

The Foundation Review

Volume 1
Issue 1 *Open Access*

2009

The Colorado Trust's Healthy Communities Initiative: Results and Lessons for Comprehensive Community Initiatives

Ross Conner
University of California Irvine

Doug Easterling
Wake Forest University School of Medicine

Follow this and additional works at: <https://scholarworks.gvsu.edu/tfr>



Part of the [Nonprofit Administration and Management Commons](#), and the [Public Affairs, Public Policy and Public Administration Commons](#)

Recommended Citation

Conner, R., & Easterling, D. (2009). The Colorado Trust's Healthy Communities Initiative: Results and Lessons for Comprehensive Community Initiatives. *The Foundation Review*, 1(1). <https://doi.org/10.4087/FOUNDATIONREVIEW-D-09-00002>

Copyright © 2009 Dorothy A. Johnson Center for Philanthropy at Grand Valley State University. The Foundation Review is reproduced electronically by ScholarWorks@GVSU. <https://scholarworks.gvsu.edu/tfr>

RESULTS

The Colorado Trust's Healthy Communities Initiative: Results and Lessons for Comprehensive Community Initiatives

Ross Conner, Ph.D., University of California Irvine;

Doug Easterling, Ph.D., Wake Forest University School of Medicine

Key Points

- This article summarizes how 29 diverse communities throughout Colorado implemented the Colorado Healthy Communities Initiative (CHCI), which was conceived and funded by The Colorado Trust to engage community residents in the development of locally relevant strategies to improve community health.
- In line with the World Health Organization's Healthy Cities model, CHCI emphasized (a) inclusive, representative planning; (b) a broad definition of "health"; (c) consensus decision making; and (d) capacity building among local stakeholder groups.
- Communities implemented an array of projects (on average, six per community) that extended well beyond traditional health promotion and disease prevention. The most common action projects focused on community problem solving, civic engagement, and youth development. Many of the grantees established projects or new institutions that had a long-term community impact.
- Key success factors for CHCI included (a) a well-specified planning model, (b) a planning process facilitated by expert consultants, (c) a unifying "healthy community" vision developed at the beginning of the process by diverse stakeholders, (d) a willingness by stakeholders to work collaboratively to define "key performance areas" and then to implement "action projects" to achieve them, and (e) an appropriate level of funding for implementation (\$50,000 per site per year).
- The outcomes and impacts of CHCI might have been improved by better anticipating the requirements for sustaining the energy and work initiated during the planning process.
- At the end of the initiative, CHCI provided the funders with a broader, deeper understanding of the requirements, opportunities, and realities associated with promoting "community health."

Over the past 20 years, a small but influential cohort of foundations (e.g., Annie E. Casey, Ford, Kellogg) has experimented with comprehensive community initiatives (CCIs) as a means of generating sustainable, community-wide improvements in health and quality of life (Kubisch et al., 2002). Rather than funding individual organiza-

tions to achieve a particular set of programmatic outcomes, CCIs seek to transform "communities" (neighborhoods, towns, cities, or larger regions) through a locally driven approach to system reform or community development. According to Brown and Garg (1997), these initiatives are characterized by (a) the devolution of authority

At the time of the evaluation, Ross Conner headed the evaluation team and Doug Easterling was the director of research and evaluation at The Trust. From the outset, the relationship between the evaluation team and The Trust's project team was a collegial, collaborative one, with both teams contributing ideas for the development and implementation of the initiative and the evaluation.

and responsibility from state and federal agencies to local collaboratives or interagency planning bodies, (b) the introduction of a comprehensive lens that promotes an integrated, cross-sector approach to community change, (c) the involvement of residents in articulating goals for community change and in designing strategies to achieve those goals, (d) the mobilization and deployment of new resources, and (e) an investment by the funder in building the capacity of the local community.

The Colorado Healthy Communities Initiative (CHCI) was one of the earliest and largest of these CCIs. It was designed and funded by The Colorado Trust as a means of empowering citizens to make their communities healthier. Beginning in 1992, a diverse group of 29 communities throughout Colorado embarked on an in-depth strategic-planning process designed to generate an action plan and to lay the groundwork for future problem-solving efforts. Follow-up funding from The Trust allowed each community to implement key elements of the action plan and extend the community-building activities that occurred during the planning phase. CHCI was initially conceived as a \$4.45 million, five-year initiative, but it increased in scope to become an \$8.8 million, eight-year investment.

CHCI's design made it distinct from more traditional community-health initiatives. First, it required participation from a broad cross-section of the community's residents, organizations, and sectors. Purposefully diverse "stakeholder groups" collaborated in defining how their communities should improve and in determining which actions would be taken to affect and change community health. Second, the concept of "health" was framed broadly, with each stakeholder group deciding for itself what was meant by the term "healthy community." Third, the planning process was facilitated by outside experts working under contract to the foundation. Fourth, the process was designed to foster capacity building on an individual and group level, with a special emphasis on expanding the involvement of citizens in civic affairs. Fifth, CHCI allowed each applicant group to define "community" according to its own geographic boundaries. This led to the funding of

communities of widely varying scales (e.g., small inner-city neighborhoods, suburban cities, single counties, large multicounty areas the size of New England states). Sixth, the 29 communities were funded in three successive cycles a year apart, which allowed for learning and refinement of the program model.

As the evaluation demonstrated, CHCI produced many positive outcomes and also some longer term impacts in many of the communities.

The Trust commissioned an independent, prospective evaluation of CHCI as a means of documenting the effects of the initiative and fostering learning about community-based health promotion. That evaluation, summarized here, employed a variety of methods to assess how the funded communities carried out the prescribed planning model, how participants experienced and grew from the process, and how the grantees used their implementation funding to address local health issues. Data were collected over a seven-year period, allowing an assessment of at least three years of implementation for all three cycles of grantees. As the evaluation demonstrated, CHCI produced many positive outcomes and also some longer term impacts in many of the communities. This contrasts with many other CCIs that have not met the goals and objectives of their funders (e.g., Annie E. Casey Foundation, 1995; White & Wehlage, 1995; Walker, 2007; Brown & Fiester, 2007).

In this article, we present an overview of the CHCI program and its theory of change, its outcomes, and its implications for CCIs.¹

¹ Parts of this article draw upon reports of the initiative to The Colorado Trust. See Conner, Tanjasiri, Davidson, Dempsey, & Robles (1999a, 1999b); Conner, Tanjasiri, Dempsey, & Robles (1999); and Conner, Tanjasiri, & East-erling (1999).

