EXPLORING ORGANIZATIONAL PURPOSE, FUNCTIONS, AND STRUCTURES: A CASE STUDY OF A COMMUNITY HEALTH FOUNDATION AS COMMUNITY PARTNER

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Abstract

This study explored the role of a community health foundation in its efforts to improve the health status of the communities it serves. This exploratory study of the Carlisle Area Health & Wellness Foundation (CAHWF) offered two related opportunities to add to the existing body of knowledge on community health reform and more closely to the literatures on community foundation and community partnership theory and practice. These opportunities involved investigating the role of a community health foundation as community leader for change and within the community leadership role the responsibilities of a community health foundation as a coalition builder.

To exploit these opportunities, the study initially asked how the foundation interacted with community stakeholders in pursuing the goal of improved community health status and followed this with a second question focused on how the foundation was effective in achieving this goal. A single case study research design was used to complete the study. Data for the study came from six sources: key network stakeholders including CAHWF board members, CAHWF administrative staff, service providers, and community representatives; CAHWF source documents; and, CAHWF secondary data. Data was collected in four ways by completing focused interviews of key informants; completing focus group sessions; reviewing source documents; and, reviewing secondary data.

The research revealed a dense and intricate organization that served the community as a convener, administrator, facilitator, advisor, and grant maker in order to advance the cause of improved community health. For research purposes this variety of responsibilities was reduced to three groupings – community organizer, community resource, and community advocate. In its first five years of operation, CAHWF predominantly served in the capacities of community organizer and community resource. Community stakeholders perceived CAHWF’s efforts during its first five year of operation in the two capacities as effective in advancing the status of the community’s health.

The value of the research results from the conceptualization of the community foundation as a blended organization consisting of community partnership and foundation characteristics and the identification of five intermediate effectiveness measures (networking, collaborative planning, capacity building, disciplined funding decisions, and increased health and health related services) associated with this organizational model defined by the researcher as an “Engaged Community Health Foundation”. As a contribution, this single case study may provide a model of best practices that could be replicated by other health foundations seeking to serve in a collaborative community leadership role. Second, the research may serve as the basis for developing a way to differentiate types of community foundations operating within the health policy arena in order to begin a more systematic evaluation of these organizations and their impact on community health and health system reform. Further research is needed to determine the role of community health foundations as community partners for health improvement.
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Chapter 1 Introduction

Since the middle of the twentieth century, health care equity, financing and service related issues have repeatedly moved to the top of the public policy agenda as incremental responses to these issues, defined as problems at the times of the responses, failed to produce lasting remedies. Over the last thirty-five years, the growth rate in expenditures has been the primary factor regularly escalating health care from a societal concern to a perceived crisis.

A recent resurgence in the increase of medical prices and insurance premiums has again thrust the subject to the top of the policy agenda. As expressed by Jonathan Cohn (2001), the United States is again poised to enter the policy equivalent of “the perfect storm”. The three elements fueling the storm include: increases in medical costs; increase in the number of uninsured and under insured; and, the limited ability of the government, particularly state governments, to assume greater financial responsibility for health related services. Now more than ever there is a need to develop and implement effective and sustainable solutions to these historic challenges especially in light of newly anticipated system demands arising from rapid medical advances, globalization, and lifestyle and demographic changes (Clinton, 2004).

Throughout the second half of the twentieth century, repeated national, state and local initiatives have been proposed and some attempted to address the historic concerns stated above. These efforts have routinely focused on reforming the existing health care system. In general, these reforms focused on ensuring affordability while maintaining access and service quality for all citizens. The results of these efforts are not encouraging. There has not been successful comprehensive reform at a national level (Budetti, 2004). At the state
level results are mixed. Those states successful in initiating health care reform are constantly at risk of modifying or reversing their programs because of tightening financial constraints (Oliver and Paul-Shaheen, 1997). Community level reform initiatives have been in place for over two decades. These efforts to improve community health in a sustainable way are generally disappointing (Kreuter, Lezin, Young, 2000).

Despite these assessments of varying reform efforts, the level of community health reform activities remain high (Lasker, Weiss, and Miller, 2001). Health care policy specialists (Iglehart, 1994; Dilulio and Nathan, 1994; Colmers, 1998; Boufford and Lee, 2002; Budetti, 2004) encourage this intense commitment to community initiatives by identifying community level reform as a pragmatic way for achieving true comprehensive health reform. More importantly, increasing activity at the community level may simply be related to “a growing realization by average Americans that the risks of the current system to them personally and to the country as a whole outweigh the risks of comprehensive reform” (Fuchs and Emmanuel, p.1412, 2005). Numerous opportunities for community health reform research remain as solutions to health related problems are actively sought at the local level.

This research focuses on a community health care reform initiative – specifically a community health foundation’s collaborative actions as a community leader to improve the health status of the community it serves. As recommended in the literature (Zakocs and Edwards, 2006), the assessment of the community health foundation’s efforts to meet health status objectives in partnership with the community are described primarily from an inter-organizational perspective. The intent of this exploratory study is to contribute to the health care reform literature and more narrowly to the limited body of literature on community health foundations by identifying ways to increase the social value of
foundation lead collaborative efforts. This will be accomplished in two ways. First the study will describe the collaborative processes and organizational structures employed by the community health foundation in its role as a lead agency for community health improvement. Second, intermediate effectiveness measures associated with this course of action will be identified.

To provide context for the study of this community based health reform approach, this chapter begins by briefly summarizing health reform initiatives to date at the national, state and local levels. Second, the setting, direction, purpose and intended value of this specific study are detailed and the research questions are provided. The chapter closes with a brief summary of the study’s organization.

**Overview of Health Care Reform**

**National Health Care Reform**

Beginning with Franklin D. Roosevelt’s administration, each presidential administration has attempted to enact broad reaching health national care reform. An extreme imbalance in the relationships between traditional health system cost, quality and access measures existed most recently in the early 1990’s. At the time, despite the Clinton administration’s perception of broad based national support for reform and a belief that the political will existed to fundamentally change the American health care system, the effort to pass comprehensive national health care reform, embodied in the Plan for Health Security, was politically dead in 1994.

From a political perspective, the reasons for the failure of national health care reform enactment are numerous. These include the failure to accurately interpret public sentiment; the complexity of the proposal; the perceived secretive nature of deliberations; the ability of opponents to quickly undermine public support through the use of the mass
media; and, given the diffusion of power in Congress, the ability of opponents to influence individual political entrepreneurs creating temporary alliances capable of blocking full congressional approval of any reform legislation (Steinmo and Watts, 1995; Zelman and Brown, 1998).

The political rationales for the failure of comprehensive national health care reform simply begin to touch on the fundamental challenges facing reform advocates at a national level. The fundamental challenges include but are not limited to the following: lack of a clear, agreed upon and well articulated national vision on health, health promotion and medical care; conflict over the appropriate strategy (private market versus public intervention) to achieve national health goals and objectives; a related deep seated public concern about the level of income redistribution required to guarantee an equitable system.; the significant short term expenditures required to implement fundamental system change; and, the lack of a national forum to civilly work through the complexities of these issues without political pressures influencing the problem solving process (Shi and Singh, 2004). Comprehensive health care reform at a national level has not been attempted since the beginning of the 1990’s partially because of the Clinton administration’s failure to institute national health care reform but most likely because of the difficulties of overcoming the fundamental challenges listed above.

State Health Care Reform

The failed attempt at national reform relegated primary responsibility for meaningful reform to the states throughout the remainder of the 1990’s. Individual states accept this challenge for several reasons. First, state governments have historically accepted primary responsibility for financing and providing “welfare” programs. Second, each state plays a critical role in regulating its own health care market. Third and perhaps most importantly,
states are major purchasers of health care services. On average, twenty (20) percent of their budgeted expenditures are committed to health care services (Iglehart, 1994). State efforts at health care reform throughout the 1990’s were at best mixed (Oliver and Paul-Shaheen, 1997). The reasons for the lack of success at the state level include but are not limited to the following: the nature and national scope of the issues; the challenges of maintaining political consensus among critical constituencies through policy implementation; lack of leadership; insufficient investment in management capacity; and most importantly inadequate financial resources (Iglehart, 1994; DiIulio and Nathan, 1994; Oliver and Paul-Sheehan, 1997; Oliver, 2000). The pressing reasons for states to accept leadership roles in health care reform have not diminished, and as a result there has been a resurgence of comprehensive reform activities at the state level in this decade despite the lack of clear cut success of prior reform efforts. Notable examples include California, Massachusetts, and Pennsylvania’s most recent effort embodied in the Rendell Administration’s Prescription for Pennsylvania Plan.

Community Based Health Care Reform

Beginning in the middle of the 1980’s an approach for addressing health care issues that went beyond efforts to fix existing financing and delivery models began to emerge and gather support. Community based health reform advocates believe that community health status can only be improved through the development of holistic models of social and health related activities. This vision of healthy communities requires the development of local management capacity capable of initially facilitating organizational change (institutional policies, practices and programs) and change in community wide health related behaviors (nutrition, exercise, smoking) in the belief that these changes will lead to improved population level outcomes. Efforts to actualize this vision of health care have
been pursued with varying levels of intensity and expectations for some time at the community level by voluntary collaborative networks of diverse community organizations generally referred to as community health partnerships. Although these partnerships all share the same underlying belief in the benefits of multi-sectoral collaboration for improved community level health improvement, these partnerships take many forms; vary in structure; and are typically not financially self-supporting. Similarly the vision and mission of these partnerships may vary in scope of purpose (Roussos and Fawcett, 2000).

