

2009

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Recommended Citation

Walker, Karen E.; Gibbons, Claire; and Navarro, Marco (2009) "Children's Futures: Lessons From a Second-Generation Community Change Initiative," *The Foundation Review*: Vol. 1: Iss. 1, Article 2.
<https://doi.org/10.4087/FOUNDATIONREVIEW-D-09-00001>
Available at: <https://scholarworks.gvsu.edu/tfr/vol1/iss1/2>

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RESULTS

Children's Futures: Lessons From a Second-Generation Community Change Initiative

Karen E. Walker, Ph.D., University of Virginia; Claire Gibbons, Ph.D., and Marco Navarro, M.A., Robert Wood Johnson Foundation

Key Points

- This article describes Children's Futures, a 10-year initiative in Trenton, N.J., that seeks to improve the health and well-being of children from 0 to 3 years old and ensure that they are ready for school.
- During the first five years, the initiative was successful in implementing a number of evidence-based practices to improve children's health, such as providing home visits to pregnant women, measuring and improving the quality of day care centers, and improving the use of information systems to track childhood immunizations.
- Efforts to provide services for fathers and improve home-based child care were not successful; these are areas in which there are not any evidence-based practices.
- Leveraging public and private money beyond the Robert Wood Johnson Foundation's substantial \$20 million commitment proved challenging because the foundation's commitment was so large. The authors recommend obtaining agreements for matching funds prior to finalizing commitments.
- A lack of attention to initiative-wide communications hindered integration across programs.
- A need for a citywide data system was identified; this is being implemented in the second five-year funding cycle.

Introduction

Children's Futures (CF) is a 10-year initiative in Trenton, N.J. Begun in 2002 and funded by the Robert Wood Johnson Foundation, its goals are to improve the health and well-being of children

from 0 to 3 years old and ensure that they are ready for school. Initiative leaders planned to avoid the past mistakes of other comprehensive community initiatives (CCIs) by focusing their initial efforts on a relatively narrow age range and using evidence-based practices to ease implementation. Like other CCIs, CF convenes partners from various institutional sectors to provide services to Trenton's families. Through technical assistance, CF also works to improve local service capacities.

This article, written by the initiative evaluator and the foundation's program and evaluation officers for CF, describes the initiative's activities during its first five years, available results, and the lessons learned. In general, we found that relying on pre-existing program models with some evidence of effectiveness contributed to a relatively short start-up period, but that program adaptations and innovations were inevitable under certain conditions and produced specific operational challenges that the initiative needed to address. We also discuss the need for systematic data collection and the importance of research questions that explicitly focus on the operations of CCIs.

The Initiative's Impetus

The initiative began with a 1996 challenge from foundation trustees to do more to improve the health of children. A team of senior staff explored options for interventions with experts from

across the country. Realizing that the foundation had done much to address children's health needs, such as improving asthma management and on-time immunization rates, but had not concentrated interventions in one community, the team recommended a place-based strategy. Trenton was selected because of the city's proximity to the foundation, the initiative's potential visibility to state policymakers, and the important assets found in the city. First, the city was small enough that the foundation's funds might make a difference (85,000 population and 1,500 annual births). Furthermore, strong support for the initiative existed from the county executive and human services director, the city's mayor, three area hospitals, and the director of the city's health department. Finally, Trenton's active nonprofit community was interested in implementing research-based interventions.

Children's Futures Inc. (CF Inc.), a nonprofit organization created to lead the initiative, received \$20 million for the first five years to promote four strategic objectives focusing on children from 0 to 3 years old: 1) improved birth outcomes, 2) more effective parenting, 3) improved child care quality, and 4) stronger leadership and agency capacity to serve Trenton's families. To accomplish these goals, CF Inc. convened agencies to establish programs for parenting education and support, child care improvement, increasing eligible fathers' involvement in their child's lives, preventive health care, advocating policy change, and behavioral health services.

The Initiative's Theory of Change

Although the initiative did not have an explicit theory of change that was widely communicated, there was an implicit theory of change shared by both foundation and CF Inc. staff. The Figure shows the theory of change developed by the evaluator at the beginning of the initiative using planning documents provided by the initiative leadership.

