The Foundation Review

Volume 13
Issue 2 *Shifting Power in Philanthropy*

6-2021

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Recommended Citation

Foster, S., Doksum, T., & Dwyer, C. (2021). Shifting Power in Maine: Findings From a Six-Year Community-Based Health Initiative. *The Foundation Review, 13*(2). https://doi.org/10.9707/1944-5660.1561

doi: 10.9707/1944-5660.1561

Shifting Power in Maine: Findings From a Six-Year Community-Based Health Initiative

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Keywords: *Systems change, community engagement, partnerships, power*

Introduction

In 2013, the Maine Health Access Foundation (MeHAF) launched a grant initiative supporting communities statewide to address system gaps impeding the ability of the most vulnerable individuals to obtain equitable health-related services and supports. The foundation's Community-Based Initiatives (CBI) comprised three individual programs:

- *Healthy Communities (HC)* aimed to transform communities into supportive environments that enabled people to live healthier lives. Communities received support to come to consensus around a community-defined health issue that became the focus of their system-change efforts.

- *Thriving in Place (TiP)* aimed to help older people and people with chronic conditions to maintain or improve their health to remain thriving members of their communities.

- *Access to Quality Care (A2QC)* aimed to address the needs of those lacking health coverage by developing systems of care that delivered sustainable, high-value services and supports.

This article presents findings and lessons learned from an evaluation and learning process that spanned five of six years of the initiative. It describes the context in Maine in 2013, MeHAF's grantmaking strategy, the design of the initiative and its theory of change, the evaluation methodology, and key findings. The article concludes with a discussion of what MeHAF learned about shifting power from the funder closer to community, how those lessons have informed its

Key Points

- Between 2013 and 2019, a Maine Health Access Foundation community-based initiative provided place-based funding to communities to address system gaps and inefficiencies that impede the ability of Maine's most vulnerable individuals to obtain essential services and supports. To rebalance power between the funder and grantees, the foundation introduced grantmaking practices such as long-term, flexible funding and new ways of relating to and supporting grantees. The theory of change guiding the initiative was that systems change is more effective and sustainable when communities develop cross-sector partnerships and engage community members in planning. The foundation guided the evaluation team to conduct a developmental, participatory, and adaptive approach focused on systems change rather than on individual health outcomes.
- This article presents findings and lessons learned from an evaluation and learning process that spanned five of six years of the initiative, describing the context in Maine in 2013, the foundation's grantmaking strategy, the design of the initiative and its theory of change, the evaluation methodology, and key findings. Those findings support the original theory that partnerships contribute to effective systems change and that community-generated ideas spark innovative interventions in such social determinants of health as social isolation, stigma, and poverty.

(continued on next page)

The foundation guided communities to address social determinants of health based on a growing evidence base suggesting that when communities collectively reorient systems, services, and policies toward addressing underlying conditions (e.g., poverty) that contribute to poor health outcomes, people are more likely to access services and supports that improve health downstream.

current strategy, and what implications this has for philanthropy more broadly.

Background and Initiative Design

In 2013, Maine was experiencing significant challenges affecting the health and well-being of its most marginalized citizens. The state did not expand Medicaid under the Affordable Care Act, leaving thousands of people uninsured. Maine has the nation's highest median age and one of the highest rates of disability (Fralich et al., 2012), yet resources to help older residents remain in their homes and communities were not sufficient or fully effective. Finally, significant cuts in public health infrastructure were making it more difficult for communities to respond to the complex health needs of their most vulnerable citizens.

Key Points (continued)

