channeling the funds into grants for local programs.

The HV2000 study continued to gather data and the advisory committee continued to meet throughout the mid-1990s. Over time it became more and more clear to Trust staff that the vast majority of the 100-plus home-visitor programs operating in Colorado were unlikely to change course in response to the study findings, regardless of how compelling a case they might make for the nurse model. Although agency directors were very interested in generating outcomes in line with what Olds had produce in the Elmyra and Memphis studies, they did not necessarily aspire to run programs with that level of intensity and formality. Most home-visitor programs in Colorado simply did not have the staffing, financial resources, or organizational infrastructure that Olds' nurse model required.

Augmentations

Recognizing that evidence alone was unlikely to change practice, The Trust created a more community-based project to augment HV2000. Rather than trying to persuade the directors of local home-visitor programs to adopt the Olds model, the Home Visitation Learning Groups initiative (HVLG) convened regional clusters of program leaders to engage in peer learning and exploration of best practices. The intent was to "develop the capacity of individuals and organizations delivering home visitation in Colorado to use research literature, program evaluation, and critical reflection on practice as tools for program planning and program improvement" (Miller, Kobayashi, & Hill, 2003, p. 174). Five learning groups, comprised of leaders and program managers from 30 agencies, carried out two years of facilitated logic modeling, clarification of program intent, exploration of research literature, peer learning, and program refinement. An independent evaluation found that the vast majority of participating agencies made changes in their home-visitor programs based on the learning process. Participants reported that they valued the chance to define program goals based on their agency's own interests and perspective, as well as to decide for themselves which information to

The HV2000 and HVLG initiatives each provided a reality test of what is required for local adoption and implementation of a new program, especially one that requires significant resources and training. It became clear that, regardless of the evidence base, communities would adopt the nurse model only when key local actors had had a chance to decide for themselves that the program was valuable and appropriate. Such a realization is directly in line with what Polarity Management would recommend when an organization is operating from an evidence-based perspective.

<div style="writing-mode: vertical-rl;">REFLECTIVE PRACTICE</div>

consider when looking for ways to improve program effectiveness (Miller, et al., 2003).

The evaluation of HVLG raised a caveat with regard to the connection of the learning group process to the larger HV2000 initiative. The person serving as the executive director of HVLG was also the director of the Denver-based National Center for Children and Families, which was serving as a vehicle to promote dissemination of the Olds model. According to the evaluators,

Although [she] was widely revered by virtually all learning group participants, there was some concern among participants and facilitators that, because of her institutional affiliation, the initiative might have an underlying agenda at odds with the learning group's philosophy. In particular, her connections to [the study of the Olds model] suggested to some that the initiative was intended to displace existing community-based home visitation programs with that particular model. (Miller, et al., 2003, pp. 189–190)

While the directors of home-visitor programs across Colorado remained largely unconvinced that they should be moving toward the nurse model, the accumulated experiences of the HV2000 advisory committee and HVLG led to a shift in dissemination strategy on the part of the National Center for Children and Families. Initially the center had focused primarily on conducting randomized controlled studies to generate rigorous evidence in support of the Olds model, and then bringing that evidence to federal and state policymakers as a means of creating new streams of public funding dedicated to implementing the model in community settings. The HV2000 and HVLG initiatives each provided a reality test of what is required for local adoption and implementation of a new program, especially one that requires significant resources and training. It became clear that, regardless of the evidence base, communities would adopt the nurse model only when key local actors had had a chance to decide for themselves that the program was valuable and appropriate. Such a realization is directly in line with what Polarity Management would recommend when an organization is operating from an evidence-based perspective.

The specific approach that the National Center for Children and Families used to create community readiness for the nurse home-visitor model involved forming a collaborative partnership among local health departments, social service agencies, school systems, elected officials, and civic leaders. These partnerships would explore the needs of families and children in their community, and then consider the potential benefits of the Olds model of home visitation, which by then was known as the Nurse-Family Partnership (NFP) program. A Denver-based nonprofit organization called Invest in Kids (IIK) was formed in 1998

to provide facilitation and technical expertise to the partnerships, including assisting with recruiting stakeholders, building community commitment to the NFP program, and supporting the implementation process within the agency that was selected to operate the program (Hicks, Larson, Nelson, Olds, & Johnston, 2008). The Trust was a major funder of IIK during this initial phase of disseminating the NFP.