In general, the theory of change relied on assumptions and research about the importance of early childhood to long-term health and development (Shonkoff & Phillips, 2000). Initiative

leaders believed that interventions with parents would contribute to stronger parent-child attachment and better parenting skills, which in turn would contribute to improved child cognitive and psycho-social development and reduced child abuse. Those skills were broadly defined and included communication skills, improved nutritional knowledge, developmental activities, and discipline practices. They also included behavioral health interventions to address maternal depression, thus improving mothers' interactions with their children. These skills, in turn, would promote positive child development, including improved cognitive development, which would reinforce parents' positive behaviors and, in the long run, older children's academic and psycho-social outcomes.

Interventions with parents would contribute to stronger parent-child attachment and better parenting skills, which in turn would contribute to improved child development and reduced child abuse.

In addition to interventions with parents, the theory of change also posited that systems — such as the child and health care systems — needed to be improved to reinforce the work the initiative was doing directly with parents. In this way, multiple levers would work in concert to raise child outcomes.

CF Inc. planned to play a key role in providing funds, technical assistance, and guidance to the direct service agencies. Both the foundation and CF's leaders wanted to create an initiative that drew on the lessons of earlier CCI's. In its first proposal to the foundation, therefore, the CF Inc. president explicitly noted that CF was more targeted and focused on specific activities than

earlier CCIs. He also noted that the initiative's partners would use evidence-based practices.

Despite the explicit attempt at a narrow focus, CF has several characteristics of CCIs, which are defined by vertical and horizontal complexity and include residents, agency personnel from a variety of sectors, political leaders, funders, and other policymakers (Auspos & Kubisch, 2004; Connell, Kubisch, Schorr, & Weiss, 1995).

In these terms, CF has limited horizontal complexity. It encompasses several major care sectors: early care and education, behavioral health care, and physical health care. Where services already exist, such as child care centers and pediatric practices, CF works to improve practice. Where needed, it funds services, such as parenting education or behavioral health care.

Overall, CF has much vertical complexity. It involves people from the state, county, and city governments along with staff from multiple levels within agencies. Initiative planning and leadership are provided by staff from both CF Inc. and the city's Division of Health. The roles of the residents in the initiative, however, are limited to those of client and lower paid staff; they were not consulted as the program developed.

Evaluation Methods and Analysis

When the initiative began, there was much discussion about when to expect outcomes for children and families. Internally, the foundation's evaluation staff played a key role in managing their more operationally focused (and perhaps more optimistic) colleagues' expectations. Outcomes would be unavailable in the short term for several reasons. First, some of the outcomes had long-term horizons (e.g., school readiness), and many parents would enter the initiative around the time of a child's birth. Four years would not be sufficient to observe such outcomes. Furthermore, data for other outcomes (e.g., vital statistics) would be unavailable until two or more years after they had been collected: Indeed, for the evaluation, as of fall 2008, city-level birth data were available through 2004, only the second full year of implementation. This extended timeline

is typical for evaluations of CCIs (Auspos & Kubisch, 2004).