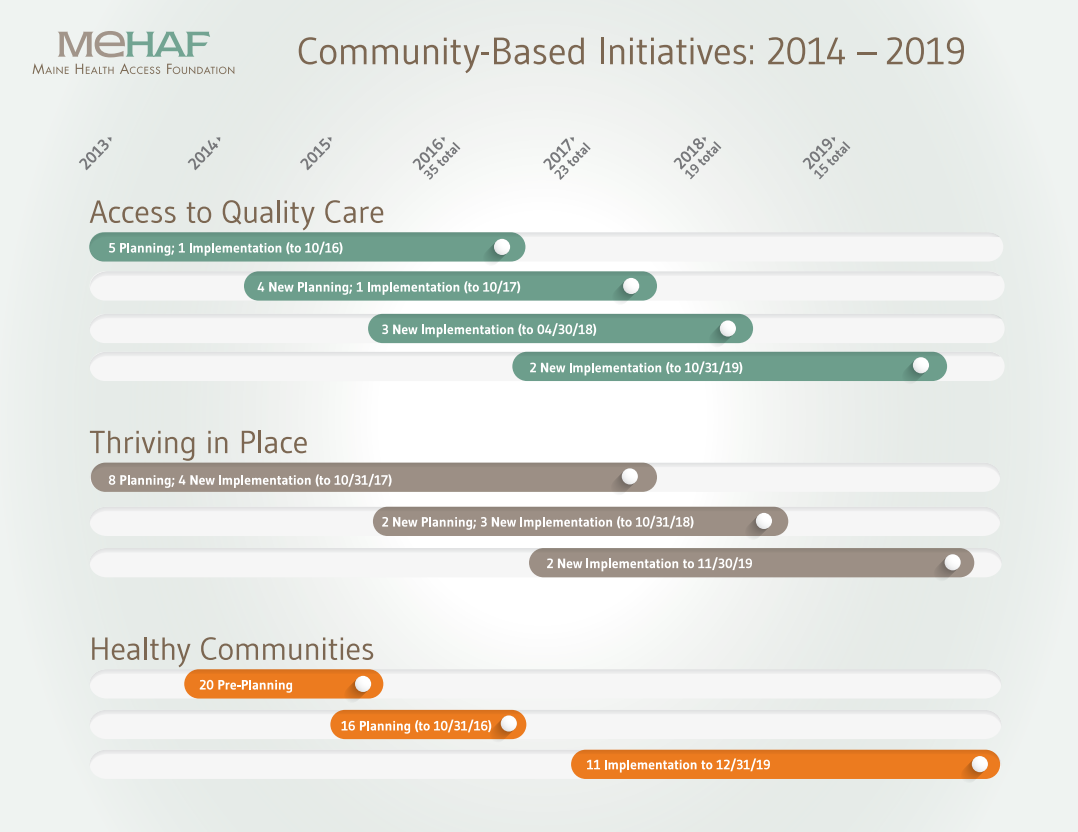
- Learning from the community-based initiative suggests that changing the power dynamic between funders and grantees can facilitate project success. This article concludes with a discussion of what the foundation learned about shifting power away from the funder and closer to the community, how those lessons have informed its current strategy, and what implications this has for philanthropy more broadly.

That year, MeHAF initiated a set of programs to support place-based community health improvement activities. Place-based grantmaking focuses on improving outcomes within specific geographic areas, rather than on a specific issue or cause (Murdoch, 2007). The foundation designed the initiative using several intersecting approaches: community change initiatives (Bailey & Jordan, 2006; Brown & Fiester, 2007; Kubisch, Auspos, Brown, & Dewar, 2010), meaningful community engagement (Centers for Disease Control and Prevention, 2011), and partnership or network development (Jolin, Schmitz, & Seldon, 2012; Zakocs & Edwards, 2006). The foundation guided communities to address social determinants of health[1] based on a growing evidence base suggesting that when communities collectively reorient systems, services, and policies toward addressing underlying conditions (e.g., poverty) that contribute to poor health outcomes, people are more likely to access services and supports that improve health downstream (University of Wisconsin, n.d.). The CBI centered on the idea that improved health sits at the intersection of many systems and sectors within communities, and that change should be sustainable (Trent & Chavis, 2009; Wong, Norris, & Solomon, 2009).

The CBI funded up to 35 grantees at any one point between 2013 and 2019. (See Figure 1.) At the end of the planning phase, grantees applied to move to the implementation phase, resulting

[1] Social determinants of health are defined as "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, 2020, para. 6).

FIGURE 1 Initiative Timeline



in some attrition. Implemented through several rounds of funding, the TiP and A2QC programs consisted of several cohorts that entered the initiative in different years.

Grantmaking to Facilitate System Change

The foundation understood that systems change is a long-term process, so the programs built in planning periods to allow communities time to build collaborative networks and develop work plans. Healthy Communities grantees received initial "pre-planning" grants to help them convene organizations and community members to develop consensus around a community-defined health issue. Grantees in all three programs received planning grants followed by three years of implementation funding. Required elements, such as multisector partnerships and the engagement of community members, were intended to bring communities together to drive and sustain change.