After more than two decades of activity, the efforts of community partnerships are being widely evaluated. The findings on partnership effects on long-term population health outcomes are mixed. Some studies demonstrate a relationship under certain conditions but most study results are insufficient to draw reliable conclusions (Roussos and Fawcett, 2000; Kreuter, Lezin, Young, 2000; Shortell and Mitchell, 2000).

Despite the lack of conclusive evidence, belief in the approach still remains high (Emmanuel and Titlow, 2002). There are several reasons for continued confidence in the benefits of community health collaborations. First, there are separate collections of case study findings indicating positive relationships between community partnership activity and organizational change and between community partnership activity and community-wide behavioral change (Roussos and Fawcett, 2000). Second, despite limited evidence linking intermediate and long-term community partnership outcomes, intermediate-term partnership success is still believed to serve as the platform from which long-term community health goals may be reached (Mitchell and Shortell, 2000; Kreuter et al., 2000; Sofaer et al., 2003; Zakocs and Edwards, 2006). Third, there is broad support for the proposition that given sufficient social capital complex multi-system problems are
best addressed at a community level. Community level problem solving is considered effective because there is greater acceptance of shared ownership of problems; a more immediate sense of urgency to correct problems due to limited resources; and, a sense that local solutions more accurately reflect the community’s beliefs (Bracht, 1990; Schlaff, 1991; Zuckerman, Kaluzny, and Ricketts, 1995).

The general belief in the value of community health collaborations is evidenced by the investments of hundreds of millions of dollars by foundation and government agencies into these types of organizations (Butterfoss, Goodman, and Wandersman 1996; Lasker, Weiss and Miller, 2001). Examples of these initiatives include Healthy Communities sponsored by HHS and the National Civic League, the Robert Wood Johnson Foundation’s Community Care Network as well as the W.K.Kellog Foundation funded Community Voices: Health Care for the Underserved and Turning Point: Collaborating for a New Century in Public Health.

In addition to community health partnerships, community health foundations are playing an increasingly important role in community health reform. More than 700 community foundations currently operate in the United States (Ostrower, 2007). At a minimum 185 of these may be classified as community health foundations. These 185 health foundations were created from the proceeds of the sale of nonprofit health care organizations to for profit health care organizations. These foundations are commonly referred to as health care conversion foundations. Of the 185 health care “conversion” foundations 151 or 82% were created since 1990. The combined assets managed by these 185 community health foundations are approximately $21.5 billion (Grantmakers in Health, 2007).
Similar to community health partnerships, community health foundations support a wide range of health and health system improvement initiatives designed to benefit the communities they serve. The foundation support is routinely demonstrated through the distribution of grant awards to non-profit community service providers.

In contrast to community health partnerships, community health foundations are not solely reliant on external sources of funding to maintain operations. From the perspective of community involvement, very few of these foundations are required by law to seek community input. Through their governing documents, a minority (19%) of the health care conversion foundations require community input on board of trustee nominations and a small number (12%) must seek out community recommendations on the selection of community needs. Despite limited formal requirements, health care conversion foundations routinely seek community input to help direct their combined $1.0 billion annual investment in community health initiatives (Grantmakers in Health, 2007). The ways in which health care conversion foundations interact with community stakeholders and the impacts of their actions on community health and health care have not been comprehensively evaluated.

Health Care Reform Summary

Health care equity, financing and service issues remain at the top of the public policy agenda. These policy issues remain high on the agenda due to the continued alarm over escalating health expenditures and the impact of these costs on access to care. National and state health policy actions have historically focused on reforming existing health care systems to ensure affordability and accessibility to care. These efforts have met with limited success. National health care expenditures currently represent approximately 16%
of GDP. And the number of uninsured nationally is estimated at 45 million individuals (Budetti, 2004).

The level of community health reform activities remains high due in part to the limited success of national and state reform efforts and on a more positive note to broad support for collaborative community efforts to address complex problems. In contrast to simply attempting to fix existing systems, collaborative community health initiatives attempt to address the multiple factors influencing individual and community health in their efforts to develop and implement sustainable solutions to health and health care problems. Understanding how to create community health partnerships; mobilize community stakeholders within these networks; and sustain meaningful community action capable of resolving complex societal problems is critical to our society’s quality of life. Discovering ways to achieve these objectives through disciplined research is essential for the public good.

**Case Study Focus and Purpose**

As briefly stated in the introduction, the intent of this research is the completion of an exploratory case study of a community health care foundation in its role as a lead agency for community health improvement. To provide a more detailed explanation of this specific study, this segment of the chapter is organized as follows: the research setting, opportunities, direction, purpose and value, and questions.

**Research Setting**

The research setting for the exploratory case study is The Carlisle Health and Wellness Foundation (CAHWF). CAHWF was created in June, 2001 from the proceeds of the sale of the Carlisle Hospital and Health Services, Inc. (CHHS) to Health Management Associates, Inc. (HMA) and the transfer of CHHS related endowments and trusts. The
Foundation serves a population of approximately 130,000 individuals residing in western Cumberland county, western Perry county, northern Adams county and parts of Franklin county.

The Carlisle Health and Wellness Foundation represents a health care conversion foundation. The case study focuses on the first five years of the Foundation’s operations (2001-2006). From 2002 through 2005, I served as an ad hoc member of the Foundation’s planning committee and thus had an opportunity to observe the development of the Foundation during its formative years. During its first five years of operation (2001-2006) the community health foundation attempted to establish its role as a community leader for the improvement of community health. This desired role is articulated in the Foundations vision statement to “be a leader and catalyst to ensure continuous improvement of health in our communities.” To achieve this vision CAHWF intended to address both health and health care system issues within its service area.

CAHWF had no legal obligation to seek community involvement in their selection of vision, mission, strategy or actions with the exception of corporate governance requirements to identify and select six members of the twenty-two members of the Board of Trustees with specific institutional and/or community ties (a member from the educational community, religious community and United Way and three residents of Perry County). Despite the absence of a requirement to actively seek community input, CAHWF worked closely and extensively with community individuals and organizations during this five year period to fulfill its vision and achieve its mission. During the first five years of operation, CAHWF expanded its leadership role to include – coalition building, grant making and policy advocacy. The two most significant organizational
capacities assumed by CAHWF during this time were coalition building and grant making.

**Research Opportunity**

An exploratory study of CAHWF offers two related opportunities to add to the existing body of knowledge on community health reform. These opportunities involve investigating the role of a community health foundation as community leader for change and within the community leadership role the responsibilities of a community health foundation as a coalition builder.

Interest and related research on the role of foundations in creating social value has grown as public demand for nonprofit accountability has increased over the last decade (Light, 2002, 2004). Foundation research has primarily focused on the relationship between foundations and their grant recipients, typically non-profit service organizations. In general, the research identifies ways that foundations and nonprofits can work together to leverage limited resources for the purpose of achieving the greatest social impact (The Center for Effective Philanthropy, 2002; Regenstreif, Langston, and Reider, 2004; Grantmakers for Effective Organizations, 2006; Ostrower, 2006a). Although there is a growing body of knowledge on foundation “best practices” as they relate to their grantees, the role of foundations serving more broadly as leaders for community betterment is just beginning to be explored (Ostrower, 2006b, 2007). More specifically, it is acknowledged that community foundations may be more effective in advancing the welfare of their communities by taking on a community leadership role but there is an absence in the literature on how community foundations can best accomplish this transition to community leader (Ostrower, 2007).
In the case of CAHWF, an organizational capacity instrumental in its efforts to lead change during its formative years was its ability to build and manage community health coalitions. Over the last twenty years, extensive theory building and research has been conducted on community health coalitions and their effectiveness (Butterfoss, Goodman and Wandersman, 1993; Gamm et al., 1998; Fawcett et al. 1995; Provan and Milward, 1995; Lasker, Weiss, and Miller, 2001; Shortell et al, 2002; Weech-Maldonado et al, 2003; Hasnain-Wynia et al, 2003; Alexander et al., 2001; Bazzoli et al., 2003; Conrad et al., 2003).

Despite extensive research and theory building on the subject of community health coalitions there is no agreement on a common set of health coalition effectiveness determinants or measures associated with the development of effective coalitions (Roussos and Fawcett, 2000; Zakocs and Edwards, 2006). Ronda Zakocs and Erika Edwards (2006) maintain that one reason for the variation in effectiveness determinants and indicators is the lack of collaboration across academic disciplines. The authors suggest that one social science field capable of linking multiple and disparate discipline for the purpose of better understanding health coalitions is the inter-organizational relations (IOR) field. An exploratory study of CAHWF creates the opportunity to model and assess the effectiveness of community health foundation lead coalitions through the integration of an IOR conceptual framework as part of the research. Based on a review of the literature (Zakocs and Edwards, 2006) a research approach employing an IOR framework to community foundation administered coalitions has not been completed.