Development and Design of the Initiative

Origins

Two sets of activities converged to catalyze CHCI. The first was a study carried out by Trust staff to understand the trends and forces affecting health and quality of life throughout the state. The second was the development of healthy cities and healthy communities programs around the world.

Environmental Scan

In 1990, five years after its founding, The Colorado Trust began a large-scale environmental scanning effort designed to assess the social, economic, political, and technological trends that would affect Colorado's future (The Colorado Trust, 1992a, 1992b, 1992c, 1993). This scan used existing data and the results from commissioned studies and focus groups with residents and leaders from throughout the state. Several of the findings from the scan anticipated and informed The Trust's decision to create CHCI. For example, the study found that citizens were not particularly engaged in local decision making:

Many participants in this study report that Coloradans are not participating in decisions that affect and determine their future.... Study members see participation as the single most important remedy to the problems discussed in this report. (Colorado Trust, 1992a, p. 13)

Another important finding from the study related to a sense of community:

[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. (Colorado Trust, 1992a, p. 15)

A third finding focused on the advisability of local action:

Coloradans — especially those living outside the Denver metropolitan area — believe state and

federal governments do not understand basic community health, education and social service needs... Coloradans view local governments far more favorably than state and federal governments. They see local government as a potentially viable conduit for providing effective services. (Colorado Trust, 1992a, p. 18)

Finally, prevention and individual involvement were common themes:

Participants in the study frequently mentioned prevention as a way to meet part of the health care challenge, regardless of changes in the system. They also took a wider view of prevention and talked of it as their preferred strategy to deal with family, neighborhood and community problems of all types... participants supported it as an important strategy, particularly if health promotion can be generalized to other parts of community life, such as civic governance. (Colorado Trust, 1992a, p. 21)

Responding to these findings, the board and staff of The Trust designed a proactive initiative that would provide communities throughout the state with new opportunities to come together to establish their own health promotion priorities and take collective action to address local issues.

Healthy Cities and Communities Programs

The World Health Organization's (WHO) Healthy Cities program became the point of reference in designing The Trust's first multisite initiative. This program began in Europe in the mid-1980s, and, by the early 1990s, it had grown to involve several hundred cities and towns around the world (Hancock & Duhl, 1986; World Health Organization, 1986; Kickbusch, 1989; Ashton, 1992). The WHO initiative had five major elements: facilitating the development and adoption of city plans for health, developing models of good practice, monitoring the effectiveness of models of good practice, disseminating ideas and experiences between collaborating cities and other interested cities, and fostering mutual support, collaboration, and learning among cities and towns (Ashton, 1992, p. 8). The essence of the WHO program was the first element, the adoption of city plans for health. Health was defined holistically and included

nearly every aspect of city life (e.g., transportation, housing, employment, education). The development of the health plans involved many citizens and diverse community sectors following their own approaches since no specific steps were set out by WHO, which provided no financial resources but instead gave guidance.

In the United States, healthy cities programs were slow to start. Indiana and California were among the first to develop programs, following the WHO example (Flynn, 1992; Twiss, 1992). As with the WHO initiative, these programs emphasized citizen participation and local government involvement, but did not have detailed steps for participants to follow and did not give significant financial resources to participating cities.

To foster healthy cities programs in the United States, the US Office of Disease Prevention and Health Promotion contracted with the National Civic League (NCL) in 1989 to prepare and disseminate materials on the approach. NCL also applied its expertise in community development and strategic planning to develop a more concrete healthy communities model. The NCL model set out planning steps that communities could use to develop and implement locally relevant projects. The Trust drew upon this work as it created the CHCI model and then contracted with NCL to play a major role in carrying out the initiative.

The CHCI Model

As with prior healthy cities and healthy communities programs, CHCI embodied the principles that (a) “health” should be defined broadly and (b) community members need to be engaged in determining which health issues are addressed and how they are addressed. At the same time, CHCI brought a heretofore lacking structure to the “healthy communities” concept, including a specific planning process that coalitions would undergo in order to define and address their community’s most important health issues, as well as a provision for implementation funding.

CHCI Logic Model

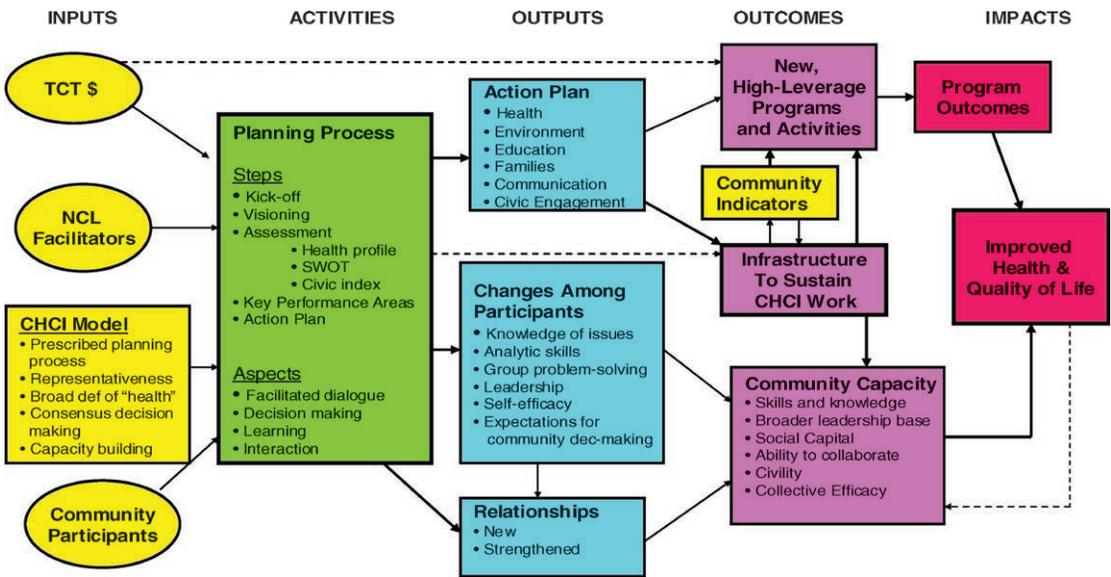
The logic model shown in Figure 1 provides an overview of how CHCI was expected to

improve community health. This model was developed jointly by the evaluation team and foundation staff over the course of the initiative. The key inputs into the initiative are depicted in the yellow boxes. Based on these inputs, each funded community was expected to convene a group of “stakeholders” who would carry out the planning-related activities listed in the green box. These activities, in turn, were expected to yield an action plan, increased capacity, and new relationships on the part of stakeholders (the blue boxes), which would set the stage for improvements in local health and quality of life (the red boxes). These improvements would presumably occur through two complementary pathways: (a) implementing high-leverage action projects and (b) increasing the community’s capacity to address whatever health issues might arise in the future (in the purple boxes). The yellow “Community Indicators” box was an unexpected outcome and additional input to the project.