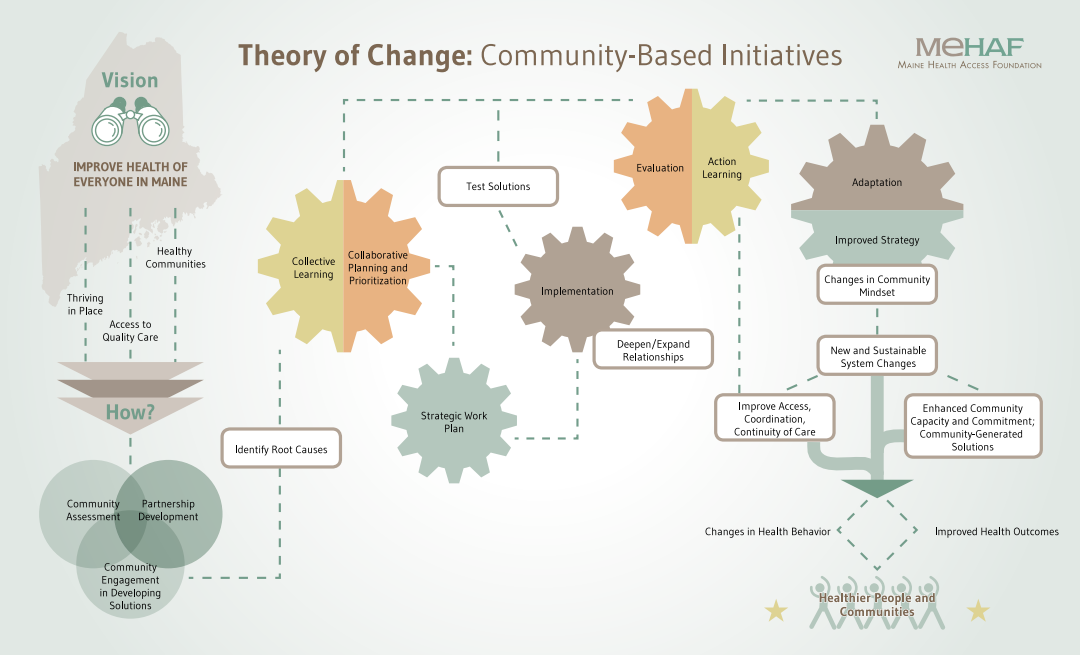
Changing the Funder–Grantee Power Dynamic

In order to address the power imbalance between funders and grantees, MeHAF adapted its traditional practices in four key ways:

1. Program officers reimagined site visits, traveling to communities and participating in local meetings and activities. Learning about the diversity of communities in Maine helped program officers realistically assess what was achievable and be more flexible with grant funds.

2. Program officers became thought partners, using their networks to help grantees

FIGURE 2 Original CBI Theory of Change



overcome obstacles and arranging meetings among peer organizations to share ideas.

3. Staff designed progress reports that asked meaningful questions, and they consistently read the reports and used them to spur productive conversations with grantees.

4. The foundation provided additional resources as needed, such as a consultant to provide strategic support and facilitation to community collaboratives at key pivot points in their development.

An Emphasis on Learning

In addition to its grantmaking, MeHAF invested in collective learning. Biannual learning-community gatherings afforded grantees the opportunity to build relationships with each other and to learn from subject matter experts and one another. Gatherings were professionally facilitated and centrally located at a retreat center, and grantees were reimbursed for travel expenses. An external learning and evaluation team was engaged in 2014 to provide evaluation support, ongoing learning, and local evaluation capacity building. Finally, MeHAF provided funding to some grantees to support local evaluation and product development.

The Evaluation Design Process

The foundation sought an evaluation and learning approach that was systems-focused, developmental, adaptive, and participatory. In communications with potential evaluation teams, MeHAF emphasized that the evaluation would not assess success based on a set of measures decided upon by the funder. Instead, it would focus on how things worked and what strategies made a difference. Evaluation was to be more about discovery and learning than about monitoring and accountability. The standards the foundation used focused on grantees' commitment to collaborative partnerships and the level of inclusion of community members in the design, implementation, and assessment of program strategy. An emphasis on quantitative measures of health outcomes would have meant unrealistic expectations given the time frame and resources.

TABLE 1 Evaluation Indicators and Questions

Indicator Type and Description	Evaluation Questions
Systems Change: Behavioral/structural/practice/policy changes within and across organizations and service systems that increase coordination, collaboration, and access to services and supports	What systems gaps were identified? What changes were observed in various systems?
Partnerships: Relationship building, leadership, trust, participation, common sense of purpose	How did partnerships develop? What was the perceived contribution of partnerships to observed systems changes?
Community Engagement: Active, meaningful participation in the project; roles; new skills acquired; activities; leadership development	How were people most affected by the health issue involved in the process? What mechanisms were used to lower barriers to participation? What was the perceived contribution of community engagement to observed systems changes?
Sustainability: Effective community changes stay in place and continue to evolve to promote progress toward long-term health and equity goals. Relationships created during the initiative continue to grow and drive social action to improve health.	Which project components and systems changes were sustained? How and by whom? What roles are partners, including community members, playing in sustainability?