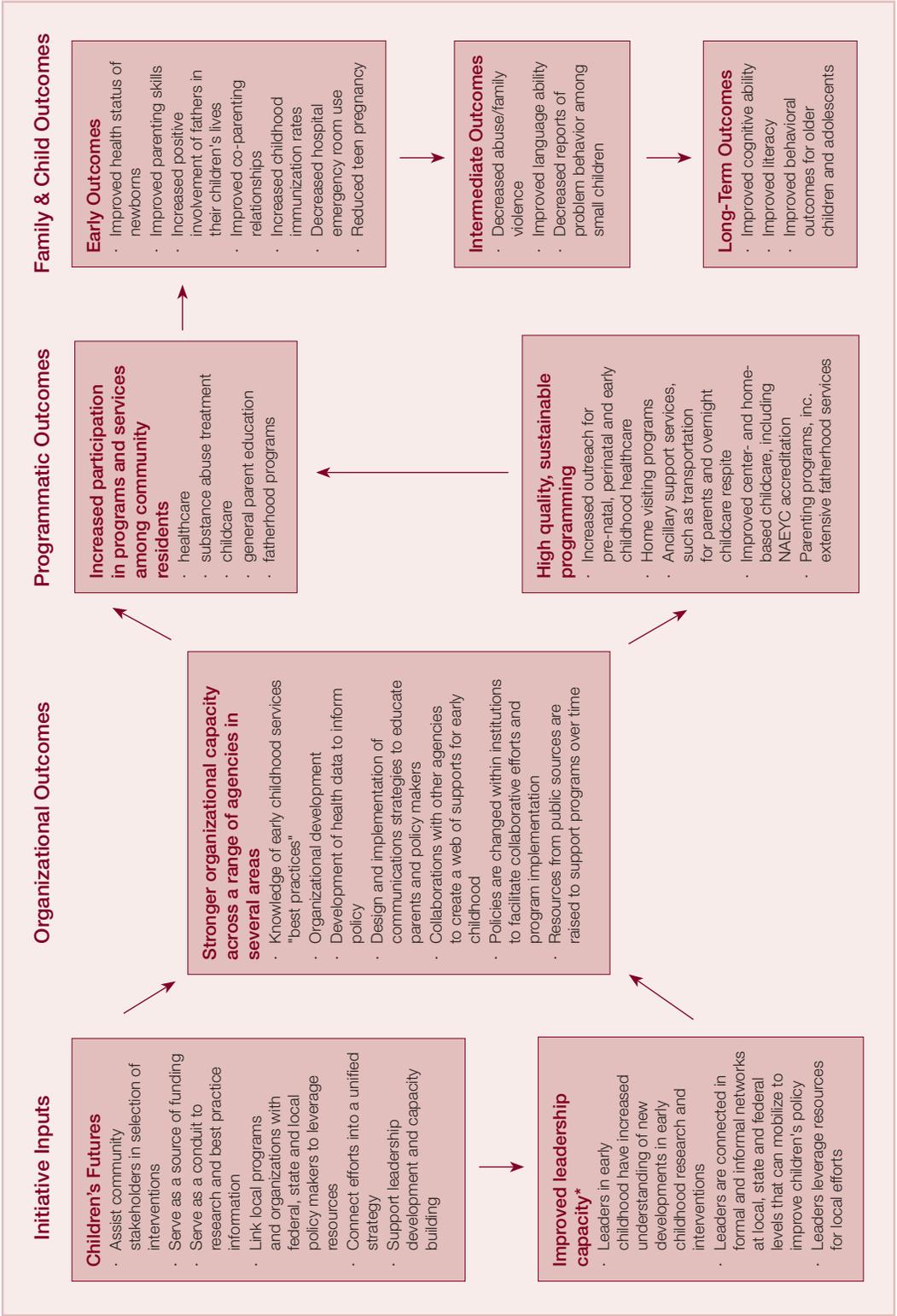
Because it recognized at the outset of the initiative that achieving desired outcomes in CF would take a number of years, the foundation evaluation staff emphasized that the first five years of the evaluation should focus primarily on implementation. However, the initiative leaders and foundation hoped to see some outcomes, particularly among participants. Therefore, the key evaluation questions were:

- Are the interventions implemented effectively, and what adaptations are necessary?
- Can the initiative attract sufficient resources to Trenton over its course to permit the implementation of known-to-be-effective health interventions for a large proportion of at-risk and disadvantaged children?
- By the end of the five-year implementation period, do the interventions make a detectable difference in selected indicators of well-being?

To address these questions, the evaluation, conducted by Public/Private Ventures, used a mix of qualitative and quantitative methods, including analysis of administrative data (birth statistics, emergency department data, and hospital discharge data); surveys; semistructured interviews; and focus groups with agency staffs, policymakers, community leaders, and community residents. Data on participant services included enrollment information, activities offered, service outcomes (such as on-time immunizations), observations, and individual-level outcomes (primarily birth outcomes) and were collected for the period January 2003 to December 2006.