CHCI brought a heretofore lacking structure to the “healthy communities” concept, including a specific planning process that coalitions would undergo in order to define and address their community’s most important health issues.

The logic model explains how CHCI is a “comprehensive community initiative.” In particular, CHCI was “comprehensive” in three important respects: (a) the planning process allowed for consideration of any and all aspects of quality of life, as opposed to prescribing a particular topic area; (b) actions were selected to improve the health of the overall community, as opposed to serving the interests of a particular sub-

FIGURE 1 Logic model for Colorado Healthy Communities (CHCI)



group; and (c) decision making directly involved residents from throughout the community, as opposed to having professional representatives make the key decisions.

CHCI Guiding Principles

The CHCI planning model advanced four distinct principles: representativeness of participants, broad definition of health, consensus decision making, and capacity building.

Representativeness of participants. CHCI was anchored in the belief that citizens rather than “experts” are the best source of community definition, diagnosis, and action. Since different citizens have different views about their community, it was important to have a broad representation of individuals participating in the process, defined in terms of demographics (e.g., gender, education, income, race-ethnic group) and sectors/interests (e.g., business, education, environmental groups, religious groups).

Broad definition of health. In developing a locally relevant action plan, each group considered the multiple dimensions (social, political, economic, environmental) of the WHO definition of health (WHO, 1986).

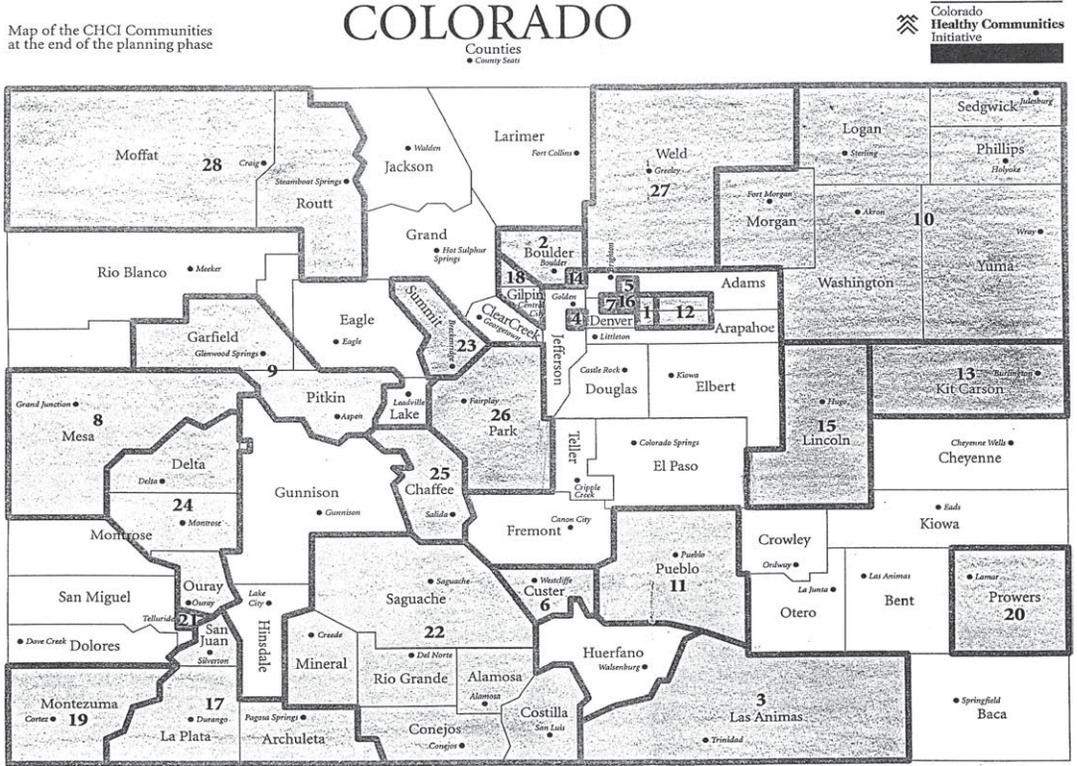
Consensus decision making. The stakeholder groups followed a consensus decision-making approach. Everyone’s ideas and comments were encouraged, wide-ranging discussion followed, and then the group as a whole made decisions via a consensus-oriented process. In a consensus approach, the decision results from compromise among the participants such that the final choice is an option that everyone agrees “to live with.” This contrasts with majority voting, where a final choice results in winners and losers.

Capacity building. The CHCI approach aimed at building both individual and group capacity as part of the process. On the individual level, participants had opportunities to develop skills in understanding community issues and problems, facilitating meetings, working with diverse groups of individuals, achieving consensus on issues, and exercising leadership generally. On the group level, CHCI groups developed a group vision, operating rules, and outreach activities designed to generate longer term benefits that would extend to the larger community.

Steps of the Planning Process

The planning phase was organized in a sequence

FIGURE 2a Map of CHCI projects



of specific steps adapted from NCL's Healthy Communities model (Norris, 1993).

1. Create an initiating committee that then helps to form the stakeholder group and to establish some working committees.
2. Hold a project kickoff and (re)define "community health."
3. Gather and discuss data pertaining to the community's current realities and trends, using a community health profile, an environmental scan, and NCL's Civic Index.
4. Develop a healthy community vision.
5. Select and evaluate key performance areas.
6. Create an action plan.

Resources to Communities

Outside facilitators, working either as staff or under contract for NCL, assisted communities during both the planning and implementation phases. Two facilitators worked with each CHCI community during the planning phase to imple-

ment the steps of the process. This amounted to a \$40,000 in-kind contribution from the foundation. During the implementation phase, a facilitator continued to work with the community but at a much-reduced level (a visit or two per year).

In addition to the facilitation services, each community received \$7,500 during the planning grant phase to fund clerical support, postage and telephone expenses, day-care services, snacks, and supplies. Each community also had \$8,000 available to hire consultants with specific expertise as it developed its action plans.