Within these parameters, the evaluation and learning design drew from several theoretical frameworks: developmental evaluation (Gamble, 2008; Patton, 2011), evaluation of social innovation (Preskill & Beer, 2012), network theory (Plastrik, Taylor, & Cleveland, 2014; Vandeventer & Mandell, 2011), and collective impact evaluation (Preskill, Parkhurst, & Splansky Juster, n.d.a).

Using a developmental evaluation approach, the evaluation team became embedded in the initiative's learning community gatherings and conducted telephone interviews with each grantee to create grantee profiles, which were shared among grantees and staff to identify common themes and unique grantee characteristics. The profiles guided the development of data collection tools and the theory of change. (See Figure 2.) The theory of change represented what change was expected to looked like, depicting a nonlinear pathway toward change.

Each project had unique characteristics and operated under variable local conditions, so the evaluation plan had to include indicators broad enough to apply to grantees regardless of health issue or specific strategy, yet inclusive enough to cover variable approaches to meeting their goals. The final indicator list, which was reviewed by grantees, became the foundation for data collection instruments. (See Table 1.)

To address the evaluation questions, the evaluation team used mixed methods to collect data from various sources:

- *Document review* — This consisted of content analysis of grantee proposals, semi-annual progress reports, local evaluation reports, and other grantee-produced documents.

- *Grantee meeting observations* — Evaluators attended learning community meetings, documented themes that emerged from them, and conducted participatory exercises to elicit grantees' interpretation of preliminary findings.

TABLE 2 Example Targets and Strategies for Systems-Change Efforts

Targets	Strategies
• Social isolation • Underserved individuals in rural areas • Supports for aging safely in place • Gaps in mental health and substance use prevention services • Social determinants of health, such as poverty and food insecurity • Stigmatizing attitudes and behaviors associated with poverty, aging, and mental health and substance use disorders	• Social engagement activities, revitalizing senior centers • Evidence-based programs for older adults (e.g., tai chi, falls prevention, chronic disease management) • School-based restorative justice practices, recovery coach training • Food insecurity screening and referrals, summer meals programs, healthy cooking classes • Intergenerational activities with youth and older adults to build relationships and help reduce stigma associated with aging • Training for health care providers on poverty and stigma, stigma reduction campaigns

- *Project director surveys and interviews* — Between 2016 and 2018, evaluators conducted an annual, quantitative, web-based survey of project directors' opinions about progress. Response rates ranged from 100% in 2016 to 72% in 2018. After each round, the team conducted semi-structured telephone interviews with project staff to obtain more in-depth information. Since there were only five A2QC projects, those survey findings were not included among the findings.

- *Case studies* — Added to the evaluation design in 2016, case studies highlighted innovative projects and provided in-depth descriptions of emergent issues such as social isolation and stigma.

- *Technical assistance site visits* — During 2017 and 2018, the evaluation team visited each grantee to interview stakeholders and observe collaborative meetings. Following each visit, the evaluator shared a brief report with the grantee, including recommendations for local evaluation design.

Results

Evaluation findings support the theory of change that partnerships and community engagement were primary contributors to effective system change. Key system changes reported by communities included improvements in coordination of services and supports, spread of innovative and evidence-based programs and systems solutions to rural areas, and increased organizational commitment to addressing social determinants of health. Community members identified and led responses to systemic challenges such as rural transportation, social isolation, and stigma. (See Table 2.)

System Changes

Community assessments revealed system inefficiencies resulting in poor coordination, service gaps, and duplication of services and supports. The majority of grantees made substantial progress in improving how systems work to benefit the people they served. Grantees reported that they identified gaps in services, increased access to and coordination of services, and enhanced service availability and uptake in rural communities. They also increased the efficiency and responsiveness of existing services and supports and expanded awareness of services. (See Table 3.)

Developing new mechanisms for reaching people of all ages who are underserved or isolated was an early and ongoing focus of systems-change efforts (Foster & Doksum, 2016). Social isolation adversely affects the health and well-being of older people, but communities learned that feelings of loneliness and

TABLE 3 System-Level Changes, 2016 and 2018

Which system-level changes are being made, either directly or indirectly, as a result of your initiative's work?				
System-Level Changes	**Agree or Strongly Agree**			
	HC 2016	HC 2018	TiP 2016	TiP 2018
New mechanisms to reach underserved/isolated individuals (e.g., screening, alert systems, neighbor-to-neighbor check-ins, newspapers/social media)	60%	50%	78%	75%
Enhanced service coordination (e.g., referral systems, case review meetings, common forms)	60%	13%	78%	50%
Mechanisms to integrate health and behavioral health and/or social services (e.g., food insecurity screening in health care settings)	27%	13%	67%	25%
Identification of gaps in services (e.g., via provider meetings and knowledge exchange)	87%	88%	100%	100%
Strategies to increase awareness of eligibility criteria and available services (e.g., navigators)	60%	63%	89%	100%
Mechanisms to increase access to services (e.g., in-home services, transportation, flexible hours, efforts to decrease wait time)	47%	0%	89%	50%
Mechanisms that improve transitions from one level of care to another (e.g., warm handoffs, home visits, transportation)	20%	38%	78%	50%
New strategies to address social determinants of health (e.g., transportation, recreation, changes to built environment, access to healthy foods, community gatherings)	67%	88%	89%	100%
Total Number of Grantees Answering Question	**15**	**8**	**9**	**4**