**Research Direction**

Given the opportunities presented above, the intended direction of this research is to explore the role of a community health foundation, CAHWF, in its role as a community
leader working in collaboration with other community stakeholders to improve the overall status of community health. Taking into consideration CAHWF’s collaborative approach to change, a specific focus of the research will be on CAHWF’s actions as a community coalition builder and administrator. An integration of inter-organizational relationship, community health partnership, and foundation literatures will be relied upon to describe CAHWF’s organizational purpose, functions and structures and to identify intermediate measures of foundation effectiveness.

Research Purpose and Value

By delving into the operations of the Carlisle Health and Wellness Foundation, the intent of the researcher is to exploit an opportunity to contribute to a community foundation topic that has not been fully investigated – the role of a community health foundation as a collaborative community leader. From a pragmatic perspective this single case study may provide a model of “best” practices that could be replicated by other health foundations seeking to take the lead on improving community health in partnership with other community stakeholders. Second, the research may serve as the basis for developing a way to differentiate types of community foundations operating within the health policy arena in order to begin a more systematic evaluation of these organizations and their impact on community health and health system reform.

Research Questions

Two exploratory questions were developed to complete the research. The first question is as follows:

Q1. In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community?
The purpose of this question is to gain a complete understanding of CAWHF’s organizational purpose, functions and structures as they relate to community stakeholders and to the overall welfare of the community.

The second question is as follows:

Q2. In its first five years of existence how has the Carlisle Area Health and Wellness Foundation been effective?

This question was designed in a broad enough way to identify intermediate effectiveness measures for each of the Foundation’s key organizational capacities. A definition of the construct of effectiveness follows this segment in recognition of the challenges associated with effectiveness research.

Defining Effectiveness

The construct of effectiveness serves as the central theme in organizational analysis (Goodman and Pennings, 1980; Cameron and Whetton, 1983; Quinn and Rohrbaugh, 1983). Although a construct of central importance, effectiveness presents researchers with challenges from both theoretical and empirical perspectives. Despite the elusive nature of the construct, numerous efforts to model effectiveness have been made.

The earliest models are characterized by a singular dimensional perspective of the construct. These include goal based models (Etzioni, 1964), system-resource models (Katz and Kahn, 1978; Yuchtman and Seashore, 1967), and multiple constituency models (Connolly, Conlon, Deutsch, 1980; Zammuto, 1984). In response to perceived weaknesses in these singular dimensional models, efforts to capture the complexity of the construct have and continue to be attempted through the development of multi dimensional effectiveness models such as the competing value framework introduced by Robert Quinn and John Rohrbaugh (1983).
In reflecting on the multiple models of organizational effectiveness Richard Hall (1977, p 95) states that there “are no single models or prescriptions for effectiveness”. Hall presents a practical description of organizational effectiveness that includes elements of the various models listed above. Basically all organizational stakeholders assess effectiveness in terms of the achievement of operative goals established by key decision makers. As importantly, organizations maximize their effectiveness (achievement of operative goals) by actively adapting their organizational processes and structures in anticipation of or in response to changes in the external environment (Hall, 1977).

Relying on Richard Hall’s description (1977) for the purpose of this research, measures of effectiveness will be broadly recognized as both indicators of organizational capacity building and operative goal achievement.

**Summary**

In this chapter health care reform efforts at the national, state, and local levels were briefly reviewed to provide context for the selection of the research topic on community based health reform. A discussion on the purpose and value of the research followed this opening summary. The chapter concluded with an introduction of the research questions.

The second chapter is dedicated to a review of the literature on the research topic. A brief summation of current foundation literature is initially provided. A review of inter-organizational literature specifically the literature on organizational networks is then provided. A review of the health care partnership literature follows. The chapter concludes with an effort to integrate the network and partnership literature in anticipation of the analysis of the research findings.

The third chapter accomplishes four objectives. These are as follows: to describe the organization under study, the Carlisle Health and Wellness Foundation (CAHWF); to
identify the research questions and propositions; to describe the research design and 
methods; and to acknowledge and describe study limitations.

Chapter four presents the case study findings and the analysis of the findings. The case study findings are organized by research question. In response to the first research question the organizational processes and structures relied upon by CAHWF to interact with community stakeholders are provided. Measures of effectiveness associated with CAHWF’s course of action are then identified in order to answer the second research question. The case study analysis is based on an application of the relevant literature. The order of presentation of the case study analysis parallels the presentation of the case study findings.

Chapter five provides a discussion on the contribution of the research to community health foundation theory and practice with an emphasis on the capacity of a community health foundation as a community partner. The chapter concludes with recommendations for further research.
Chapter 2  Literature Review

To perform effectively, an organization’s structure and functions must reflect the complexity of the environment in which it operates; and as importantly, for an organization to remain effective over time it must continually adapt to ongoing changes in its environment (Lawrence and Lorsch, 1969; Galbraith, 1977).

Since the end of the nineteenth century, four broad organizational types have emerged in response to complex and dynamic external factors. These organizational types (functional, divisional, matrix and network) built on each other in successive order. In the 1980’s, a network form of organization emerged in response to dramatic shifts in environmental conditions. The private sector quickly embraced the model and continues to employ network strategies in response to international competition and rapid technological change. By employing this organizational form private sector firms are better able to focus on their core competencies; reduce layers of management hierarchy; and outsource a wide array of supporting activities (Miles and Snow, 1992). The non-profit and public sectors also embraced the model and continue to rely on network structures. The ongoing establishment of network organizations in these sectors results from a recognition of the interdependence of groups; the growing complexity of the environment; the difficulty of social problems; and, the limited availability of resources to address these complex, interrelated issues (Chisholm, 1996).

Community health partnerships reflect public acceptance of a network organizational approach for the resolution of complex and difficult health related issues. These partnerships form in the belief that sustainable improvement requires the assessment of multiple determinants of health and the development and execution of coordinated
strategies. In the United States this problem solving approach strongly resonates with the values of democratic participation and local community control.

In its efforts to identify and resolve both community health and health system problems, CAHWF expanded beyond its core responsibility of grant making to include the management of health care partnerships. As stated in Chapter 1, the direction of this research is to explore CAHWF’s entire operations as a collaborative community health improvement leader with careful attention to CAHWF’s leadership actions as a community coalition builder and administrator. The purpose of the chapter then is to review and integrate literature on foundations, organizational networks and community health partnerships in ways that will support the research questions and methods targeted at disclosing CAHWF’s organizational purpose, functions, structures and intermediate measures of effectiveness.

This chapter is organized into five sections. These are the introduction, a review of the foundation literature, a review of inter-organizational network literature, a review of literature on community health partnerships, and a chapter summary. The introduction includes the purpose and structure of the paper. A general overview of foundation literature follows the introduction. The inter-organizational literature review consists of six subsections. These are definitions, models and types, developmental process, governance and management, effectiveness, and summary. The literature review on community health partnerships is composed of six subsections. These are concepts and definitions, models and types, developmental process, governance and management, research, and summary. The chapter summary integrates the key literature findings serving as the basis for the research questions and methods.
The Foundation Literature

Interest and related research on the role of foundations in creating social value has grown over the last decade. There are several reasons for this increased attention. First, nonprofit assets currently exceed $2 trillion in value with foundation assets representing $500 billion (25%) of the total asset value. Second it is anticipated the rate of giving will increase as “baby boomers” reach their prime giving years during the first quarter of this century. With this growing resource however comes increasing demand on nonprofits to increase their services in ways that justify the investments in these organizations. A primary reason for the increasing reliance on nonprofit services is related to declining public sector capacity to broadly address all critical environmental and social issues. This declining capacity is associated with ongoing pressures to reduce government spending coupled with government mandates requiring the payment of health and social welfare benefits for a rapidly aging population (Bradley, Jansen, Silverman, 2003). Third, foundation writers and researchers believe these organizations may be in the best position to enhance the efforts of nonprofit organizations. This is because foundations can investigate new approaches to solving societal problems free from political pressures. And, foundations possess sufficient management and financial capacity to sustain support for those programs carried out by nonprofit organizations which prove effective (Porter and Kramer 1999).

Foundation research has primarily focused on the relationship between foundations and their non-profit grant recipients. In general, the research identifies ways that foundations and nonprofits can work together for the purpose of maximizing their combined social impact. More specifically the research often attempts to identify the “best practices” of
foundations as these practices relate to improving nonprofit performance. Several of these practices are consistently identified throughout the literature (Porter and Kramer 1999, The Center for Effective Philanthropy, 2002; Regenstreif, Langston, and Reider, 2004; Grantmakers for Effective Organizations, 2006; Ostrower, 2006a).

According to foundation theorists and researchers an effectively performing foundation exhibits the following attributes:

1. The foundation selects where and how it plans to make an impact on society.
2. The foundation’s decisions consistently reflect its stated mission and strategy.
3. The foundation supports research and projects that produce more effective ways to address social and environmental problems.
4. The foundation selects the highest functioning and most effective nonprofit organizations to carry out its mission.
5. The foundation supports these nonprofit organizations by encouraging and incentivizing other funding sources to support these nonprofit organizations.
6. The foundation supports these nonprofit organizations by creating opportunities for these organizations to build greater management capacity.
7. The foundation holds itself as well as its grant recipients accountable for results that truly result in net social benefit.