At the end of the planning phase, each community could apply for an implementation grant to cover high-priority elements of the action plan. The maximum award was \$100,000, which was expected to be expended over a two-year period. The Trust initially restricted the implementation grants to projects that specifically advanced

FIGURE 2b Listing of CHCI projects

Site #	Geographic description	Project name
1	City of Aurora	The Aurora Project
2	Boulder County	Boulder County Civic Forum
3	Las Animas County	CHANGE
4	City of Lakewood	Citizens for Lakewood's Future
5	Commerce City	Mission Possible!
6	Custer County	Custer 20/20
7	Globeville neighborhood of Denver	Globeville Community Resource Center
8	Mesa County	Mesa Co. Healthy Community Civic Forum
9	Garfield, Pitkin, Eagle counties	Healthy Mountain Communities
10	Logan, Morgan, Sedgwick, Washington, Yuma counties	Healthy Plains Initiative
11	Pueblo County	Healthy Pueblo Communities 2010
12	I-70 Corridor	High Five Plains Foundation
13	Kit Carson County	Kit Carson County Healthy Communities
14	City of Lafayette	Lafayette Healthy Communities Initiative
15	Lincoln County	Linc-Up
16	Northeast Denver	Center for Self Help and Development
17	La Plata, San Juan, Archuleta counties	Operation Healthy Communities
18	Gilpin County and Nederland	Peak to Peak Healthy Community
19	Montezuma County	Pinon Project
20	Prowers County	Prowers Progress to a Healthy Future
21	Telluride	REACH
22	San Luis Valley	SLV Community Connections
23	Summit County	Shaping Our Summit
24	Delta, Ouray, eastern Montrose, Somerset	Uncompahgre Healthy Communities
25	Chaffee County	Valley Visions
26	Park County	Vision 20/20
27	Weld County	WeCan
28	Routt and Moffett counties	Yampa Valley Partners

Healthy People 2000 objectives, but eased these restrictions based on concerns raised by the first round of communities.

Augmentations to the CHCI Program

Beyond the features just described, The Trust

funded three important additions to CHCI as the initiative unfolded:

- a networking organization, the Colorado Center for Healthy Communities (CCHC), that organized annual statewide conferences for

CHCI-funded groups and facilitated cross-community communication (Conner, Tanjasiri, et al., 2003);

- a challenge-grant program administered by CCHC that allowed CHCI-funded groups to apply for programmatic funds beyond the \$100,000 available through the implementation grants; and
- a community-indicators project that supported 15 of the CHCI communities in developing locally relevant systems for tracking health and quality of life (Conner, Easterling, Tanjasiri, & Adams-Berger, 2003).

With these augmentations, The Trust increased its total investment in CHCI from \$4.45 million to \$8.8 million. Although all funding was initially expected to terminate in 1998, the challenge grants and community-indicators grants provided support to some communities into 2000.

Participating Communities

Communities across Colorado were encouraged to apply for CHCI. A total of 29 Colorado communities received planning grants in one of three cycles. Of these communities, 13 participated in Cycle 1 (begun in 1993), eight in Cycle 2 (begun in 1994), and eight in Cycle 3 (begun in 1995). Of the 29 communities that started the planning phase, 28 finished it. Of the 28 who began the implementation phase, 27 completed it. Figure 2, a and b, displays and lists the 28 CHCI projects that completed the planning phase.

The communities that participated in CHCI were spread across the state of Colorado and ranged in size from large to small, both geographically and demographically. In terms of geography, the smallest community was two square miles and the largest was 9,247 square miles. In terms of population, the smallest community had 2,700 residents and the largest had 249,000 residents. See Conner et al. (1999b) for additional information.

Evaluation Methods

There were three goals of the evaluation, one focused on formative evaluation and two focused

on summative evaluation. First, the evaluation-research team tracked the CHCI program as it was put into operation in individual communities. Second, the team identified short-term outcomes (e.g., products of the planning phase, changes in participants, new relationships). Third, the team investigated longer term impacts on the communities. The primary methods to achieve these goals were case studies, stakeholder surveys, community leader interviews, and progress report reviews from the implementation phase.

Case studies involved focused observation of a subset of the 29 communities. Thirteen communities were chosen to reflect the diversity of the overall set. In each case, a member of the research team made regular visits to observe the stakeholder meetings and to talk with individual stakeholders.

Stakeholder surveys, developed with input from stakeholders, were completed by all stakeholders at the end of the planning phase. Stakeholders provided assessments of the processes and outcomes of the planning phase, including assessments of the specific action projects developed by their group. A total of 1,090 stakeholders across 28 communities completed the nine-page survey (79.5% average response rate).

Community leader interviews were conducted in four communities at the beginning and end of the implementation phase to track changes in community decision making and to gauge the success of project activities. These interviews involved two parts: (a) discussion of recent changes in community decision making due to CHCI and (b) assessments of the processes and outcomes of the implementation phase activities that occurred.

Implementation phase progress report assessments were conducted by a team of two members of the research team and, independently, by The Trust's CHCI project officer. These raters assessed project activities along several dimensions, including involvement of new community sectors beyond health and social services, expanded

TABLE 1 Key Performance Areas (KPA) Selected by the Stakeholder Groups

Area	Number of communities (out of 28)
Health, illness, wellness	16
Education	16
Economy, poverty	13
Community (community identity, sense of community)	12
Environment	11
Families	11
Governance	10
Youth	9
Infrastructure (housing, transportation)	8
Growth management	8
Communication	7
Recreation, culture, arts	6
Community leadership	5
Safety (crime, violence, abuse)	4
Diversity	2

Note: Each community had multiple KPAs. Total number of areas = 149.

participation in community decision making, and important community-level changes due to the action projects.

To supplement these primary evaluation components, there were several secondary components, including interviews and surveys with the NCL facilitators, assessments of planning phase products, several non-CHCI comparison community case studies, as well as the “quality of life” indicator sets developed by 15 CHCI communities (see Conner, Easterling, et al., 2003, for details on this component). Throughout the evaluation, the evaluation team incorporated participants into the design of the components relevant to them, revised and adjusted parts of the design as the program changed, and provided feedback on interim findings to Trust staff as CHCI progressed (see Conner & Christie, 2009, for a fuller discussion).

Additional impact data came from follow-up interviews with local stakeholders conducted by an independent team after the initiative had formally

concluded (Larson, Christian, Olson, Hicks, & Sweeney, 2002).²

Results

An initiative as lengthy, large in scope, and ambitious as CHCI can be evaluated on many criteria. This article focuses on answering three broad evaluation questions:³

- How and how well did the stakeholder groups carry out the CHCI planning process?
- What were the primary outcomes of the planning phase?