With the exception of surveys of parents and child care providers and interviews and focus groups, the evaluation team relied primarily on information collected by agencies or community institutions. For example, the city Division of Health, which oversaw the parent-child centers, required agencies to provide demographic, prenatal, and birth information on clients. Agencies that provided technical assistance conducted

FIGURE Theory of Change for Children's Futures



*Although the text box, "Improved Leadership Capacity" could be considered programmatic outcomes, we have considered it an initiative input because the reason for improving leadership capacity is to leverage resources and strengthen the local organizational environment

baseline and follow-up assessments, which the evaluators collected.

As in all evaluations of CCIs, detecting initiative effects was expected to be a key challenge (Connell et al., 1995; Fulbright-Anderson, Kubisch, & Connell, 1998). The evaluation would rely on testing hypotheses from the theory of change, the use of trend data to examine city-level changes, and the use of cross-city comparisons using administrative data such as birth outcomes. However, extensive outcomes investigation would wait until the second five years. Therefore, this article focuses primarily on the first two evaluation questions.

The initiative planners initially committed themselves to using evidence-based practices, hoping that they would be able to implement activities quickly. From the outset, however, this plan needed modifications. Evidence-based practices exist for some, but not all, of CF's desired outcomes.

Interim Results

CF implemented the initiative components with varying degrees of success. By 2006, the initiative was screening and referring about half of all Trenton's pregnant women for medical and social risks that predict adverse birth outcomes, child abuse, or neglect. However, the efforts to serve fathers were unsuccessful. The following discussion describes whether the interventions were implemented effectively and the adaptations deemed necessary.

The initiative planners initially committed themselves to using evidence-based practices, hoping that they would be able to implement activities quickly. From the outset, however, this plan need-

ed modifications. Evidence-based practices exist for some, but not all, of CF's desired outcomes. For example, previous attempts to increase fathers' involvement in their children's lives have shown little evidence of success, as have efforts to improve the quality of family child care.

In addition to a lack of evidence for selected outcomes, some of the evidence-based programs CF planners selected, such as the Nurse Family Partnership or Healthy Families, target enrollment to specific populations, which meant that some women needing services were not eligible for them. For very good reasons, therefore, the initiative adapted or created strategies.

Home-Visiting and Parent-Child-Center Programs

By early 2003, the initiative had financed six home-visiting programs: four Healthy Families programs, each run by a different agency; the Nurse Family Partnership; and home visiting provided to high-risk families by public health nurses. CF Inc. complemented those programs with centers offering additional activities for families, such as emerging literacy and nutrition programs. Together, the six home-visiting programs were serving about 370 women by 2005, equaling about 25% of the mothers who give birth in Trenton each year.

Evaluation results show that home visitors provided accurate information about pregnancy, parenting, child nutrition, and child development, along with concrete support and transportation to doctors' appointments. About 75 percent of scheduled home visits were completed, and women remained in the programs approximately 15 months. The figures do not meet their models' benchmarks (90 percent or more of home visits completed, with retention rates of two and three years), but they compare favorably to programs in other cities.

Center-based programs, serving home-visiting clients and parents ineligible for home visiting, proved challenging. A modification to Healthy Families, the programs relied on the home-visiting staff, which also needed to establish home-visiting

programs with extensive programmatic and training requirements and guidance. As a result, the staffs had limited time to establish center-based activities or recruit clients specifically for them. Although the four parent-child centers implemented a variety of support groups, music/emerging-literacy programs, and nutritional programs, they were usually operated sporadically and had limited attendance. Music programs were the most popular, and the typical pattern was for a center to offer two or three 12-week cycles during the year. They met once a week during those cycles, and their attendance was from 10 to 20 parents and children. Other groups met much less frequently, and attendance ranged from two to eight participants.

Child Care Quality-Improvement Programs

The local child care resource and referral agency provided technical assistance to family child care providers and child care centers. The program for child care centers began in spring 2003 with training in the High-Scope Infant-Toddler Curriculum for staff in seven centers. The initiative used the Infant-Toddler Environmental Rating Scale (ITERS) to observe and design individualized technical assistance for each center, to improve areas such as health, safety, learning, staff-parent interaction, and play.