Invest In Kids began cultivating partnerships across Colorado in 1999. By 2003, 16 partnerships had been established and were actively working to promote local implementation of the NFP program. At that point, more than 2,800 families were enrolled in NFP within 50 of Colorado's 64 counties (Hicks, et al., 2008).

This experience demonstrates the need to move beyond an evidence-based orientation in order to promote the adoption of effective programming. It is important to also engage a range of local actors in a process of assessment, learning, and open-ended decision-making.[15] As further testament to the importance of good community process, Hicks and his colleagues (2008) found that the partnerships with the most transparent decision-making were more likely to create the conditions that allowed successful implementation of NFP. In particular, in those communities where the partnership had a higher "authenticity" score (as measured with items that deal with openness and credibility of the process, as well as the degree to which the process is free from undue influence from special interests), the NFP program had lower attrition rates among the enrolled families.

Integrating Community-Based and Evidence-Based Perspectives on the Front End

CHCI and HV2000 were formulated according to contrasting views of how a foundation can best support the development of new community-level programming aimed at improving health. For each initiative, The Trust recognized

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[15]This finding is entirely consistent with the RE-AIM framework for implementing evidence-based programs (Glasgow, Vogt & Boles, 1999).

In retrospect it is perhaps easy to see the limitations of each of these two theories of change. Local communities do not always reach optimal decisions about how to improve health, even when a foundation provides a well-designed model of strategic planning and expert facilitation. On the other side of the ledger, rigorous research studies don't always inform the programming of service agencies, nor should they.

relatively early that the defining perspective had shortcomings. The community-based perspective didn't allow the foundation to inject research findings or recommendations into the decision-making process, while the evidence-based perspective falsely assumed that program managers and agency leaders would (and should) choose and design their programs based on particular scientific evidence. The Trust responded directly to this learning by augmenting CHCI and HV2000 in ways that drew from the wisdom of the competing perspective, but these were reactive approaches that only partially addressed the fundamental shortcomings inherent in the original initiative design.

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In order to be out in front of the shortcomings, The Trust revised its initiative-planning process in 1994 to actively consider both perspectives during the design phase. The defining question became "How can The Trust respect the right of local communities to make their own decisions while at the same time promoting the adoption of evidence-based programs?"

The Trust attempted to answer this question with the Colorado School Health Education Initiative (CSHEI), which sought to improve health-education curriculum and training programs in 21 school districts across the state. CSHEI's strategy explicitly blended scientific research with a rigorous approach to community planning in order to encourage districts to select and implement locally relevant, evidence-based curricula. The following section provides more specifics on how the CSHEI advanced both the community-based and the evidence-based philosophies.[16] (See Table 3.)

Colorado School Health Education Initiative

CSHEI was a five-year, $6.5 million initiative launched in 1994 as a means of reducing a variety of risk behaviors among school-age youth (Main, Fernald, Judge Nearing, Duffy, & Elnicki, 2003). The Trust's board and staff viewed the school setting as a particularly fruitful venue for influencing behavior on a populationwide level. There was also a keen recognition that behaviors established in adolescence, either risky or healthy, have a determinative effect on a person's health outcomes across the life span. Promoting the adoption of effective and comprehensive

health education within schools across the state was seen as a critical strategy for improving the health of Coloradans for generations to come.

The rationale for focusing on school-based health education was even more compelling because prevailing practice in this arena was suboptimal. The state of Colorado did not mandate that schools include health education in their core curricula, leaving it to individual districts and even individual teachers to determine what, if anything, would be taught. Before settling on the idea of working with individual districts across the state, some of The Trust's board members proposed an advocacy campaign to encourage the passage of legislation that would require standardized health-education curricula. But other board members pointed out that prior efforts in this regard had been unsuccessful and frustrating. Moreover, the political landscape of Colorado — with some very conservative communities, such as Colorado Springs, and some very liberal communities, such as Boulder — would make it extremely difficult to reach consensus on what curricula should be taught.