² The Larson et al. (2002) study was commissioned by The Trust to provide a second assessment of CHCI’s longer term outcomes. To maintain independence, there was limited interaction between the two evaluation teams in designing the follow-up study.

³ Limited data are presented here. The four primary evaluation reports (Conner et al., 1999; Conner et al., 1999a, 1999b; Conner, Tanjasiri, & Easterling, 1999) contain detailed evaluation data about the results of CHCI. This section is largely drawn from Conner, Tanjasiri, et al. (2003).

- What did the CHCI communities accomplish during the implementation phase?

The CHCI Planning Process

Stakeholder Participation

In large part, CHCI succeeded in recruiting and retaining a critical mass of stakeholders for the approximately 15-month planning process. Based on attendance logs kept by each group, the number of stakeholders involved in the process varied from 14 to 130 across the 28 communities, with a median of 47.5. The majority of stakeholders (55%) reported that they attended all or most of the planning sessions. Most stakeholders started their involvement early (71%) and lasted until the final step of the process (74%).

Representativeness

The stakeholder groups generally were diverse in terms of community sectors and interests. The process specifically brought in individuals who traditionally had not been involved in health-focused projects, such as members of the business and education sectors. The top three sectors represented in planning groups were nonprofits, education, and business, with one third or more of stakeholders representing each of these sectors; parents of school-age children, government/health services, and environment were not far behind.

The stakeholder groups were not as diverse in terms of age, income, and racial/ethnic background. Based on data aggregated across all 28 communities, stakeholders tended to be female (60%), middle-aged (71% between the ages of 36 and 59 years), and white (86%). In addition, there was an overrepresentation of participants with higher income (46% had household income of \$50,000 or more) and higher education (76% were college graduates). When asked to report which demographic groups were missing, the majority of stakeholder groups pointed to youth under 20 years of age, Latinos/Hispanics, Native Americans, and the poorer community members with household incomes of less than \$15,000 per year. The most underrepresented sectors were industry and agriculture.

Broad Definition of Health

All communities easily moved beyond an illness- or wellness-focused view to a perspective that encompassed the underlying factors that determine health, either those focused on community issues (e.g., housing, education, the environment) or those addressing larger structural issues, that is, the way in which the community conducts its community business (e.g., citizen involvement in governance). This broad view is evident in the list of key performance areas (KPAs), the main focuses in the communities' action plans (see Table 1). Although health (including wellness and illness), along with education, was the most frequent KPA, 43% of the communities did not have health as a KPA. Economy, family, and sense of community were nearly as high on the list.

CHCI produced individual-level and group-level benefits with regard to increased capacity for community problem solving.

Decision Making by Consensus

In moving from ideas to proposed actions, 81% of the stakeholders adhered to the CHCI definition of consensus decision making. The figure was similar in all 28 communities, with the exception of one community where only 40% agreed that decision making had been by consensus. It should be noted that achieving consensus was not a universally positive outcome. Some stakeholders reported that diverse points of view occasionally were held in check for the sake of making decisions and that risky options were sometimes avoided.

Outcomes of the Planning Process

In line with the logic model, the evaluation tracked two categories of outcomes from the planning process: (a) changes in stakeholders' capacities and (b) creation of an action plan to guide future work to improve local health and quality of life.

TABLE 2 Outcomes of Planning Process: Capacity Building Among Individuals

Capacity areas and response categories	Percentage of stakeholders ^a
Increase in ability to understand community problems as a result of the planning process (N = 593)^b	
None	8
A little	14
Some	50
A great deal	29
Increase in ability to collaborate productively with other community members as a result of the planning process (N = 594)^b	
None	6
A little	17
Some	52
A great deal	24
Increase in ability to develop creative projects to address community problems as a result of the planning process (N = 589)^b	
None	13
A little	19
Some	50
A great deal	17
Increase in ability to take a more active leadership role in community affairs as a result of the planning process (N = 590)^b	
None	17
A little	21
Some	46
A great deal	16
Feel more able to personally effect change in community as a result of the year-long planning process (N = 1,051)	
Less able	2
No change	36
Somewhat more able	52
Significantly more able	11
Increase in ability to work effectively with key power people in the larger community as a result of the planning process (N = 343)^c	
None	19
A little	20
Some	48
A great deal	14
Feel that the planning process built a foundation for future work (N = 1,057)	
Definitely no	2
Probably no	9
Unsure	27
Probably yes	42
Definitely yes	21

^a Rounded to whole numbers, so question totals do not add exactly to 100.

^b Asked only during Cycles 2 and 3.

^c Asked only during Cycle 3.

TABLE 3 Issues Addressed by the CHCI Action Plans

Area	Number of communities (out of 28)
Specific issues or target groups	
Health promotion or health care	13
Education	7
Environment	7
Families	6
Children and youth	5
Housing	4
Recreation	4
Economy	3
Employment	3
Elderly	1
Community climate/context	
Citizen participation and leadership	8
Community development	8
Communication and information	8
Cooperation and coordination	4
Sustain CHCI process	
Develop a CHCI organization or infrastructure	9

Note: Each action plan could address more than one issue area. Thus, the sum of the individual frequencies is greater than 28.

Capacity Building Among Stakeholders

CHCI produced individual-level and group-level benefits with regard to increased capacity for community problem solving (see Table 2). At the individual level, more than half the stakeholders said that they had increased their ability to understand community problems, collaborate productively with others, develop creative projects to address community problems, and take a more active leadership role in their community. In terms of group-level capacity, the majority of stakeholders believed that they had increased their ability to work effectively with key “power people” in the community (61% reported “some” or “a great deal” of increase) and that they had laid a foundation for future work together (63% reported “probably yes” or “definitely yes”).

Action Plans

Of the 29 communities that began the CHCI process, all but one produced an action plan as

part of their proposal for implementation funding. Each plan included between two and 10 projects. In general, these plans represented a portfolio of projects aimed at different aspects of quality of life, although a few of the plans focused almost completely on developing a new facility that would promote community well-being (e.g., a recreation center).

Table 3 shows which issues were addressed by the action plans. Some of these issues correspond to specific dimensions of quality of life (e.g., health, economy, education, environment), whereas others refer to the context and the mechanisms through which communities become healthier (e.g., civic participation, leadership development, communication, cooperation).