At follow-up, five centers made large improvements in their ITERS scores: three achieved overall scores of *good* and a fourth was close to doing so. The fifth improved greatly, but still met only minimal standards of care after receiving assistance. The remaining two centers closed due to financial problems.

Initially, improving family child care proved more challenging, partly because few such efforts have shown good results and thus strong models about how to do so are lacking. The first effort, begun in mid-2003, stalled when the three child care centers that operated the program could not recruit, retain, and train family child care providers. In 2005, the resource and referral agency took over the work and made significant strides in recruiting family child care providers and ensuring that they received training and technical assistance. By the end of the year, the staff had recruited about

20 providers, conducted assessments, and had begun to create individualized quality-improvement plans and provide ongoing technical assistance and training. It focused its efforts on providers who cared for children involved in the Department of Youth and Family Services, reasoning that improving care for the most disadvantaged children might have a large impact in their lives. By January 2007, the Family Day Care Rating Scale assessment showed that 14 of the 16 providers with available information¹ increased their scores; 11 scored at least a one-point increase (on a seven-point scale). Of the three providers who received *very good to excellent* follow-up scores, two had met only minimal standards at baseline, showing very strong improvement.

Efforts for Fathers

CF created a collaborative of 29 agencies designed to address the fathers' multiple needs, hoping that stabilizing men's lives would allow them to forge better connections with their children. At the time the initiative was founded, there were few evidence-based practices to improve father involvement. Therefore, the agency created its own menu of activities for fathers. The effort's lead organization, which provided case management, mentoring, and referrals, also ran father-involvement classes and worked with the local Head Start program to provide father-child activities.

The fatherhood component enrolled approximately 200 fathers a year but struggled to provide them with services they needed. The lead agency recruited men from the court system, through word of mouth, and through the agency's work-readiness programs. But once enrolled and assessed, fathers often missed their referral appointments to other agencies, and, even when they went, the vast majority discovered that many services were unavailable.

Health Care

The New Jersey Chapter of the American Academy of Pediatrics (NJAAP), using CF and state

¹ By January 2007, when data collection for this phase of the evaluation ended, only 16 of the family child care providers had been in the program long enough to have received a follow-up assessment.

funds, adapted a model developed in Pennsylvania — Educating Physicians in their Community — to improve preventive care at 11 of 13 pediatric and family practices serving Trenton’s young children. According to CF Inc. staff, those 11 practices serve about 90 percent of Trenton’s children. The academy provided on-site training to all staff members in each practice. By the end of 2006, all 11 practices were using a state-run system promoted by NJAAP to help physicians access children’s immunization records. In addition, nine practices had changed their lead-screening procedures to ensure that children were screened even if the parents did not take them to the blood-testing sites to which they had been referred.

Substantial private investment from a single source in a place-based initiative presents both opportunities and challenges.

Partly as a result of quarterly meetings that the physicians and other health practitioners had with CF Inc. and the NJAAP staff running the effort, CF Inc. began to work with state legislators and other organizations to improve the state children’s health insurance program. According to a key legislator on the committee that wrote the legislation (which passed), CF Inc. staff drafted the language that prevented children from being automatically deleted from the program’s roll every six months if their parents had not sent in the appropriate forms. By doing so, CF Inc. and the state hoped to avoid disruptions in care and ensure that patients had an ongoing relationship with their medical provider.

The initiative also attempted to improve health care through the use of Best Clinical and Administrative Practices (BCAP), in which the Center for Health Care Strategies works with a group of managed-care plans to help them identify specific problems in clinical care or administra-

tion and develop plans for improvements. One of BCAP’s key underlying assumptions is that such improvements will lead to cost savings in addition to better care. Even if such savings are modest on a per-client basis, managed-care plans have such large clienteles that significant money can be saved overall. CF modified BCAP to work with local health providers (a federally qualified health clinic and two local hospitals). Unfortunately, the effort faltered when the providers did not have the staff resources to commit to the project. Part of the problem was that the anticipated cost savings were relatively small and therefore could not serve as an incentive to the providers.