Although there is a growing body of knowledge on foundation best practices as they relate to grantees, the role of a foundation serving in a more expansive role as a community catalyst for change has not been extensively researched (Ostrower, 2006b, 2007). More specifically, Ostrower acknowledges that a community foundation capable of leading different parts of the community to address specific needs enhances foundation effectiveness, but the author does not offer detailed recommendations on how a community foundation can best gain support and meet the needs of a broad array of community stakeholders as it transitions into the role of a community leader (Ostrower, 2007).

Finally, research on community health foundations specifically health care conversion foundations is limited to survey worked completed by the nonprofit organization,
Grantmakers in Health. To date, the survey information has been descriptive in nature providing data on foundation governance and management characteristics, grant making areas, the value of foundation assets and methods employed by health care conversion foundations to involve community representatives in foundation activities. Grantmakers in Health’s researchers have not used this data to develop theories or models on the relationships between health care “conversion” foundations and other community organizations.

**The Inter-organizational Network Literature**

**Definition**

The literature on inter-organizational networks may be found within the inter-organizational literature section of organizational theory literature. Inter-organizational network literature represents an increasingly important subset of the overall inter-organizational literature. It is extensively represented in the work of numerous professional and academic disciplines (Grandori and Soda, 1995; Osborn and Hagedoorn 1997; Sofaer and Myrtel, 1991). These disciplines include but are not limited to business management (Kanter, 1994), health care management (Sofaer and Myrtel, 1991), public management (O’Toole, 1997; Agranoff and McGuire, 2001), sociology (Granovetter, 1983, 1985), social psychology (Nohria and Eccles, 1992; Gulati, 1998) and economics (Grandori and Soda, 1995; Park, 1996). Additionally, a number of organizational theories have been applied to help explain inter-organizational networks. These include resource dependency theory (Pfeffer, Salancik, 1978), ecological analysis (Hannan, Freeman, 1977), and institutional theory (DiMaggio, Powell, 1983).
Defining an inter-organizational network in a comprehensive manner is challenging given the number of disciplines contributing to the literature. A better sense of the challenge may be gained by reviewing John Hagedoorn and Richard Osborn’s view of networks.

“Alliances are older than firms, but they are still new to many firms. They are temporary mechanisms and long lasting relationships. They are cooperative and competitive weapons. Each is unique but they often share similar properties. They have intended purposes, yet their emergent benefits may be more important.”(Osborn and Hagedoorn 1997, p. 274)

Differences in definitions appear to be driven by the stated purpose of the network and the academic discipline of the definer. One grouping of definitions focuses on networks as a mechanism for resolving complex societal issues. The second focuses on the value of networks in achieving competitive advantage in a private sector environment.

Rupert Chisolm (1998) states that networks are autonomous organizations that link together to meet goals that cannot be reached if they act separately and independently. This form of organization has great potential in addressing particularly difficult multidimensional social issues. Chisolm (1998) outlines four key features of networks which distinguish this organizational from other inter-organizational relationships. These are as follows: member organizations develop networks to better understand and manage complex, ambiguous issues; member organizations work together in a collaborative manner guided by a shared vision and common purpose; members serve in a voluntary capacity and are loosely coupled; and, members control the network and its activities.

In the business management literature the definition of a network organization evolved through three stages. Initially these organizational forms were viewed as intermediate organizations existing between markets and hierarchies (Thorelli, 1986). These organizations were then acknowledged as legitimate entities and commonly
referred to as inter-firm networks (Grandori and Soda, 1995). Finally, inter-firm networks were acknowledged by business strategists as strategic networks defined as long term, purposeful modes of organization used to position firms in a stronger competitive position (Jarillo, 1988).

Although definitions vary, there is a subset of common characteristics included in all of the definitions. These are the following: the voluntary nature of the relationship; the coupling of independent entities; the existence of multiple relational links; the reliance on both formal mechanisms of control and more importantly informal mechanisms of control based on cooperation and trust; and, the belief that the new entity is designed more effectively to respond to significant strategic or operational issues.

**Model and Types**

**Model**

Although each inter-organizational network appears unique in design and structure, there are definable characteristics common to all inter-organizational network models (Noel Tichy et al. 1980). These are transactional content, the nature of the links, and structural characteristics.

An exchange of good and services; and exchange of affect (liking, friendship); an exchange of information; and, an exchange of influence (power) represent the four types of network transactional relationships. The links between pairs of individuals in the network may be measured in terms of the degree to which they are linked by multiple statuses (multiplexity); the degree to which relationships are symmetrical (reciprocity); and, the degree to which individuals will honor obligations (intensity). Extra
organizational networks, total network structure, network clusters, and individual network characteristics comprise the four levels of network structural characteristics.

A variety of mechanisms of coordination are relied upon to sustain these cooperative models. Johannes Pennings (1981) organizes specific mechanisms within the three coping strategies he defines to address environmental uncertainty. Grandori and Soda (1995) identify and describe a large group of coordination mechanisms to support their delineation of inter-firm networks. A listing of these mechanisms common to both authors but far from exhaustive includes: selection systems; information systems; incentive systems; planning and control systems; common staff; communication, decision, and negotiation mechanisms; social coordination and control; and, linking pin roles and units.

Types

The numerous reasons for creating networks combined with the multiple approaches of coordinating activities have lead network scholars to move beyond general descriptions and propose inter-organizational network typologies. Charles Snow et al. (1992) provide a typology of networks operating within a for profit environment. The typology is comprised of three structures: internal, stable, and dynamic. Internal networks represent efforts to improve performance within a firm by requiring internal units to manage inputs and outputs at market rather than internal transfer costs and prices. In the stable network, assets are owned by several firms and dedicated to a specific business. Typically a set of vendors is closely linked to a core firm either supplying inputs or distributing outputs. Dynamic networks commonly appear in rapidly changing or discontinuous competitive environment. These networks are characterized by a high
degree of outsourcing among participants with each network participant inputting its particular expertise coordinated by a network broker.

Robert Agranoff (2003) developed a network typology based on the value-added functions of intergovernmental networks. The typology consists of four classifications. The first type is an information network. The value exchanged between the members of these cooperatives is limited to information exchange on individual organization policies and programs, technologies and working solutions. Developmental networks not only exchange information but work toward building member management capacity through the establishment of educational resources and membership services. Outreach networks create opportunities for member organizations to mutually work on common problems and develop strategies to be implemented by individual member organizations. The fourth type is the action network. At this level of inter-organizational cooperation member organizations are not only planning together but also implementing joint actions to address and resolve common issues and problems.

Developmental Process

Organizations enter into inter-organizational relationships to secure limited resources, improve efficiencies, increase stability or enhance their legitimacy (Oliver, 1990). Rupert Chisolm (1998) suggests network organizations form in contrast to other forms of inter-organizational relationships because member network organizations are oriented to a higher-level purpose of common concern or because cooperating organizations must deal with meta-problems. Peter Smith Ring and Andrew Van De Ven (1994) also identify several key factors underlying the motivations of two or more firms to network. These include concern with organizational and environmental uncertainties; need for the
assurance of both equity and efficiency in exchanges; belief in informal dispute resolution methods; and, a belief in the value of interpersonal relationships. A third proposition on network formation is offered by Ranjay Gulati (1999). He argues that network relationships rather than forming solely on the basis of recognized interdependencies are strongly influenced by knowledge acquired in former alliances. And thus, the probability of a new alliance between specific groups increases not only with their interdependence, but also as a result of their prior experiences in cooperative ventures.

Several theorists (Thorelli, 1986; Ring and Van De Ven, 1994; Zuckerman et al. 1995) have offered life cycle models to assist in the analysis of network origin and development. All of these life cycle models exhibit similar characteristics. Defined in either three or four stages by each theorist, inter-organizational networks form, expand, mature, and reach a critical crossroad (Zuckerman, et al., 1995) at which time the networks form a more hierarchical organizational design, reform with new members or dissolve.

Networks are challenging to maintain. For the most part, networks do not achieve stability rather they attempt to maintain balance between formal and informal processes (Ring and Van De Ven, 1994). Several authors have delineated reasons for network dissolution. Ring and Van De Ven (1994) suggest that a network may terminate because it has met its objective. Several other reasons for dissolution include excessive legal structuring and monitoring of the relationships; conflicts between role and interpersonal behavior; and a breach of trust between member organizations. In a summary of causes of failure in network organizations Miles and Snow (1992) attribute organizational failures
in network as well as other organizational types to managerial errors. These include either the extension of the model by network managers beyond its capability or modifications of the model by network managers which violate its operating logic.

**Governance and Management**

**Governance**

The challenge of balancing formal and informal coordinating and control systems in a network setting requires governance structures and management skills that are unlike traditional approaches. Network governance articles are characterized by their integration of economic theoretical models with conceptualizations of networks. Two illustrative examples of this integration are provided below. These examples were selected because they depict network governance in two separate economic sectors and vary in their use of economic and network theories to support their respective governance models.