In reviewing the action plan focuses, it is important to note that The Trust emphasized Healthy People 2000 objectives for implementation grants. Thirteen of the 28 action plans focused on some

TABLE 4 Strategies Carried Out During the Implementation Phase

Issue addressed	Strategies		
	Strategies carried out by at least nine communities	Strategies carried out by five to eight communities	Strategies carried out by one to four communities
Community problem solving (<i>n</i> = 23)	Community indicators project (<i>n</i> = 17)	Single-issue assessments (health, education, environmental quality, land use) (<i>n</i> = 8)	
	Task forces and planning facilitation (<i>n</i> = 15)	Capacity building for nonprofit organizations (especially neighborhood associations) (<i>n</i> = 6)	
	Forums-workshops to educate public on critical issues (<i>n</i> = 13)		Community-wide planning process (<i>n</i> = 4)
Civic engagement (<i>n</i> = 16)		Leadership training programs (<i>n</i> = 5)	Training or internships to promote voting and engagement in public decision making (<i>n</i> = 3)
		Newsletter, column in newspaper, Web site, or report describing community events and issues (<i>n</i> = 5)	Services and education to orient new residents to the community (<i>n</i> = 3)
			Training on communication skills, conflict management, etc. (<i>n</i> = 2)
			Directories, marketing, awards and recognition events to promote volunteerism (<i>n</i> = 2)
Youth development (<i>n</i> = 16)	After-school/out-of-school programs (<i>n</i> = 10)	Comprehensive initiatives to promote positive youth development (<i>n</i> = 5)	Early child development programs (<i>n</i> = 3)
		Youth leadership development (<i>n</i> = 5)	Programs to address specific risks (e.g., teen pregnancy, substance abuse) (<i>n</i> = 2)

Table 4 continued on next page

aspect of health care or health promotion. Other communities addressed the Healthy People 2000 objectives in areas such as recreation, children and youth, families, and environment. Some action plans focused on more general aspects of quality of life, including civic participation, communication, and housing.

It is noteworthy that roughly a third of the action plans made specific mention of creating a new organization that would institutionalize the healthy communities process beyond the planning process. Over the course of the implementation phase, a total of 21 communities set up a new organization to implement the CHCI action plan

TABLE 4 *continued.*

Environmental Quality (<i>n</i> = 11)		Environmental planning (<i>n</i> = 6)	Environmental education programs (<i>n</i> = 2)
			Beautification programs (<i>n</i> = 2)
			Recycling programs (<i>n</i> = 2)
			Hazardous waste pick-up program (<i>n</i> = 1)
			Purchase alternative-fuel bus (<i>n</i> = 1)
Information & referral services (<i>n</i> = 10)	Guide to local services (print or electronic) (<i>n</i> = 10)		In-person or telephone-based I&R services (<i>n</i> = 2)
Health services & health promotion (<i>n</i> = 9)		Health education classes and workshops (<i>n</i> = 6)	Health care services (<i>n</i> = 2)
			Health planning (<i>n</i> = 4)
			Other health promotion programs (<i>n</i> = 2)
Arts & culture (<i>n</i> = 7)			Arts programming for youth (<i>n</i> = 4)
			Events to promote local art and/or culture (<i>n</i> = 3)
			Oral history project (<i>n</i> = 1)
Personal development (<i>n</i> = 7)		Job training and GED programs (including Welfare-to-Work programs) (<i>n</i> = 5)	Broad life skills training program (<i>n</i> = 2)
			Training on particular skills (e.g., computers, drivers ed) (<i>n</i> = 2)
Family support (<i>n</i> = 6)		Parent education and counseling (some with home visits) (<i>n</i> = 5)	Family resource center (<i>n</i> = 2)
			Respite care programs (<i>n</i> = 1)
Recreation (<i>n</i> = 4)			Recreational programs (<i>n</i> = 3)
			New recreational facility (or attempted to create one) (<i>n</i> = 3)

Note: In the first column, the number in parentheses in each cell refers to the number of communities that implemented at least one strategy to address the issue. In the other three columns, the number in parentheses refers to the number of communities that used the particular strategy. Because some communities implemented more than one strategy for a particular issue, the sum of strategies used for an issue (across the second, third, and fourth columns) is greater than the number of communities. These data are based on all 28 communities in the planning phase; although one community was not formally included in the implementation phase, it was able to carry out several strategies and therefore has been included in these data.

and/or to facilitate ongoing community problem solving.

Accomplishments During the Implementation Phase

The action plans provided an initial blueprint for the implementation phase of CHCI. Based on an analysis of communities' progress reports and the Larson et al. (2002) follow-up, we compiled an inventory of the projects and activities that the communities carried out during the implementation phase. Of the 10 different quality of life areas, the three most frequently addressed were community problem solving, civic engagement, and youth development; each was addressed by over half of the CHCI communities.

There were multiple instances where CHCI led to important new projects that directly benefited local residents. In other instances, CHCI's benefits were less concrete.

Of the 38 distinct types of strategies used, the five most frequently implemented were community indicator projects, task forces, community forums, after-school/out-of-school programs, and guides to community services. The remaining strategies involved a range of approaches to improving health and quality of life, including job training, leadership training (for adults and youth), alternative fuel buses, youth arts programs, and many others.

Table 4 demonstrates the breadth of activity but does not convey the significance of the work. These are examples of some of the most important and concrete accomplishments:

- Healthy Mountain Communities facilitated a regional planning effort on transportation issues throughout their area. This process led to the establishment of the Roaring Fork Trans-

portation Authority and the second-highest level of bus ridership in the state.

- Prowers Progress to a Healthy Community raised funds to establish the High Plains Health Center. In 2001, the center had two physicians, two physician assistants, a nurse practitioner, and a dentist, with over 10,000 patient visits for the year.
- Healthy Pueblo Communities 2010 established Eastside Health Center within a local school to provide parenting classes, health education, immunizations, and other services to low-income and Hispanic families.
- Yampa Valley Partners convened elected officials, business leaders, and others from two large counties to examine telecommunication issues. The group created a single "local calling area," reducing expenses and inconvenience.
- Kit Carson County Healthy Communities built two assisted-living facilities, developed a low-income housing community, and oversaw the development of a countywide health insurance program.

In addition to these concrete outcomes, many of the CHCI projects strengthened the civic infrastructure or social fabric of the local community. Some of the key strategies included leadership training programs, citizen academies, community forums, and interorganizational collaborations.