Other Efforts

The initiative also included efforts to improve child care quality at the state level, to screen women in prenatal clinics for behavioral health needs, and sponsored a range of trainings and services. These efforts are not described here in detail due to space constraints.

Leveraging Foundation Funds to Garner Additional Resources

The foundation committed \$20 million to CF for its first five years. Although the amount may be relatively modest considering the size of Trenton’s population, it constitutes a large investment in a single city. By providing extensive funds, the foundation hoped that the initiative could affect a large proportion of the city’s children and leverage additional resources from other funders and agencies.

Substantial private investment from a single source in a place-based initiative presents both opportunities and challenges. In CF, investment permitted substantial discretionary funding, and its leaders were able to identify areas of effort, such as working with local primary care physicians to improve lead screening and on-time immunization rates, that were not part of the initiative’s original plan. In addition, the investment brought many local agencies to the table. They, in turn, devoted some of their funds to the initiative’s activities and leveraged additional funds.

Unfortunately, the foundation’s large commitment had some unintended consequences. Although

the staff at the foundation hoped that the initiative would use the funds to leverage additional resources — which it did to some extent — the size of its commitment also acted as a disincentive to public funders. Staff from the local lead agency, CF Inc., repeatedly indicated that state government officials were uncertain about Trenton's need for services given the foundation's commitment.

Quantifying the negative effect of the foundation's commitment on efforts to raise public funds is almost impossible. There are multiple reasons for providing discretionary public funds to one city over another, including state assessments of need, relationships among state funders and local agencies, and political considerations such as geographic representation. In this complex mix of decision making, we cannot point to specific instances when potential funding was not received because of the size of the foundation's grant.

The most successful instances of leveraging funds was at the beginning of the initiative, when the city Division of Health used the CF's grant to win federal and state funds for more extensive home visiting through the Resources and Services Administration (HRSA) and the state Department of Justice.

Discussion

Although little information on individual outcomes is available, much has been learned from CF about its programs, collaborations, and ability to garner resources. Perhaps not surprisingly, some of the lessons relate directly to the research questions, whereas others emerged as the initiative unfolded, which suggests our first lesson.

The Need for Strong Cooperation Among Partners and Initiative Communications Should Be Explicit in CCI's Designs and Research Questions

One question, "To what extent were activities across the initiative integrated and how were initiative-wide communications handled?" was initially absent from the evaluation. In addition, issues of communications and integration were not explicit in the initiative's design. These issues

focus on process instead of outcomes, and emphasizing them either in evaluation or in initiative design may appear "soft" to foundation staffs and initiative leaders who want to highlight outcomes as a way of ensuring accountability. However, if CCI designs do not explicitly include operational issues such as communications and collaboration, and evaluations do not assess them, the formal knowledge base about operating CCIs will continue to be relatively shallow.

Although communications across the initiative have been one of the initiative's strengths, they have also been one of its key weaknesses. On the one hand, frequent monthly project director meetings across agencies that were implementing home-visiting programs resulted in camaraderie and shared problem solving. Shared trainings across agencies also helped direct-service staff expand their professional networks, enabling them to serve their clients better. And quarterly meetings among physicians and nurse practitioners involved in the primary care technical assistance brought shared problems to the surface, providing topics for future training.

On the other hand, even though the agency leading the child care quality improvement efforts had expertise in child development and arranging engaging and safe environments for young children, the parent-child center staffs did not know that the agency could be very helpful in designing space and some of their activities for both parents and children. Agencies involved in various aspects of the initiative did not know what agencies involved in other aspects were doing. Child care center staffs were not even aware that they were part of a citywide initiative.

The initiative leaders also failed to communicate an overall theory of change emphasizing service integration and cross-agency collaboration to various partners, resulting in uneven efforts to do so. Agencies involved in the parenting component created a centralized referral system that ensured that pregnant women were referred to appropriate programs, but in a more typical example, the agency leading the father involvement activities hoped to work with the parent-

child centers but was unable to create successful collaborations.