In an analysis of decentralized networks, Jones, et al. (1997) integrate transaction cost economics and social network theory. Through this integration the authors provide a framework for identifying the conditions under which social mechanisms develop that promote the coordination and safeguarding of economic exchanges.

In an analysis of publicly funded mental health networks, Provan and Milward (1995) describe the underlying governance principles supporting the logic of a centralized stable network design. The authors acknowledge the importance of transaction cost economics but primarily rely on principal-agent theory to describe the economic relationship between public and nonprofit agencies. The authors draw upon social network theory and inter-organizational theory to acknowledge the importance of trust-based ties. In
summary, they suggest that a combination of principal-agent relationship and trust-based linkages facilitate network governance.

**Management**

Because of the difference in direct control of organizational resources, effective network management does not fully resemble management approaches in traditional organizations. In discussing the role of public administrators in network settings, Laurence O’Toole (1997) states traditional principles of management must be applied in a different way. He suggests that initially administrators should not assume they possess unilateral authority within the network. Administrators instead should be continually monitoring their networks exploring opportunities to identify coordination points for the full set of participants in the network. With a comprehensive knowledge of the network and its governance structure, administrators should continually act within the network to move clusters of participants toward cooperation in the interest of program success. As an alternative strategy, administrators should act to alter the network toward a more favorable array in order to achieve state objectives.

In related articles on the management of public networks, Michael McGuire (2002, 2003) concurs with Laurence O’Toole’s position on network management. McGuire believes the management of networks is more about the application of sound management principles rather than the creation of new management guidelines. To provide greater clarity on the subject, McGuire (2002) organizes the activities of network managers into a set of managerial behaviors. These include activating, framing, mobilizing, and synthesizing behaviors. The description of these behaviors closely link to related network life cycle models. Activating behaviors refers to management actions
taken to identify and recruit those individuals and acquire resources required to meet
organizational objectives. Framing behaviors refer to those activities taken to create
network identity such as the development of network beliefs, rules and member roles.
Mobilizing behavior reflects management efforts to elicit commitment and support for
network activities from both network members and external stakeholders. Synthesizing
behavior is related to activities employed to achieve network objectives.

These same types of network management responsibilities are also reflected in the
business management literature. Snow et al. (1992) incorporates these skills into a
typology of network managers. More specifically the authors describe three types of
managers—architect, lead operator, and caretaker. Managers who act as architects
facilitate the emergence of networks. The focus shifts from design to operational decision
making as the network evolves around a particular set of services or products. The
primary function of the lead operator is to establish the contractual relationships between
network members in order to establish a more stable network. The caretaker manager’s
primary role is maintenance of the network.

Regardless of the typology, successful network managers like all managers must
possess strong traditional management skills. Additionally, in these operating
environments the outstanding network manager routinely exhibits exceptional negotiation
and brokering skills, and most importantly, the ability to anticipate and adapt to rapidly
changing circumstances.

**Inter-organizational Network Effectiveness**

The literature on inter-organizational effectiveness is limited (Provan and
1998) because the work primarily focuses on public sector networks specifically mental health service networks at the community level. This model has not been applied to nonprofit driven health coalitions focused on broader community health concerns.

Provided below is a summary of their findings.

The most significant empirical research and theory building to date on public sector network effectiveness was produced by H. B. Milward and K. G. Provan (1995, 1998, 2000, 2003). These researchers initially completed a comparative study of four community mental health systems for the expressed purpose of determining the relationship between funding, network structure and network effectiveness.

The initial findings of the researchers (Provan and Milward, 1995) are as follows: network effectiveness is highest when the network is integrated through a powerful core agency; network effectiveness is the highest when mechanisms of fiscal control by the funding source are direct; although resource munificence alone does not guarantee an effective network nor does resource scarcity along prevent effectiveness, network effectiveness is most likely in a resource-rich environment and is least likely in a resource-scarce environment; and, although stability alone is not a sufficient condition to produce effectiveness, network effectiveness will be highest under conditions of general network stability (Provan and Milward, 1995, pp 210,211).

In a subsequent review of their 1995 findings, Milward and Provan (1998) added to their earlier propositions by incorporating into the predictive model not only principles of network theory but also principles of organizational economics especially principal – agent theory.
Provan and Milward (2001) offer a framework for evaluating public sector organizational networks. Consistent with the multiple constituency effectiveness model (Zammuto, 1984), the authors suggest the evaluation of network effectiveness is dependent upon the perspectives of varying constituency groups. The authors then utilize agency theory as an organizing framework for the three constituent groups typically involved in community health and human services networks. These groups include those who monitor and fund the network (principals); network administrators (serving both as principals and agents); providers of services (agents); and receivers of services (clients).

With regard to the roles of network administrators, the authors state public sector networks are often led, coordinated and managed by a central, local administrative entity. In the context of agency theory, the administrator of this central entity serves both an agent of the community and the principal of the network service providers. The authors further state that these networks may be evaluated at three level of effectiveness. These are the community level, the network level, and the network’s participant level.

At the community level of analysis, network effectiveness is based on the network’s ability to improve community health as the result of improved service coordination and service efficiency. Subjective and objective indicators employed to determine network effectiveness at this expansive level of analysis include public perception that problems are being solved as well as objective measures of population level health outcomes and related treatment costs for the clients served within the community. Key constituents at the community level include those receiving services (clients) from participating network service agencies as well as those (principals) who fund and monitor network
administrators and service providers. Examples of principals include representatives of advocacy groups, local nonprofit funders, and elected and appointed officials.

The network level of analysis focuses on the collaborative relationship between a wide range of health and human services service organizations (agents), community representatives (principals and clients) and network administrators (serving both as principal and agent). Effectiveness at the network level of analysis is indicated by the degree to which the network’s existence is critical for the attainment of community defined goals. Examples of operational indicators of network level effectiveness include: network membership growth; membership commitment to network lead, community defined goals; the range of network services; and the integration and coordination of these services. At the network level, key constituents include representatives of the community, representatives of the service agencies, and the network administrators.

The network participant level of analysis focuses on service providers and clients. Effectiveness at this level is primarily assessed by measuring the service organization’s net membership benefit. Operational indicators of participant effectiveness include: measures of client outcomes, and organizational legitimacy, resource acquisition, and cost reduction. At this level of analysis, key constituents include member organization’s board members, management, staff and clients.

A critically important point made by the authors is that network effectiveness is based on the interactions across all three levels of the analysis because only by minimally satisfying the needs of each group (principals, agents, clients) can network effectiveness be realized. Network effectiveness at one level, however, does not ensure effectiveness at the other two levels. In fact there is typically an inherent tension in community service
networks between the needs and expectations of the community, network, and individual agency and client stakeholders and the effectiveness outcomes valued by each group. In addressing this dilemma, the authors conclude that in the end overall network effectiveness will ultimately be judged by community level stakeholders.

Finally, in a related paper on network management, Milward and Provan (2003) continue to build their public network model by identifying and describing a set of effectiveness determinants to complement network effectiveness indicators provided in earlier work (Provan and Milward, 2001). Three of the determinants relate to the composition and management structure of the network. These include the size of the network defined as the number of participating network members; limited network variety described as the similarity in characteristics of member organizations; and, the existence of a central network organization capable of influencing member organization behavior. Two determinants focus on organizational process. These include leadership and the multiplicity of linkages among participating members.

Section Summary

In summary, a dramatic change in organizational design is taking place in response to increasing environmental complexity and turbulence. These inter-organizational networks are present in both the public and private sectors and appear to have infinite variations in structure and purpose. These networks, however, demonstrate definable structural, governance, and management attributes. These networks may also be characterized by observable stages of development. Common to all efforts at organizational conceptualization, a construct of effectiveness and a related effectiveness operational model are required to determine the relative value of these organizational
forms. The measurement of inter-organizational network effectiveness is fraught with challenges. Nevertheless, the integration of effectiveness models with inter-organizational network models is essential for the purpose of evaluating community health partnership efforts.

The Community Health Partnership Literature

Concept and Definitions

Concept

Community health partnerships come together to address a meta-problem namely society’s diminishing capability to maintain community wide health and well being for its members. Participating members of these multi-sectoral partnerships recognize the need to rally around a common vision and goals in order to affect positive systemic change at a community level (Roussos and Fawcett, 2000).

The vision of these partnerships are defined in terms of four primary goals: (1) a focus on the health status of all community members beyond those actively receiving medical care; (2) development of a “seamless” continuum of care integrated into community institutions especially health, education and social service organizations; and, (3) active management of the continuum within limited resources (4) based on democratic principals of community stakeholder involvement and accountability (Sofaer et al., 2003).

The achievement of this vision is guided by a theory of action comprised of four principal actions. These actions include aspects of community organizing and development, social planning, and policy advocacy (Roussos and Fawcett, 2000) and reflect a network view of organizational development. The first required action is the
development of an effective collaborative consisting of the right partners organized in ways that allows for good decisions based on a shared vision and trust in each other. The second action involves the initiation of specific intermediate initiatives. These intermediate activities include typically focus on a specific community health issue or the needs of a group within the community. These actions may also include the development of the partnership and improvements to community and health delivery infrastructure. The third action involves taking steps to address significant systemic problems in a comprehensive manner. Finally, long term success is dependent on the partnership’s ability to institutionalize systemic change and demonstrate in measurable ways improved community health status (Sofaer et al. 2003).