Discussion

The CHCI experience demonstrates that comprehensive community initiatives can engage a wide range of stakeholders in an in-depth exploration of community issues, leading to the creation of a locally relevant action plan. Did communities change as a result of these efforts? There were multiple instances where CHCI led to important new projects that directly benefited local residents. In other instances, CHCI's benefits were less concrete, such as increased civic participation, broader social networks, more sophisticated approaches to regional planning, and increased willingness of local institutions to engage the larger community when making decisions. These outcomes are important in their own right but may take time before they translate into clearly visible improvements in health,

economic prosperity, educational attainment, and child welfare.

Compared to the larger universe of CCIs, CHCI is among the more successful in fostering positive, long-lasting change within the participating communities. The outcomes were similar to those of the Sierra Health Foundation's Community Partnerships for Healthy Children initiative, which employed many of the same principles and planning steps as CHCI (Sierra Health Foundation, n.d.) In contrast, CHCI appears to have generated much more positive outcomes than the William and Flora Hewlett Foundation's Neighborhood Improvement Initiative (NII), which also used a resident-driven planning process to reduce poverty and develop new leaders among three low-income communities in northern California (Brown & Fiester, 2007). Two of the three NII communities implemented various new programs (e.g., health, education, leadership development) and established groups to continue the initiative. Nonetheless, Brown and Fiester concluded that "NII did not fulfill its participants' hopes and expectations for broad, deep, and sustainable community change" (p. i), and Hewlett's President labeled NII "an acknowledged disappointment."

Contrast With a Similar CCI

Because CHCI and NII produced markedly different outcomes, it is instructive to contrast the two models to identify factors present in the CHCI model but absent in the NII model; these factors may point to promising practices within the field of CCIs.

NII operated from 1996 to 2006 and included a one-year planning process designed to be "resident-driven," followed by six years of implementation that were supported by significant financial resources (\$750,000 a year) and by training and technical assistance. In addition, NII also involved the "designation or creation of a neighborhood-based lead organization to oversee implementation; local advisory committees with representatives from the public, private, and nonprofit sectors;... site-level data collection and development of a tracking system; and a multi-

site implementation evaluation" (Brown & Fiester, 2007, p. ii).

NII was similar to CHCI in a number of ways. Both initiatives involved a major strategic planning phase at the beginning; financial resources during the implementation phase; technical assistance at various points during the process; active representatives from the public, private, and nonprofit sectors; community-level tracking measures; and a multisite evaluation component. There were, however, three important differences that point to particular strengths of CHCI. First, NII's strategic planning model was open-ended and organic, whereas CHCI employed a prescribed planning process facilitated by experts trained in the CHCI model. Second, the CHCI process made stakeholders transcend their formal affiliations and even their personal views as to how the community should change, resulting in a new group-developed vision. Third, NII invested much larger financial resources in the participating communities (\$750,000 per year for six years) than did CHCI (\$50,000 per year for two years). These differences suggest that the CHCI communities benefited from having a well-defined planning model, professional facilitators, a common vision of how the community would change, and appropriately sized implementation grants.

Lessons

One of the most important lessons from CHCI is the power of initiative-based grantmaking. By investing in a focused, deliberate approach to community-based planning, The Trust was able to affect the way communities went about decision making and problem solving. We believe that these positive outcomes were due to a number of interrelated factors, including a well-designed planning process, professional facilitators, extensive outreach efforts in recruiting stakeholders, and local discretion in choosing which issues to address.

Although CHCI met many of The Trust's expectations, it is important to recognize the limitations of CHCI. The prescribed steps and exercises in the planning model were geared

to well-educated, analytically oriented participants. In order to attract and maintain stakeholders less familiar and/or comfortable with strategic planning, the model was allowed to become less structured in the second and third rounds of CHCI.

By investing in a focused, deliberate approach to community-based planning, The Trust was able to affect the way communities went about decision making and problem solving.

One of the most critical lessons concerns sustaining the new approach to community problem solving that CHCI spawned. During the implementation phase, it became apparent that sustaining the process of convening stakeholders, facilitating planning efforts, and incubating new projects required new locally based organizations dedicated to the principles of CHCI. Fifteen of the 28 communities established a new organization with the mission of extending the process of community problem solving. Many of these organizations gained widespread credibility and achieved important outcomes when they were supported with funding from The Trust. The majority of the local CHCI organizations, however, found it difficult to raise the resources required to maintain their staff and operations.

This dynamic raises the question of how long a foundation should commit to support a CCI. This is not simply a question of obligation but also opportunity. Many of the new organizations that emerged out of CHCI proved to be valuable local partners for subsequent community-based initiatives funded by The Colorado Trust, focused on topics such as youth assets, teen pregnancy, violence prevention, and services for seniors. In retrospect, CHCI might have been framed as a process for developing a decentralized statewide

infrastructure for ongoing community problem solving. This, however, would have required an even larger and longer commitment of grantmaking dollars, as well as different expectations on the part of The Trust's staff and board and among the stakeholder groups.

Another lesson for funders relates to clarifying expectations among the various players involved in the initiative. The NCL played an essential role in carrying out CHCI, but NCL's interests were somewhat different than The Trust's. The Trust was more concerned with health promotion, while NCL was focused almost exclusively on improving the civic infrastructure of the funded communities. This created good synergy, but there were instances when grantees heard inconsistent messages, especially related to the focus of the implementation proposals. This experience indicates how important it is for a foundation to clarify expectations with its partner organizations prior to going into the field, and then to allow for regular check-ins as the initiative encounters inevitable surprises.

CCIs have many opportunities for unforeseen twists and turns. In some CHCI communities, the planning process became bogged down in interpersonal issues or mired in controversy. There were occasions when staff from The Trust were called in to clarify their expectations or to defend the approach. Before entering into a CCI, a foundation should be clear about its intent and open to the possibility that it will be challenged. Importantly, initiatives like CHCI provide foundations with invaluable first-hand experience in how communities work and how change happens. By the end of the initiative, CHCI communities had provided the board and the staff of The Trust with a broader, deeper understanding of the requirements and opportunities associated with promoting community health, which helped make The Trust a more effective grantmaker.

The major successes, however, were for Colorado communities. Residents who had never been involved in civic affairs joined with established leaders to consider and plan their community's future.

Local stakeholders took a long, hard look at their community's deeper, systemic issues, as opposed to focusing on a narrowly defined problem. As a result, projects emerged that were creative and localized, with clear benefits for community members, putting these Colorado communities on a path toward a healthy community.