Finally, because no explicit theory of change existed, logical gaps in its links could not be discussed. For example, although the theory of change indicates that increased outreach to encourage early prenatal care use was a programmatic outcome, no outreach strategies were in place during the first five years to do that. Had the theory of change been shared and discussed, agency executives might have identified some of the gaps between strategies and outcomes.

The Balance of Shared Decision Making in CCI Is an Ongoing Challenge

A key challenge for CCIs is how decision making across participants (funders, agencies, and residents) can be shared effectively (Walker, Watson, & Jucovy, 1999). In its first five years, CF tended toward a top-down model of decision making, somewhat unusual for a CCI. Although this strategy enabled the initiative to get programs off the ground quickly, it also generated frustration among Trenton agency executives who disagreed with decisions made by CF Inc. staff. In addition, residents' roles were restricted, and opportunities to further the initiative's goals were missed. Decision making is an area where many CCIs continue to face challenges, despite numerous evaluations. Comparative research that examines the strengths and challenges of various models of decision making and inclusion could help future CCIs make more informed decisions about these issues.

If Possible, Matching Financial Commitments From Public Agencies Should Be Garnered Before Private Foundation Funds Are Disbursed at the Beginning of the Initiative

Although CF does bring public and private funds together for children and family services in Trenton, public commitments are framed as contingent upon available funds rather than as permanent or semipermanent allocations. In addition, the initiative's leaders' efforts to get those commitments by positioning the city as the ideal locale for pilot programs to improve children's outcomes have met with only modest success.

One important lesson may be that public commitments should be secured before private commitments are finalized. This approach was taken by the San Francisco Beacon Initiative, in which a consortium of private funders in San Francisco elicited budget commitments from the city prior to fully committing their funds (Walker & Arbretton, 2004). From the outset, therefore, the initiative was seen as a public/private partnership.

Substantive Expertise Within the Initiative Is Required to Address Challenges That Arise From Program Modifications and Creation

Given the state of knowledge about what works in social programs, it would be difficult to create an initiative sensitive to a particular community's needs and dynamics without adapting or creating at least a few programs. The foundation fully expected that there would be at least some modifications.

Modifications, however, should not only be anticipated, but plans should be formulated for addressing the challenges that arise from them. Sufficient expertise about the programs and targeted populations must exist within the initiative to identify the source of the problems and ensure that modifications succeed. This expertise did not exist in two of the four cases in CF — parent-child center and father-involvement activities — and major improvements to these efforts were not made during the initiative's first phase. In the other two cases, however, strong expertise existed, and the programs were significantly changed in ways that addressed the challenges (changes to the BCAP program were made after data collection for the first phase of the evaluation had ended).

CCIs Should Collect and Use Systematic Information for Program Management and Planning

A major challenge facing the initiative was the limited information available about clients and service use across the initiative. Without such information the lead agency, CF Inc., could not assess service use and make adjustments to improve or more clearly target services to those who most needed them. Referring agencies did not have

good information about other agencies' successes or challenges in serving clients. The existence of a citywide database that collected key information on home-visiting clients ensured some shared information, but little information was available for clients in behavioral health, center-based, or father-involvement services. Without information, agency personnel tended to assume that partner agencies were not performing. With more information, a greater understanding of the challenges to serving clients and their potential solutions could have been developed.

Agencies had different capacities for storing and retrieving information about their programs. Two agencies, which provided technical assistance to child care centers and pediatric practices, collected good data on the services they provided and on their clients' changes in practice. The staffs' ability to collect and use information was critical in identifying and addressing operational challenges and additional topics for future technical assistance.

Most agencies, however, had limited capacities to store and/or retrieve program information, restricting CF's capacity to understand its clients and services. The home-visiting programs used databases required by their technical assistance providers that limited the Trenton staff's ability to query information. Importantly, staff could not combine information across programs. Fears of compromising client confidentiality also prohibited information sharing.

Even if agencies had been able to use and share information more effectively to maximize services, collating such information across a community requires standardization in how data are collected and dedicated staff resources to examine the information. This is part of a larger problem of nonprofit and public sector management and information technology use (Hackler & Saxton, 2007) that has received relatively little attention from the philanthropic community and very little support from the public sector.