Definition

Roussos and Fawcett define community health partnerships as “alliances among people and organizations from multiple sectors, such as schools and businesses, working together to achieve a common purpose” (Roussos and Fawcett, 2000, p369). Frances Butterfoss suggests that community health partnerships are “inter-organizational, cooperative, and synergistic working alliances” (Butterfoss et al., 1993, p316). Butterfoss et al. (1993) further state that these organizations are issue oriented with defined partnership goals. The partnerships address the formalization of certain structural (membership roles and rules) and functional aspects (leadership) of the collaborative. The partnerships actively recruit members possessing diverse capabilities and resources. And, the partnerships direct their actions at multiple policy and operational levels.
Models and Types

Models

Several models exist to describe and evaluate community health partnerships (Francisco, Paine, Fawcett, 1993; Butterfoss, Goodman, Wandersman, 1993; Mitchell and Shortell, 2000; Provan and Milward, 2001; Lasker and Weiss, 2003). Both Francisco et al. (1993) and Butterfoss et al. (1993) employ a developmental framework to describe the structure and function of health partnerships.

Francisco et al. (1993) initially state that the purpose of a partnership is to plan and implement community wide interventions to improve community health status. These interventions must target individuals and institutions capable of implementing change as well as vulnerable populations who are the target of change. Evaluation of partnership effectiveness may be gained by assessing process measures, intermediate outcomes of interventions and the long term impact of these interventions.

Butterfoss et al. (1993) describe community health partnerships as community based or agency dominated coalitions organized to complete planning, coordinating and advocacy functions for their respective communities. In the Butterfoss model, partnerships proceed through four stages – formation, implementation, maintenance, and goal accomplishment. The researchers describe both determinants and indicators of partnership effectiveness in the model. In both the Francisco and Butterfoss models determinants and indicators of effectiveness are specifically related to a developmental stage of the partnership.

Mitchell and Shortell (2000) provide a typology of governance and management characteristics of community health partnerships. The authors suggest that effective
partnerships result from the ability of the partnership to attain appropriate external and internal alignment. External alignment is the primary concern of governance. External alignment refers to the match between community priorities and problems addressed with partnership composition. Internal alignment is primarily a management responsibility. Internal alignment relates to management efforts to organize membership activity to match the complexity of partnership tasks. The authors suggest that community health partnerships may be described and classified by defining governance and management practices for each of seven dimensions. In a subsequent evaluation of twenty-five Community Care Network health partnerships, Shortell et al. (2002) identified six governance and management determinants of highly performing community health partnerships to complement the identified seven partnership dimensions.

Lasker and Weiss (2003) describe a community health collaborative process as community health governance. The authors identify three challenges to community problem solving. These are the prevalence of political interest groups; the eroding sense of community; and, the reduced involvement of community residents in matters directly affecting them. To attain long term community health goals the authors suggest that several intermediate goals must be reached. These include creating a sense of individual empowerment; building social capital; and generating new ways of thinking and acting on these innovations. To reach these intermediate goals partnerships must identify and recruit a wide array of participants especially those most directly affected by the problems being addressed. Second, equitable and efficient processes must be in place to encourage participation in decision making; to reach consensus on problem solutions; and to address conflict resolution. Third, the problems and related solutions must be
addressed at a systems level. In summing up the authors indicate that the achievement of both intermediate and long term goals is ultimately dependent upon leadership.

Several common characteristics are shared by most or all of these models. These characteristics include but are not limited to the following: the stated purpose for partnership formation; the recognition of an organizational development process; the identification of external and internal (structural, functional) determinants of partnership effectiveness; the relationship between determinants of effectiveness and organizational stages of development; the identification of indicators of effectiveness; the recognition of substantive and outcome effectiveness indicators; the identification of intermediate and long term effectiveness indicators; the variation of effectiveness indicators based on constituency perception and level of organizational analysis. These models particularly the work of Francisco, Paine, Fawcett (1993) and Butterfoss et al. (1993, 1996) serve as the foundation for the community health partnership theory of action as outlined by Shoshanna Sofaer and her fellow researchers (2003).

**Types**

There are many variations of community health partnerships. Examples include grassroots and advocacy initiatives; networks predominated by service agencies; and collaboratives made up mostly of health care providers (Roussos and Fawcett, 2000). In general, these partnerships may be organized based on membership, patterns of formation; functions performed, structure or some combination of these attributes (Butterfoss et al., 1993). The type of partnership selected is often determined by contextual factors such as local political issues, prior organizational interactions, available resources, or identified issues (Hasnain-Wynia et al. 2001).
Romania Hasnain-Wynia et al. (2001) offer a typology of community health partnerships consisting of four different types – centralized action, decentralized action, facilitating and foundation. Centralized action partnerships are self-contained, formally organized entities. These partnerships typically have dedicated staffs and directly act on implementing their strategic plans. Typically a hospital or health system serves as the anchoring organization for the activities of the partners.

Similar to centralized types, decentralized action partnerships identify community health needs and jointly agree on programming to address these needs. Decentralized types, however, do not jointly act on the collectively formulated plan. The decentralized action partnership initiatives are independently implemented by one or more of the partnership members and at times by organizations that are not formally recognized as members of the partnership. Facilitating community partnerships come together to allow participating members to exchange ideas on problem solving and collaboration.

The foundation partnership also facilitates the development of community based planning. In contrast to the other forms of partnerships, foundation representatives in the partnership have more power than other members to prioritize community objectives and influence actions taken through their review and financing of selected community initiatives.

Although the authors present four distinct types of community health partnerships, they warn that operating partnerships often reflect characteristics of more than one of the types and that partnership characteristics may change as these partnerships develop over time.


**Developmental Process**

Community health partnership researchers and writers (Francisco, Paine, Fawcett, 1993; Butterfoss, Goodman, Wandersman, 1993; Kreuter, Lezin, Young, 2000) offer numerous reasons for the formation of partnerships and delineate partnership development stages. Commonly cited reasons for the formation of community health partnerships include but are not limited to recognition of mutual purposes; resource scarcity; the realization that a single organization cannot solve the problem; prior successful outcomes of collaborative efforts among members considering participation in the partnership (Butterfoss et al. 1993).

Butterfoss et al. (1993) offer a specific development model of community health partnership comprised of four stages – formation, implementation, maintenance, and goal accomplishment. A variation on this developmental approach is provided by Kreuter et al. (2000). For the most part their model mirrors the Butterfoss et al. model (1993). There, however, is one exception. In contrast to the Butterfoss model which begins with partnership formation and funding, Kreuter and his colleagues begin the process with recognition of a pre-formation stage. This stage occurs prior to the official formation and funding of a coalition. During this stage efforts are undertaken by potential partnership members to assess whether a collaborative solution to a perceived problem is viable.

Each of the development models by community health partnership specialists slightly differ in the range of activities and timing of activities listed in each stage. Yet, across all of the models several key activities are commonly recognized. These include the following: the selection and recruitment of community members to the partnership; the creation of a clear organizational vision and mission, the establishment of operating rules
and procedures and the definition of member roles and expectations; the planning and initiation of partnership activities; and, the maturation of the partnership culminating in the achievement of partnership goals.

**Governance and Management**

**Governance**

Mitchell and Shortell (2000) state that community health partnership governance consists of the following tasks: setting priorities for strategic goals; choosing partnership members; securing financial resources; and, ensuring accountability for partnership actions. Effective community health partnership governance must therefore successfully negotiate three interrelated sets of governance issues (Weiner and Alexander, 1998). Given the voluntary nature of partnerships, it is not surprising that the first of these is the challenge of aligning partner and partnership interests and resolving conflict resulting from divergent views (turf issues). The second challenge relates to demonstrating broad community accountability. The third challenge involves sustaining partnership development and growth.

**Management**

In complementing their definition of community health partnership governance, Mitchell and Shortell (2000) describe partnership management as the execution or implementation of governance responsibilities. Partnership managers are therefore responsible for sustaining members’ interest in the partnership’s vision and mission; developing and maintaining partnership management structures for decision making, problem solving and conflict resolution; coordinating and supporting partnership actions; and implementing information systems to collect and report partnership activities.
Utilizing the life cycle model of federation development provided by D’Aunno and Zuckerman (1987), Bryan Weiner et al. (2000) present guidelines on effective health services management participation in community health partnerships. Although the article focuses on partnership participants and not directly on the role and responsibilities of partnership administrators, the guidelines presented are nevertheless relevant to the executive position. The authors state that management responsibilities during the emergence phase of the partnership include communicating the purpose of the partnership; recruiting members; clarifying member roles and expectations; and, beginning to build working relationships. Instrumental to manager’s success in this phase is the development of collaborative management skills and trust building capabilities.