References

- ANNIE E. CASEY FOUNDATION. (1995). *The path of most resistance: Reflections on lessons learned from New Futures*. Baltimore: Author.
- ASHTON, J. (ED.). (1992). *Healthy Cities*. Milton Keynes, UK: Open University Press.
- BROWN, P., & GARG, S. (1997). *Foundations and comprehensive community initiatives: The challenges of partnership*. Chicago: Chapin Hall Center for Children
- BROWN, P., & FIESTER, L. (2007). *Hard lessons about philanthropy and community change from the Neighborhood Improvement Initiative*. Menlo Park, CA: The William and Flora Hewlett Foundation. Retrieved October 1, 2008, from <http://www.hewlett.org/Publications/NII.htm>.
- COLORADO TRUST. (1992a). *Choices for Colorado's future: Executive summary*. Denver, CO: Author.
- COLORADO TRUST. (1992b). *Choices for Colorado's future: Reference materials*. Denver, CO: Author.
- COLORADO TRUST. (1992c). *Choices for Colorado's future: Regional summaries*. Denver, CO: Author.
- COLORADO TRUST. (1993). *Choices for Colorado's future: Environmental scan*. Denver, CO: Author.
- CONNER, R. F., & CHRISTIE, C. A. (2009). Evaluation of the Colorado Healthy Communities Initiative: An interview with Ross Conner. In J. Fitzpatrick, C. Christie, & M. M. Mark (Eds.), *Evaluation in action: Interviews with expert evaluators* (pp. 269–298). Los Angeles: Sage Publications.
- CONNER, R. F., EASTERLING, D., TANJASIRI, S. P., & ADAMS-BERGER, J. (2003). Using community indicators to track and improve health and quality of life. In D. V. Easterling, K. M. Gallagher, & D. G. Lodwick (Eds.), *Promoting health at the community level* (pp. 43–76). Thousand Oaks, CA: Sage Publications.
- CONNER, R. F., TANJASIRI, S. P., DAVIDSON, M., DEMPSEY, C., & ROBLES, G. (1999a). *Citizens making their communities healthier: A description of the Colorado Healthy Communities Initiative*. Denver, CO: Colorado Trust.
- CONNER, R. F., TANJASIRI, S. P., DAVIDSON, M., DEMPSEY, C., & ROBLES, G. (1999b). *The first steps toward healthier communities: Outcomes from the planning phase of the Colorado Healthy Communities Initiative*. Denver, CO: Colorado Trust.
- CONNER, R. F., TANJASIRI, S. P., DEMPSEY, C., & ROBLES, G. (1999). *Working toward healthy communities: Outcomes from the implementation phase of the Colorado Healthy Communities Initiative*. Denver, CO: Colorado Trust.
- CONNER, R. F., TANJASIRI, S. P., DEMPSEY, C., ROBLES, G., DAVIDSON, M., & EASTERLING, D. (2003a). The Colorado Healthy Communities Initiative: Communities defining and addressing health. In D. V. Easterling, K. M. Gallagher, & D. G. Lodwick (Eds.), *Promoting health at the community level* (pp. 17–42). Thousand Oaks, CA: Sage Publications.
- CONNER, R. F., TANJASIRI, S. P., & EASTERLING, D. (1999). *Communities tracking their quality of life: An overview of the Community Indicators Project of the Colorado Healthy Communities Initiative*. Denver, CO: Colorado Trust.
- FLYNN, B. (1992). Healthy Cities in the United States. In J. Ashton (Ed.), *Healthy Cities* (pp. 49–56). Milton Keynes, England: Open University Press.
- HANCOCK, T., & DUHL, L. (1986). *Healthy Cities: Promoting health in the urban context*. Copenhagen, Denmark: FADL Publishers. (World Health Organization Healthy Cities Papers No. 1)
- KICKBUSCH, I. (1989). Healthy Cities: A working movement and a growing project. *Health Promotion International*, 4, 77–82.
- KUBISCH, A. C., AUSPOS, P., BROWN, P., CHASKIN, R., FULBRIGHT-ANDERSON, K., & HAMILTON, R. (2002). *Voices from the field II: Reflections on comprehensive community change*. Washington, DC: Aspen Institute.
- LARSON, C., CHRISTIAN, A., OLSON, L., HICKS, D., & SWEENEY, C. (2002). *Colorado Healthy Communities Initiative: Ten tears later*. Denver, CO: The Colorado Trust.
- NORRIS, T. (1993). *Colorado Healthy Communities handbook*. Denver, CO: The National Civic League.
- SIERRA HEALTH FOUNDATION. (n.d.) *A 10-year investment in community building to improve children's health: Evaluation of the Community Partnerships for Healthy Children initiative*. Sacramento, CA: Author. Retrieved October 1, 2008, from http://www.sierrahealth.org/assets/files/other_pubs/shf_cphc_final_report.pdf.

- TWISS, J. M. (1992). California Healthy Cities project: Piloting community-based health promotion statewide. *National Civic Review*, 81(2), 105–114.
- WALKER, G. (2007). *Midcourse corrections to a major initiative: A report of the James Irvine Foundation's CORAL experience*. San Francisco: The James Irvine Foundation.
- WHITE, J. A., & WEHLAGE, G. (1995). Community collaboration: If it is such a good idea, why is it so hard to do? *Educational Evaluation and Policy Analysis*, 17(1), 22–38.
- WORLD HEALTH ORGANIZATION. (1986). *The Ottawa charter for health promotion*. Ottawa, Canada: Health and Welfare Canada.

Acknowledgments

Well over 1,000 people contributed to the evaluation of CHCI, either in designing and carrying out the study or in reporting on their experiences. This includes members of the evaluation team, staff from The Colorado Trust, facilitators from the National Civic League, and stakeholders from the CHCI communities. We are grateful to them

all for their assistance and insights. We specifically want to acknowledge members of the evaluation team, including Catherine Dempsey, Marc Davidson, Gabriela Robles, Sora Park Tanjasiri, and Lois Wagner.

Ross Conner, Ph.D., is professor emeritus at the University of California Irvine, founder and former director of the university's Center for Community Health Research, former president of the American Evaluation Association, and former president of the board of the International Organization for Cooperation in Evaluation. His main work focuses on the implementation and evaluation of community-based health promotion, most recently with Chinese and Korean communities. Correspondence concerning this article should be addressed to Ross Conner, School of Social Ecology, University of California Irvine, Irvine, CA 92697-7075 (e-mail: rfconner@uci.edu).

Doug Easterling, Ph.D., is the chair of the Department of Social Sciences and Health Policy within the Division of Public Health Sciences at Wake Forest University School of Medicine. He has provided consulting services to a number of local, regional, and national foundations in the areas of evaluation, strategic planning, and organizational learning, particularly in the areas of social capital and community building.