disconnection can affect the behavioral health of youth as well. Communities implemented a wide array of activities to build social connection. (See Table 2.) The popularity and impact of these activities underscored the need to address root causes of presenting health problems.

Later in the implementation period, there was increased evidence that projects were successfully spreading innovative programs to previously underserved geographic areas (Foster, 2020). Pilot programs were a low-cost strategy for testing, adapting, and demonstrating the feasibility of new ideas. Grantees were particularly successful in using this process to establish new food access programs, evidence-based programs for older adults, and other community improvements. (See Table 2.) Local success bred interest and funding from municipalities, built the capacity of small organizations that adopted the programs, identified new community leaders, and helped grantees learn that documenting results helped make the case to sustain programs and provided information for future project leads.

The majority of HC projects and nearly all TiP projects addressed social determinants of health, most often around food insecurity. Through partnerships developed with health

"Our partner organizations are thinking differently about what 'community engagement' looks like in action, are sharing methods and resources with each other."

care providers, grocery stores, farmers, food banks, and food cupboards, grantees identified people experiencing food insecurity, raised awareness of hunger, and created stronger food distribution networks.

The A2QC projects surfaced more intractable system gaps than did the other two programs. In a stressed health and social support system, people without health coverage are the first to lose access to care. However, several A2QC projects made strides in educating health care providers on social determinants of health, improving communication and coordination between acute care and community-based services, and increasing access to primary and behavioral health care and social services.

Partnerships and Their Contribution to System Change

All MeHAF grants included funding for a coordinator who was instrumental in creating healthy, sustainable partnership collaborations. One of the most positive evaluation findings was that grantees' yearslong investment in building relationships with partners resulted in increased trust, understanding of roles, and shared responsibility for results. Keeping partners engaged during the planning phase was resource-intensive, but once communities came to consensus on a health issue they would address, partners consistently and enthusiastically participated in the collaboratives. Most groups eventually operated smoothly, and some collaboratives added larger provider networks to share knowledge and resources. Project directors attributed this positive shift to the value partners were getting from collaborative participation.

Project director surveys produced similar findings. The majority of grantees in both programs and cohorts (2016 compared to 2018) agreed with nearly all positive indicators of partnerships, such as increased communication, referrals, resource sharing, and trust. (See Table 4.) Notably, grantees were much less likely to report collective efforts to respond to policy opportunities and challenges, attributing this to the regressive policy environment in Maine at the time. Almost all grantees across programs and years agreed or strongly agreed that new collaborative efforts resulted in action that advanced their goals. Project directors provided numerous examples of how partners worked differently together because they knew more about each other's services and about client preferences.

Most key sectors directly involved in the priority topic were eventually engaged at the level needed for the project. These included home- and community-based services, public health, mental health, community health centers, community action agencies, media, volunteer networks, transportation, and substance use prevention and treatment. However, grantees reported difficulties engaging some health care institutions affected by financial struggles, mergers, and leadership turnover. Other sectors from which grantees wanted more involvement included local government, businesses, public safety, and the faith community. By the end of the initiative, however, municipal government increasingly engaged in sustaining project activities.

Leadership and network structure evolved over time. Many partner networks moved from centralized to distributed leadership models as projects matured. This involved organizations and project leaders actively letting go of power and control over direction. One project that ceded control to local community members observed that leading from outside the community was neither productive nor appropriate for sustaining the program. Network structure also shifted — from "hub and spoke," with the coordinator at the center of all activities, to