Initiative Design and Theory of Change

Setting aside, at least temporarily, the idea of changing educational policy at the state level, the staff and board began exploring what a locally oriented strategy might look like. To inform their thinking, The Trust engaged the Rocky Mountain Center for Health Promotion and Education (RMC), a Lakewood-based training organization which had a 25-year history of providing staff development to school health educators across the country on evidence-based health-education curricula. RMC had a sophisticated understanding of how to work with school administrators as well as classroom teachers to implement health-education curricula. Rather than engaging in debates around ideology or values, they remained focused on what existing research tells us about the effectiveness of alternative programs in improving health behavior. Moreover, because many RMC staff members were former teachers, they fully appreciated the practical realities and competing demands that come into play when attempting to deliver a health-education curriculum.

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[16]Shortly after the introduction of the CSHEI, The Trust introduced a second of these hybrid strategies, the Colorado Violence Prevention Initiative. This initiative supported 26 community-based organizations and coalitions in developing violence-prevention programming that would be relevant to the community's most pressing violence issues while also based on evidence. In addition to providing grants to fund program development and operation, The Trust hired the Center for the Study and Prevention of Violence at the University of Colorado to work individually with the grantees as they designed their programs. The center brought research findings on the predictors of the particular type of violence that the organization was addressing, as well as evidence on various programs and policy approaches that might be relevant for that issue (OMNI Institute, 2001).

TABLE 3 Assumptions and Pathways for the Colorado School Health Initiative (a Hybrid of Community-Based and Evidence-Based Philanthropy)

ASSUMPTIONS	
Responsibility of local actors in selecting programs and setting strategy	A representative community-based committee is responsible for choosing health-education programming based on local needs, community values, and research evidence.
Which programs are assumed to be most effective?	Programs that have been selected to fit the local context and that have an evidence base indicating that they will be effective in that context
THEORY OF CHANGE PATHWAYS	
What are the key steps in achieving impact?	• Activate local actors to engage in a process to identify critical health needs and opportunities for intervening in K-12 settings • Review candidate programs and assess fit and evidence • Engage the larger community in decision-making and consensus building • Implement the selected programs with fidelity • Change policy and institutions to support the strategies • Evaluate and adapt the strategies to optimize impact and remain relevant
Role of the foundation in fostering positive impact	• Provide forums and resources that help activate local actors and that support community-based analysis and planning • Bring evidence-based models to the attention of organizations that could benefit from adopting them • Provide grant funding to implement evidence-based models • Help organizations build the capacity and infrastructure to implement evidence-based models (e.g., through staff training) • Assist in changing policy and institutions to support community-driven strategies

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The Trust built CSHEI around the idea of helping districts to select and implement comprehensive, research-based curricula. RMC was brought in as the managing agency for CSHEI, but Trust staff also played key roles in designing the initiative. In particular, The Trust brought more of a communitywide orientation to the curriculum-selection process than RMC was accustomed to supporting. Building on its experience with CHCI and Teen Pregnancy Prevention 2000 Initiative, The Trust contended that the larger community, not just schools, must have a voice in decision-making if comprehensive school health-education programs are to be valued, implemented, and sustained.

CSHEI codified the principle of community-based decision-making in the form of formally chartered advisory committees. Each of the 21 funded districts was required to have a Health Education Advisory Committee (HEAC) to serve as a forum for reviewing curricula and overseeing implementation. They were typically composed of parents, students, clergy, health and business professionals, district- and school-level administrators, teachers, and school nurses.

Beyond promoting the adoption of evidence-based curricula, CSHEI also succeeded in building the capacity of the participating communities to adopt and sustain effective school health-education programs.

Committee members worked together to establish the criteria for curricula selection, as well as to set decision-making rules and group norms.

The HEACs were tasked with recommending specific health-education curricula to the respective school boards, as well as to other administrative bodies with oversight over health education. Under CSHEI, the participating districts were required to decide on two distinct forms of health education:

1. a comprehensive health-education curriculum that would be taught in kindergarten through eighth grade, and

2. more targeted educational programming that would be taught in high school in order to address specific health issues that were particularly critical within the local community.

The K–8 curriculum needed to be chosen from a defined set of options that RMC had determined to have a sufficient evidence base. A more open-ended choice was left for the high school programming, although the HEACs were still encouraged to consider what had been learned through research.

The RMC staff provided the HEACs with both technical expertise and general guidance on how to reach decisions that would satisfy the evidence-based and community-based considerations contained within the CSHEI approach. In line with evidence on effective health education

(Dusenbury & Falco, 1995; Dusenbury, Falco, & Lake, 1997; Kirby, 1997), RMC staff encouraged the committees to consider curricula that are research based, theoretically driven, factually accurate, developmentally appropriate, interactive, skills-based, and of sufficient duration to promote positive behavior change. They also recommended that the classes that are taught in any given grade level be built on what has been taught in prior grades.