In the transition phase managers are responsible for developing mechanism for decision making and coordination necessary for effective membership participation. According to the authors there are two associated management abilities and skills required to accomplish these tasks. Managers must develop the capacity to manage both organizational and demographic diversity. And, managers must begin to develop mechanisms to measure partnership progress.

In the maturity and “critical crossroads” phases managers are primarily responsible for sustaining the partnership for the time period necessary to accomplish the partnership’s mission and related long term goals. During these phases managers must find ways to maintain partner’s commitment by demonstrating the value of partnership achievements to individual members and by minimizing member’s participation costs in time and resources in the process of achieving these outcomes.
Community health partnership managers must possess excellent traditional management abilities and skills. Given the nature of the organization, trust building capabilities, diversity management strategies coupled with collaborative management skills are critically important.

Research

Extensive empirical research has been completed on community health partnerships. There are several current published literature reviews on the topic (Roussos and Fawcett, 2000; Zakocs and Edwards, 2006). Roussos and Fawcett (2000) provide an excellent overview of the results of this research. The authors summarize findings on the impacts of community health partnership interventions on population outcomes; community behavioral change; and, community and systems changes. The authors also identify conditions and determinants of partnership effectiveness found in the literature.

The authors found insufficient evidence to determine the relationships between partnership interventions and community health outcomes primarily because of research design weaknesses. The authors do note however that one third of the reviewed studies indicate a positive correlation between partnership interventions and community health status improvements. Regardless of the outcomes of these studies other researchers suggest caution as well when reviewing these findings (Mitchell and Shortell, 2000; Shortell et al. 2002). These researchers suggest community health partnerships have at best modestly impacted community health outcomes.

A review of studies focused on community-wide behavioral changes revealed better results. Improved behavioral outcomes resulting from community programming were reported for tobacco use, alcohol use, illicit drug use, physical activity and safer sexual
practices. The authors caution readers that the weaknesses of these studies involve the population level behavioral outcome data employed in the research. Poor survey methods often limit the accuracy and reliability of the collected data (Roussos and Fawcett, 2000).

Community and systems change is defined by Roussos and Fawcett (2000) as an intermediate outcome resulting from community health partnership action to create or modify individual institution or community programs, policies or practices. Examples of these targeted interventions include the introduction of health prevention programs in business settings; creation of walking trails within the community; changes or modifications of smoking policies in public settings. There is an abundance of studies in the literature demonstrating a connection between the actions of community health partnerships and the development or improvement of programs, services and policies.

In addition to studies on the effects of partnership interventions on community level change, a significant number of studies solely target community health partnership development. These studies routinely attempt to answers questions on how to build effective coalitions. Two literature review articles (Roussos and Fawcett, 2000; Zakocs and Edwards, 2006) provide information on determinants and indicators of community health partnership effectiveness commonly used in studies. In their review of the literature Zakocs and Edwards (2006) identified 55 determinants of community health partnership effectiveness. Only six of these determinants were used in five or more studies. The authors also identified five commonly employed measures of partnership effectiveness among 26 measures examined in 26 studies.

Roussos and Fawcett (2000) identify and summarize seven interconnected determinants of partnership effectiveness commonly found in the literature. Interestingly,
although the lists of effectiveness determinants compiled by each set of researchers (Zakocs and Edwards, 2006; Roussos and Fawcett, 2003) overlap, they are not exact matches.

Section Summary

Individual communities have responded to the growing national concern over health related issues as resolutions to these issues have not been forthcoming from either the national or state level. The organizing framework for these responses is typically some variation of a collaborative model. In the literature these collaboratives are often referred to as community health partnerships. These partnerships are appealing at both an emotional and rational level and are thus seen as the one best way to address this multifaceted and intractable issue. Documented performance results on the partnerships however have been less than promising. Numerous reasons are offered to explain the gap between promise and performance. Reasons offered to explain the gap include: an incomplete understanding the complexities of the problem and the organizational structures evolving to address the problem; and, the related theoretical and operational challenges associated with defining and measuring partnership effectiveness.

The Integration of Network and Partnership Literatures

The inter-organizational network literature and community health partnership literature are linked in several ways. Specific topics demonstrating a relationship between the two streams of literature include similarities in concepts and definitions; organizational types; developmental processes; and governance and management. Both literatures address the issue of organizational effectiveness citing similar challenges in defining and measuring the construct.
Concepts and Definitions

In line with reasons for inter-organizational network formation, community health partnerships come together to address a meta-problem namely society’s diminishing capabilities to maintain community wide health and well being for its members (Chisolm, 1998). And like inter-organizational networks the environmental and organizational factors driving partnership formation include a belief that these collaborative efforts will improve access to and acquisition of limited resources (Pfeffer, Salancik, 1978); improve operating efficiencies through coordination and possible integration (Grandori and Soda, 1995; Park and Ungson, 1997); and increase organizational stability and legitimacy (DiMaggio, Powell, 1983).

As stated earlier in chapter two, Frances Butterfoss actually defines community health partnerships as “inter-organizational, cooperative, and synergistic working alliances” (Butterfoss et.al., 1993, p316). Butterfoss et al. (1993) further state that these organizations are issue oriented with defined partnership goals. The partnerships address the formalization of certain structural (membership roles and rules) and functional aspects (leadership) of the collaborative. The partnerships actively recruit members possessing diverse capabilities and resources. And, the partnerships direct their actions at multiple policy and operational levels. Incorporated in Butterfoss’s description are defining characteristics of inter-organizational networks including the voluntary nature of the relationship; the coupling of independent entities; the reliance on both formal mechanisms of control and more importantly informal mechanisms of control based on cooperation and trust; and, a belief that the new entity is better designed to respond to significant policy or operational issues.
Models and Types

As summarized by Lasker, Weiss and Miller (2001), researchers rely on several models to analyze health partnerships. Within this grouping is a network model (Provan and Milward, 1995, 2001) employed by Milward and Provan to analyze community mental health systems and by Weech-Maldonado et al. (2003) to investigate the effectiveness of community health partnerships at multiple levels.

There also appears to be a relationship between inter-organizational networks and community health partnership types. Romania Hasnain-Wynia et al. (2001) offer a typology of community health partnerships consisting of four different types. In a review of this typology it appears that the rationale for distinguishing community health partnership types is based on the network concept of value-added functions advanced by Robert Agranoff (2003). Employing Agranoff’s (2003) network typology, it may be argued that facilitating community partnerships align with exchange and developmental network types. Decentralized action partnerships are representative of outreach networks. And, centralized action partnerships parallel Robert Agranoff’s (2003) description of action networks.

Developmental Processes

Community health partnership researchers and writers (Francisco, Paine, Fawcett, 1993; Butterfoss, Goodman, Wandersman, 1993; Kreuter, Lezin, Young, 2000) borrow heavily from the inter-organizational network literature (Ring and Van De Ven, 1994; Chisolm, 1998; Gulati, 1999) in their descriptions of community health partnership formation and development. Each of the development models outlined by inter-organizational network theorists and modified by community health partnership...
specialists slightly differ in the range of activities and timing of activities listed in each stage. Yet across all of the models several key activities are commonly recognized and described in either three or four stages. These include the following: the selection and recruitment of community members to the partnership; the creation of a clear organizational vision and mission, the establishment of operating rules and procedures and the definition of member roles and expectations; the planning and initiation of partnership activities; and, the maturation of the partnership culminating in the achievement of partnership goals. These activities reflect a linear developmental trajectory. In reality, these actions/stages as suggested by Ring and Van de Ven (1994) are repetitive in nature.

**Governance and Management**

The network literature and community health partnership literature share several common governance themes. Evident in both the network literature (Jones et.al., 1997; Provan and Milward, 1995; Milward and Provan, 1998) and the community health partnership literature (Mitchell and Shortell, 2000) is the significance of informal means of control. This is attributed to the voluntary nature of these cooperatives. Both literatures rely on tenants of social network theory to describe the cultural aspects of these entities and transaction cost economics to support the perceived economic incentives of these types of relationships.

The relationship between network management and partnership management is not immediately apparent in the literature. Yet upon closer examination the similarities reveal themselves. For example, the role of the partnership’s manager is to implement governance responsibilities (Mitchell and Shortell, 2000). One of these responsibilities is
to maintain membership satisfaction and commitment. This reflects a critical
management capability common to both network and partnership management - the
ability to primarily secure support for strategic objectives and related actions by building
mutual trust and facilitating collaborative processes among participating members. A
closer link between the management styles employed in networks and community health
partnerships is offered by Bryan Weiner et.al. (2000). The responsibilities and associated
guidelines cited by Weiner et.al. (2000) reflect Robert McGuire’s (2003) interpretation of
network management behaviors – activating, framing, mobilizing, and synthesizing. For
example management responsibilities during the emergence phase as outlined by Weiner
et.al. (2000) link to Robert McGuire’s (2003) notion of activating responsibilities. In the
transition phase Weiner et al. (2000) state that managers are responsible for developing
mechanism for decision making and coordination necessary for effective membership
participation. These responsibilities mirror Robert McGuire’s description of network
manager’s framing and mobilizing responsibilities. In the maturity and “critical
crossroads” phases managers are primarily responsible for sustaining the partnership for
the time period necessary to accomplish the partnership’s mission. These duties align

Effectiveness

Network theorists and community health partnership researchers recognize common
challenges in assessing organizational effectiveness. Examples of these concerns include
the following: the complexity of the societal problem typically being addressed; the
complexity of the organization especially as it pertains to the issue of joint production
involving numerous member organizations each with multiple sets of constituents; the
focus on evaluating progress toward long term goals rather than intermediate measures of success; the lack of standard measures of collaborative process; the limited availability of network effectiveness theory; and, the practical limitations associated with the application of effectiveness theory in research (Shortell et al. 2002; Provan and Milward, 2001; Roussos and Fawcett, 2000; Lasker and Weiss, 2003; Weiner et al., 2000).