TABLE 4 Relationships Across Organizations, 2016 and 2018

Rate your agreement with the following statements about relationships across organizations and sectors.				
Statements About Relationships	**Agree or Strongly Agree**			
	HC 2016	HC 2018	TiP 2016	TiP 2018
Communication has increased.	93%	88%	88%	100%
Community awareness/endorsement of projects has widened.	92%	100%	100%	100%
New collaborative efforts are resulting in action that advances goals.	92%	100%	75%	100%
Increased referrals are seen across sectors.	85%	75%	62%	100%
Sharing of resources, data, and/or other information has increased.	85%	100%	75%	75%
Trust among diverse and competing organizations has increased.	85%	88%	75%	100%
Partners are responding collectively to policy opportunities and challenges.	54%	50%	50%	25%
Total Number of Grantees Answering Question	**15**	**8**	**9**	**4**

smaller "constellations," or work groups. This change accelerated the pace of the work and built a sense of shared ownership that facilitated sustainability. For example, one project transitioned from the grantee guiding it to becoming a "backbone organization model,"[2] with grantee staff providing administrative, logistical, and grant-writing support to four working groups. Even with more manageable structures, supporting a collaborative network required dedicated coordinator time.

"The idea that the coordinator function can fade away at the end of a grant is unrealistic; in fact, collaboration demands constant attention to process and relationships."

— Project Coordinator

Grantees credited partnerships with accelerating the impact of the systems-change work. A notable effect of partnership development was on sectors other than public health and health care. Partners from fields as diverse as law enforcement and education not only agreed to be collaborative members, but also began embracing broader ideas from other fields about how to make communities healthier and more connected (e.g., integrating restorative practices into schools, embracing youth supports to prevent drug use, addressing food insecurity, and supporting community meals).

[2] Backbone functions are performed by dedicated staff with specific skills to coordinate such collective impact functions as grant writing and facilitation (Preskill, Parkhurst, & Splansky Juster, n.d.b).

TABLE 5 Logistical and Leadership-Building Supports for Community Members

Logistical Supports	Leadership-Building Supports
• Flexible options for when and how to participate • Compensation such as honoraria, stipends, paid consulting arrangements • Transportation assistance (e.g., rides to meetings; gas cards) • Meals during meetings or grocery gift cards • Child care or babysitting stipends • Interpreter services	• Scholarships to conferences • Coaching and peer-learning sessions • Orientation and leadership training on topics such as meeting processes, collaborative decision-making, public speaking and advocacy • Opportunities to present at community events or conferences

Community Engagement and Its Contribution to Systems Change

In the earliest phase of the CBI, most grantee collaboratives were comprised primarily of organizational representatives. Grantees soon learned that simply inviting community members to the table was insufficient to create lasting change. Most learned that genuine community engagement required innovative strategies over multiple years to thoughtfully engage, support, and retain members of the community as meaningful participants. They accepted that one size did not fit all community members, who needed to participate in different ways depending on their individual circumstances.

One of the most common strategies grantees used to facilitate community engagement was to create a formal structure for participation, such as a steering committee, action team, or paid community consultant position. Other projects had several community members serve as equal partners on the collaborative body of organizational representatives.

Most grantees provided supports to facilitate community member engagement, especially underserved individuals. They also made intentional investments to support skill building and leadership development among community members. (See Table 5.) These investments increased community members' ability to actively participate in grant-funded activities, build confidence to express their opinions, lead project design, and develop effective working relationships with organizational representatives.

By the final year of the initiative, most grantees reported that community members were making significant contributions to the design, implementation, and success of their projects. Community members identified and led the response to systemic challenges such as rural transportation, social isolation, and stigma. Their personal experiences and knowledge of what the community needed and would accept enabled them to design activities that would be well received.

Community members of all ages influenced changes in the overall direction of projects. For example, stigma emerged as a major barrier to the success of several of the projects, primarily as a result of community members becoming more vocal about their treatment by the systems that were designed to help them (Foster & Doksum, 2019). Stories from community members revealed that people experience stigma related to food insecurity, mental health and substance use, and aging. As a result, many grantees redirected resources to activities designed to reduce such stigma, which helped change community attitudes and reduce bias on the part of health care providers, educators, food resource volunteers, and other service workers.

The idea that community members were essential partners in community change initiatives was not initially shared by all grantees, but it

was striking how prevalent that view became by the end of their grants. Most grantees eventually reported that addressing complex health-system issues takes a community response and that strategies were more effective when their design was informed by community members. Some even considered nurturing local leaders among their greatest achievements. The CBI's efforts to engage community members resulted in community-driven and more effective and lasting improvements to health care and other systems.

Sustaining the Gains

Sustainability in community health initiatives has been defined in two dimensions: the systems changes themselves and the relationships formed as a result of the initiatives (Wong et al., 2009). Interviews conducted with grantees after the end of their grants revealed that many CBI communities were able to sustain multiple critical components of their systems-change projects, and reported that both the systems changes and the relationships they had built over many years would likely be sustained:

- *Systems change:* Creative, relatively low-cost solutions that primarily used existing resources were the most effective way to improve systems and were especially important in rural areas where resources were scarce.