At the outset, both the foundation's evaluation staff and the evaluator understood that having a

data system was critical for assessing whether CF was reaching Trenton's neediest families. However, the foundation staff had observed negative evaluator-community relationships in previous efforts, which it wanted to avoid by ensuring that the evaluation did not impose significant burden by superimposing an initiative-wide data system in addition to data already being collected. Therefore, although the evaluation team offered to set up a system, it did not insist when the offer was refused.

In retrospect, the decision to minimize burden on agencies by not implementing an initiative-wide data system was unwise. As the initiative progressed, the operations staff at the foundation requested increasing amounts of information from the initiative about its reach into the community — information that neither initiative leaders nor the evaluation team had.

As the first five years came to an end, the foundation concluded that the lead agency needed to hold its grantees more accountable and agreed to the evaluator's proposal to use unspent evaluation funds to buy a Web-based software system to collect information across the initiative for performance management and evaluation purposes. Implementing the software has been time-consuming for the agencies' staffs, but they increasingly recognize the utility of demonstrating whom they serve. Requests from agencies' staffs for ways to record previously unrecorded activities are common.

Focusing on a Particular Population in a CCI Has Significant Operational Benefits

In the 1990s, many CCIs — in keeping with their leaders' philosophy that a more holistic approach to community change was required in order to better the lives of the poor — tried to address a host of community needs, believing that focusing narrowly on particular people or particular interventions would limit success. In part, these initiatives faltered because of their broad scope.

Focusing on a specific age range, as CF does, brings clarity to decisions about what will be funded but also limits the initiative's abilities

to respond to crises in the community. For example, gang activity increased in Trenton in the early 2000s, creating fear among community members. Although leaders discussed how CF might address the gang problem, they ultimately decided that the issue fell outside the initiative's purview. Arguably, this narrow focus, therefore, is a disadvantage. From the evaluation team's perspective, however, the advantages of being able to prioritize funding and work with a set of agencies that had shared interests outweighed the drawbacks.

Foundation Evaluation Staff Can Play a Key Role in Managing Expectations for Outcomes

When there was little evidence of citywide change at the end of the initiative's first phase (or four full years of implementation), the foundation staff was disappointed but not surprised. From the evaluator's perspective, having the foundation's evaluation staff manage expectations for their operational colleagues was a significant advantage because she did not need to spend much time at the beginning of the initiative suggesting that the proposed timeline for outcomes was overly ambitious. In addition, it enabled the evaluation to collect primarily implementation data for the first five years, with a focus on outcomes reserved for the second five years of the initiative.

The Second Five-Year Commitment

At the outset, foundation staff considered a 10-year commitment crucial to the CF strategy. Previous experiences and evaluations of CCIs unanimously recommended patience and sustained effort (Auspos & Kubisch, 2004). Also, a long-term funding plan would convey the foundation's commitment to Trenton. Foundation staff assumed that funding for the initiative's second five years would be based on lessons learned during its first five years, but anticipated that the amount would be similar. Staff also expected that priorities for phase two might expand to address other age cohorts, depending on phase one outcomes.

As the grant's renewal loomed, the foundation staff communicated to the CF leadership that it did not think direct-service support was the

best use of philanthropic dollars. In addition, the staff thought that the number of people receiving direct services was too small relative to the funds being spent and indicated that the grant amount might be reduced. Foundation staff thought it obvious that programs that were not reaching people in sufficient numbers should not be funded. Not surprisingly, perspectives in Trenton differed. CF Inc. staff thought that the discussion of reducing the funding level for the second grant reflected a shift in priorities due to a leadership change at the foundation.

The overall evaluation conclusion that the initiative was generally going well confirmed a prediction to renew the grant at a substantial level, despite lingering questions among foundation staff. The second grant was approved for \$14.5 million.

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Acknowledgments

The evaluation on which this article is based was funded by the Robert Wood Johnson Foundation. We would like to thank the staffs at many Trenton social service agencies who contributed their insights, knowledge, data, and time to the evaluation effort. In addition, we would like to thank Teri Behrens and two anonymous reviewers who posed good questions and provided helpful guidance during the preparation of this manuscript.

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