In addition to outside support from RMC, each HEAC was supported by a local health education coordinator. These coordinators served as advocates for health education, supported teachers, and helped mobilize and sustain local support for health education. To support the curriculum-selection process, the coordinator increased awareness and stakeholder participation and facilitated curricular decision-making. The Trust funded 100 percent of the coordinator's salary and benefits for the first year, and then 75 percent in the second year, 50 percent in the third and 25 percent in the fourth. Districts agreed to increase their own funding in order to keep the coordinator funded at a full-time level. In addition to supporting the coordinator, The Trust covered the costs associated with acquiring the curricula and with training teachers and administrators.

Results

Across the 21 funded school districts, the HEACs took seriously their task of reviewing and recommending health-education curricula. The processes for curricula selection varied, but generally followed a similar pattern: establishing group decision-making norms, reviewing local data, hearing from key constituencies to assess local needs and values, establishing comprehensive health education priorities, determining selection criteria, reviewing possible curricula, deciding (through voting or consensus), public review, presenting to school board, and district school board approval. By the end of the initiative all but two of the 21 participating districts had adopted K–12 health-education curricula.

Beyond promoting the adoption of evidence-based curricula, CSHEI also succeeded in building the capacity of the participating communities

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to adopt and sustain effective school health-education programs. This occurred through the professional development of specific actors who were engaged in new work as a result of CSHEI (especially the health education coordinators, but also the members of the HEACs), as well as through the experience of carrying out a comprehensive process of selecting and implementing curricula.

At the outset of CSHEI it was generally expected that there would be less controversy surrounding health education in elementary school than in middle school or high school. Thus RMC staff counseled the HEACs to begin their process with decision-making around elementary school curricula. In practice, there was relatively little controversy of any sort across the 21 districts. When controversy did arise, it did not reach a level where it threatened to derail the decision-making process. The relative inclusiveness of curriculum-review processes, the fact that group norms and selection criteria were determined and agreed to collectively, and the presence of skilled facilitators (RMC staff and locally based health education coordinators) each contributed to an environment that tolerated disagreement but staved off conflict.

Although successful in promoting the adoption of evidence-based health education, CSHEI did not achieve its ultimate goal of ensuring that all students receive effective health education. One year after being trained on the new curriculum that their district had adopted, the vast majority of teachers (71 percent) reported that they were teaching less than half of the prescribed lessons. Only 10 percent were teaching the entire curriculum. The situation was worse a year later, when 81 percent of teachers reported that they were teaching less than half the lessons.

The major obstacle that prevented full implementation of the adopted curricula was a new statewide policy, the Colorado Student Assessment Program, which instituted student testing in reading, writing, and math. The program was enacted in the spring of 1997. Regional and local newspapers published the first round of fourth-grade reading and writing test scores

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in the fall of 1997, which put public pressure on schools to address their apparent deficiencies in these content areas. At about the same time, the governor proposed that the testing data be used to create a "report card" for individual schools. These political dynamics resulted in teachers having much less time to teach health education, particularly in the elementary-grade levels where a single classroom teacher is responsible for teaching all subject areas.

While CSHEI was able to lead a broad cross section of stakeholders through a complex and potentially controversial decision process, paying attention to research evidence as they went, the initiative was ultimately unable to overcome the dominant challenge of bringing health into parity with more traditional academic subjects. By focusing exclusively at the local level, The Trust had left itself exposed to policy developments that undermined an otherwise highly successful community-based decision-making process.

Larger Issues for Foundations as They Manage Polarities

The CHCI and HV2000 case studies demonstrate that the community-based and evidence-based approaches to grantmaking each have merit, but each approach also has its shortcomings. By recognizing and compensating for those shortcomings, The Colorado Trust was better able to achieve its ultimate goal of improving health programming across the state. Consistent with the philosophy of Polarity Management, The Trust found that its

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What Sort of Mindset Is Required?