- *Partnerships:* Most collaborative networks formed during the grant period are still functioning because they are highly valued by their members and are proving effective at responding to emergent needs, including COVID-19. Partners played a key role in supporting activities once the grant ended; their willingness to adopt activities increased when projects could be demonstrated to be effective and feasible.

- *Community leadership:* Community leaders continue to provide invaluable input into the design, implementation, and evaluation of activities in many grantee communities. Cultivating community leaders helped to ensure that project activities were sustained.

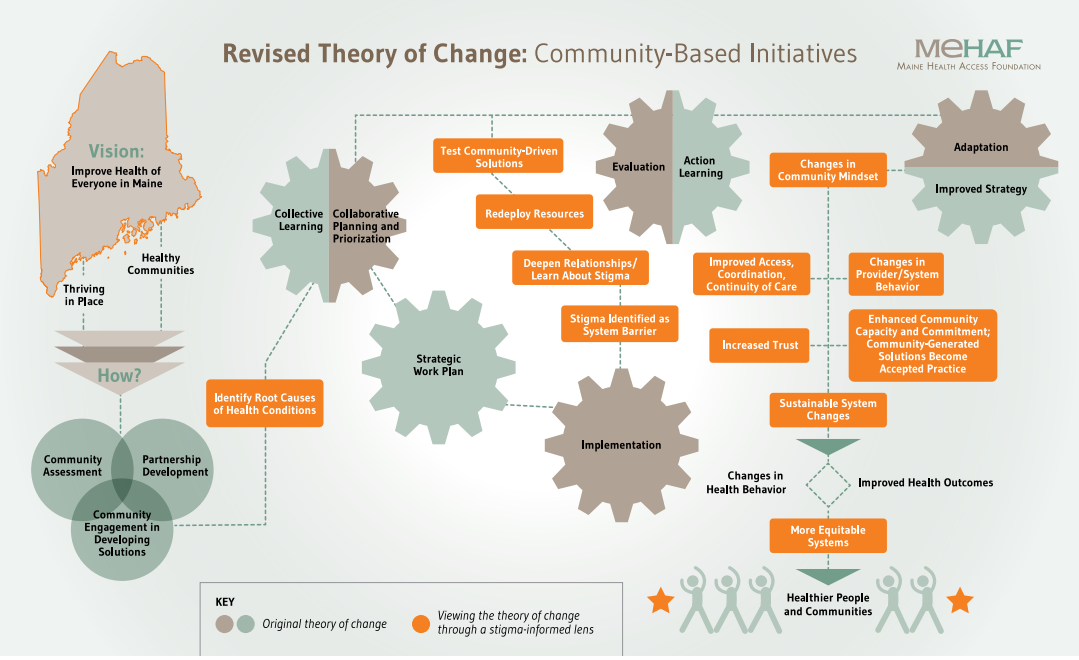
Most grantees eventually reported that addressing complex health-system issues takes a community response and that strategies were more effective when their design was informed by community members.

- *Cross-sector and community-member relationships:* The centrality of relationship building to the success of the CBI became clearer each year. Many communities reported that their work to build mutual trust and support, identify and address stigma, and respond to social isolation and loneliness had resulted in a shift in attitudes and an increase in community connectedness.

Findings from the evaluation of the CBI support the original theory of change, but lessons learned over six years added key components and nuance. The revised theory of change recognizes that addressing stigma and building trust help change mindsets, which is critical to creating equitable systems that improve health for everyone. (See Figure 3.) Even the most data-informed systems-change strategies will not work if a community does not learn about and improve how people are treated in those systems.

Grantees reported remaining challenges: securing funding to sustain key positions and supports, and ensuring that services are coordinated and well-known to all who need them. In some cases, changes in key personnel were crises, especially in rural communities where one person tends to hold multiple roles. The communities that distributed leadership across partners to carry out activities and to sustain their initiatives tended to be more resilient in the face of change.

FIGURE 3 Revised Theory of Change



MeHAF'S Relationship With Grantees

The foundation's grantmaking strategy and efforts to shift power and decision-making to local leaders were important factors in these programs' success. Grantees frequently expressed their appreciation regarding program officers' flexibility, enthusiasm, and willingness to partner to make their projects successful. Grantees said that they felt trusted and understood. They spoke most positively about the following aspects of MeHAF's approach to grantmaking:

- *Flexibility:* Communities were empowered to use their funding to meet needs as they emerged.
- *Multiyear funding:* Four years of total funding enabled communities to plan, experiment with new ideas, and learn from failure and success.
- *Progressive thinking about health:* Program officers encouraged grantees to focus on the most pressing barriers to health and wellness in their communities, which led to innovative interventions around stigma, poverty, and social isolation.
- *Measuring progress at the system level:* The foundation supported developmental and participatory evaluation that focused on systems change rather than individual health outcomes.
- *A focus on learning:* This involved learning community gatherings, creating peer-learning and relationship-building opportunities, and offering community-specific opportunities for growth.

Grantees made a number of recommendations to MeHAF to further its efforts to shift power to the communities it funds and thereby enhance its impact:

- Provide general operating funds.
- Continue the focus on learning, but consider other options (e.g., virtual, shorter-length

meetings) due to the costs of travel from remote communities.

- Increase emphasis on training grantees in leadership, community organizing, and communications.
- Convene discussions across funders on how to sustain initiatives that work.
- Magnify MeHAF's voice in informing policy.

Discussion

Findings from this evaluation support what MeHAF understood from the beginning: that it takes time for community-based systems-change efforts to take root, grow, and bear fruit. By the final year of the initiative, evaluation findings were increasingly positive. Using terms like "breakthrough," "acceleration," and "deepening" to describe their efforts, grantees reported positive results associated with the changes they were making.

Grantees were less successful in promoting policy change. The prevailing policy climate in Maine during the period of the community-based grants was not amenable to change, so it was not surprising that grantees focused on local efforts and preserving the public health system. All of the grantees bought into the idea that collective action through partnerships is the most effective way to generate change, and that the involvement of community members improves project design, ensures that interventions are better received, and contributes to sustained change. Community engagement, when practiced in earnest, changed the focus of the work and made strategies more effective.

An undergirding theme was that stigma arose as a systemic barrier only when the community voice was harnessed. Findings from the evaluation reinforce the importance of community-driven solutions to complex health problems, and they suggest that the theory of change must include addressing stigma in order to create more equitable systems to improve the health and well-being of all Mainers.

This initiative has provided insights on what forms of learning and evaluation are important to grantees (e.g., rapid feedback; stories to illuminate successes and challenges). The foundation's support of the external evaluation team was a critical factor in the success of the work. The foundation gave the evaluation team full access to documentation and many opportunities to interact with and build relationships with participants. These supports contributed to a high participation rate for annual surveys and site visits.

Since the grant programs ended, MeHAF has continued to move even further toward trust-based grantmaking, adopting many of the recommendations provided by the CBI grantees. For example, it has changed its grant review process to include more people with firsthand experience with the issues being addressed, through their own lived experience and as service providers. The foundation is also increasing its use of general operating fund grants and providing more support for organizational capacity building to community-based organizations serving marginalized populations. Finally, MeHAF is placing increased emphasis on equitable grantmaking, in which grantees are partners who co-design solutions to the problems they face. Grantees fully endorsed the idea of grantee gatherings to facilitate learning, but it was suggested that MeHAF could enhance learning through cross-initiative convenings.

Implications for Philanthropy

This experience produced lessons that have implications for how foundations use the power, resources, and tools at their disposal:

- Engage in learning and self-assessment around racial equity; reflect on current grantmaking practices and ask if they perpetuate inequity.
- Use one's networks and relationships to amplify the concerns of grantees and the communities they serve; for example, serve as liaison or convener between local organizations and state agencies.

- Identify community information needs that will help grantees advance their efforts, and agree on evaluation practices that bring the most value to their communities.

- Develop deeper relationships with grantees (e.g., by visiting them or volunteering in local organizations); increase understanding of the communities in which projects operate.

- Provide longer-term funding to give grantees the time to form relationships across differences, which is the underpinning of collaborative change. Whether the initiative is place-based or issue-driven, engaging organizations and community members with lived experience of the issue as partners in the design, implementation, and evaluation of the work leads to greater success.

- Be flexible with funding and timelines to enhance projects' ability to adapt. Stay in regular communication with grantees to assist them as their needs evolve.

Data Strengths and Limitations

This learning and evaluation process aimed to assess systems change and highlight social innovation. On the whole, it achieved its goals. Using a mixed methods approach helped evaluators assess change over time on indicators of systems change; employing participatory methods to promote shared sense-making engaged grantees and strengthened the evaluation. Case studies helped evaluators document how innovation occurred at the local level.

The evaluators obtained project director survey, site visit, and interview data from almost every grantee, so the findings are representative of the initiative as a whole. The site visits were particularly rich opportunities for data collection and learning more about the context and environment in which grantee work was being done. Attempts to gather information on partnership development via self-assessment tools had mixed results; to reduce burden on grantees, using these tools was not a required part of the evaluation, so participation was variable from year to year, making the data difficult to analyze across grantees and over time.

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