While there is value in appreciating the merits of competing philosophical perspectives, it is not necessarily easy for people to find this equivocal, nuanced frame of mind, or to stay there if it is found. When a foundation is solving a problem or planning a project, it typically starts from a particular perspective — the one that feels most natural and that has served the foundation in the past. That perspective may feel so natural that it's difficult to recognize a contrary perspective that also offers insights. And even if staff and board

recognize that there is a competing perspective, they may be so bought into their preferred perspective that they are unwilling to acknowledge that each has limitations and merit.

Johnson's (1992) model of Polarity Management offers a set of practices that allow people and organizations to stand back and take a larger look at the upsides and downsides of competing perspectives, while at the same time working through the tensions that naturally arise when different members of an organization endorse competing perspectives. This can help organizations to find win-win strategies that respect the merits of each perspective and the validity of each person's experience. There obviously are challenges in actually achieving this level of equipoise and equanimity, especially in organizations where staff and board have strong points of view. If, however, an organization is able to live with this much ambiguity, its strategies can be made more comprehensive and effective.

Other Polarities

Polarity Management can be helpful to foundations as they navigate a variety of competing theories and philosophies. In addition to the community-based versus evidence-based tension that has been the focus of this article, two other philosophical tensions are prominent within philanthropy — both within the field and within individual foundations.

The first of these tensions involves the question of who is best suited to decide which programs should be implemented or which strategies to deploy. Some foundations (often termed "responsive") leave most of the discretion to the organizations that apply for grants, believing that they are in the best position to know what will work. Other foundations (sometimes referred to as "proactive") retain discretion internally, believing that their staff have both the expertise and the broader perspective required to determine which approaches are most likely to produce the desired results. Much of the debate around "strategic philanthropy" boils down to a fundamental question of whether foundations or grantees should be setting strategy (Kania, Kramer, & Russell, 2014;

Brest, 2015). Polarity Management would suggest that funders and grantees should find ways to collaborate and learn from one another.

A second strategic tension within philanthropy involves the preferred locus of change when seeking to create large-scale impact. During the 1990s, The Colorado Trust sought to improve population health through locally oriented change efforts. Local actors were supported in coming together to assess, plan, design programs, carry out new work, form relationships, and build capacity. It was hoped that these community-level changes would aggregate up to improve health throughout Colorado. A competing perspective would hold that the most effective strategy for improving conditions on a statewide basis is through policy change. The Trust actually moved strongly in that direction in 2006, when Irene Ibarra took over as CEO when John Moran retired. When Ned Calonge became the CEO in 2010, the pendulum swung back toward a community-oriented strategy (Csuti & Barley, 2016). Polarity Management would suggest that there is value in blending the two perspectives. Foundations such as the Health Foundation for Western and Central New York (Harder+Company, 2013) and the Health Foundation of Central Massachusetts (2016) have been intentional in this way.

Should Contrasting Philosophies Be Supported?

It is important to acknowledge that there is a competing view on whether foundations should seek to accommodate contrasting philosophies when developing their strategies. As described earlier in the article, the concept of holistic alignment would argue against embracing two competing philosophies that lead to contrasting theories of change and that point in different directions when designing strategy. The question of organizational leadership is also intimately tied to this discussion. If one views the CEO's primary responsibility as setting strategic direction for the foundation, the idea of embracing competing philosophies would seem to be counterproductive.

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This leads to the conclusion that holistic alignment and Polarity Management provide two competing views for how an organization should set strategy and organize itself. Some foundations will go one direction and some will go another. This would seem to be one of the defining questions that a foundation should consider when developing its theory of philanthropy.

A Meta-Polarity

Finally, it is interesting to point out that the contrast between holistic alignment and Polarity Management can be viewed as a meta-polarity. At one end of the meta-polarity, the principle of holistic alignment helps an organization to clarify its purpose and approach, and then to bring organizational processes and structures into alignment for maximum impact. The downside of this perspective is that the organization may be blinded to the inherent shortcomings of its strategy and may avoid looking toward contrary bodies of work that might offer useful insights. On the other end of the meta-polarity, the Polarity Management approach of actively integrating competing perspectives keeps the organization open to shortcomings and solutions wherever they might arise, but it also begets at

least some ambiguity and possibly confusion about organizational purpose and direction.

This raises the question of whether it is possible and desirable to integrate the holistic alignment perspective with a Polarity Management approach. Can an organization operate from both perspectives in a way that advances its strategy? Or alternatively, does an organization ultimately need to pick one perspective over the other? This is the definitive test of how far the concept of Polarity Management can be taken.

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