Despite these hurdles efforts at creating and applying organizational effectiveness models are ongoing. First, as summarized in the chapter, Provan and Milward (2001, 2003) developed a network model of effectiveness. Second, effectiveness determinants and intermediate effectiveness indicators have been identified in both literatures (Provan and Milward, 2003; Shortell et al., 2002; Roussos and Fawcett, 2003: Zakocs and Edwards, 2006). Certain determinants (membership size and composition; leadership; network management capacity) and indicators (member organization net benefit; network growth; implementation of community initiatives and programs) are commonly identified by both sets of writers and researchers.

**Summary**

Sustaining the physical, mental and social well being of individuals and communities requires an understanding of the multiple determinants of health and an ongoing social commitment to design and integrate systems capable of efficiently maintaining a high level of health. Individual communities stepped into the health reform vacuum as early as the 1980’s forming community coalitions to address pressing local health and health care problems.

The community health coalition model which supports an ecological view of health problems and champions a participative approach to problem solving is conceptually well
designed and appealing. Health coalitions have garnered substantial financial support from both the public and nonprofit sectors due in part to this belief in community based reform.

In the case of CAHWF, the Foundation expanded its role beyond grant making to include the management of coalitions and community advocacy in its efforts to partner with community stakeholders for the purpose of improving overall community health status. In its first five years of operations CAHWF’s relied primarily on its capacities as coalition builder and grant maker to lead health improvement initiatives. The literature on foundations, organizational networks and community health partnerships will be relied upon to describe and analyze CAHWF’s efforts to directly address pressing local health and health care problems in its combined capacities as a coalition builder and grant maker.
Chapter 3 Research Design and Methods

The objectives of this chapter are as follows; to summarize the purpose of the study; to describe the organization under study, the Carlisle Health and Wellness Foundation (CAHWF); to identify the research questions and propositions; to describe the research design and methods; and to acknowledge and describe study limitations. To accomplish these objectives the chapter is divided into the following sections: introduction; the Carlisle Health & Wellness Foundation; research questions and propositions; research design and methods; and study limitations.

The exploratory study of CAHWF is designed to examine the first five years of a community health foundation’s efforts to improve the health and wellbeing of its community residents by positively affecting health related behavior across community sectors while simultaneously increasing the availability and accessibility of health services within the community. CAHWF was selected as the case study site because of the Foundation’s lead role in facilitating a collaborative process with community representatives for the purpose achieving its vision and mission.

To accomplish its objectives as a lead community organization for health status improvement, CAHWF expanded its role to include the capacities of community coalition builder, community grant maker and community advocate in its first five years of operations. At the start of the study in June 2005, it was not certain that CAHWF presented a unique example of a health foundation relying strongly on community coalitions to ensure the health and well being of the community. Given the researcher’s close relationship with the Foundation as a three year ad hoc member of the organization’s planning committee it did present at a minimum a singular opportunity to
explore in depth a community health reform entity that appeared to blend the attributes of a community health partnership with those of a community health foundation. Given this initial impression of CAHWF’s organizational attributes, the researcher elected to examine in detail the two Foundation’s capacities that directly impacted community health status in the first five years of Foundation operations – coalition building and grant making. Through these efforts, the researcher hopes to add to the theory and practices of community health foundations by revealing ways to maximize the social value of foundation lead collaborative efforts.

**Carlisle Area Health and Wellness Foundation - CAHWF**

Over the last three decades, the hospital industry has experienced an increasingly challenging and competitive operating environment. As a result, numerous non-profit hospitals elected to convert to a for-profit status for the purposes of accessing capital and improving their market position. The conversion of these non-profit hospitals resulted in the formation of new community health foundations. These foundations, referred to as health care conversion foundations, assumed fiduciary responsibility for community financial resources generated by the sales of the hospitals. In turn the foundations have used these funds to award grants to local community providers for health and health related programs and services. Historically the contributions of these conversion foundations represent one third of total foundation giving to health care causes.

The Carlisle Health and Wellness Foundation (CAHWF) represents a health care conversion foundation. CAHWF was established in June, 2001 from the transfer of income from endowments and trusts belonging to Carlisle Hospital and Health Services, Inc. and from the proceeds of the sale of Carlisle Hospital and Health Services, Inc. to
Carlisle HMA, Inc., a subsidiary of Health Management Associates, Inc. Foundation assets currently are $83 million. In its first five years of operation the foundation approved $10.6 million in grants for community health and health related activities. These grants are awarded to health and social service organizations providing services to a population of approximately 130,000 individuals residing in western Cumberland county, western Perry county, northern Adams county and parts of Franklin county. A depiction of CAHWF’s service area is provided below in Figure 3-1.

Figure 3-1 Carlisle Area Health & Wellness Foundation Service Area

The foundation is governed by a community board of between eighteen and twenty-two members. The foundation staff is comprised of six administrators and two administrative staff members. An organizational chart of CAHWF is provided in Appendix A.

CAHWF’s vision is to be a “leader and catalyst to ensure continuous improvement of health in our communities”. To reach this vision CAHWF states that its mission is to “identify and address health care needs and policies, promote responsible health practices and enhance access to and delivery of health services”.

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The activities of the foundation extend beyond the traditional definition of foundation responsibilities. In its role as lead community organization for community health care improvement, CAHWF elected to develop social and environmental conditions conducive to sustaining community wide health and well being. CAHWF actively collaborated with community stakeholders throughout the process required to implement these changes. The actions taken by CAHWF in partnership with community service providers consistently align with community supported objectives. The interventions initiated by CAHWF and its partners reflect a holistic response to complex and challenging community health and health care concerns and problems.

Research Questions and Propositions

This research addresses two questions. They are as follows:

Q1. In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community?

As an ad-hoc member of the foundation’s planning committee for three years (2002-2005) the researcher observed and participated in CAHWF’s efforts to mobilize community stakeholders within organizational structures ranging in form from networks to dyadic relationships. The conceptualization of the study is based on the researcher’s experience with the Foundation prior to the collection of any data. With this prior knowledge, the intent of the researcher’s first question is to achieve a complete and accurate understanding of CAWHF’s organizational purpose, functions and structures as they relate to community stakeholders and to the overall welfare of the community. The first objective of this research was to complete an analysis of CAHWF utilizing an inter-
organizational approach as advocated by Zakocs and Edwards (2006). This was completed by comparing and contrasting CAHWF’s purpose, functions and structure to those identified in the inter-organizational literature particularly the inter-organizational network and community health partnership streams of this literature.

Implicit with research questions are propositions. These propositions are typically developed for the purpose of identifying issues requiring closer examination in the study. In this instance, the researcher’s first proposition associated with the first question relies on the work of Meyers et al. (1993), Chisolm (1996), and Roussos and Fawcett, (2000). The proposition is as follows:

- The formation of networked organizations result from a recognition of the interdependence of groups; the growing complexity of the environment; the difficulty of social problems; and/or the limited availability of resources to address these complex, interrelated issues.

**Q2. In its first five years of existence how has the Carlisle Area Health and Wellness Foundation been effective?**

Prior to the start of the research, as a participant observer, the researcher sensed that CAHWF’s collaborative efforts were beginning to positively affect the community. With this knowledge, the intent of the researcher’s second question is to identify in what ways CAHWF was effective in its first five years of existence. Of course, organizational effectiveness is a challenging construct to evaluate. There have been numerous efforts to identify effectiveness determinants and effectiveness measures associated with collaborative initiatives. These efforts are documented in the inter-organizational, community health partnership and foundation literatures (Butterfoss et al. 1993, 1996; Francisco et al. 1993, Provan and Milward 1995, 2001, 2003; Porter and Kramer 1999;
Hasnain-Wynia et al. 2003; Sofaer et al. 2003; and Weech-Maldonaldo et al. 2003; Regenstreif, Langston, Rieder, 2004; Ostrower, 2006). Despite these efforts, there is still no consensus on a common set of coalition effectiveness determinants or measures. The failure to date of empirical research to determine common factors that explain the relationship of coalition actions to community outcomes or define effective internal operations of community coalitions is not surprising. There are numerous challenges associated with the study of this subject including but not limited to the complexity of the societal problem being addressed and the complexity of network and partnership functions and structures developed to address these problems.

Based on the researcher’s knowledge of the foundation, a proposition on CAHWF effectiveness was established by the researcher prior to the start of research. This proposition primarily relies on the community partnership literature (Sofaer et al. 2003; Butterfoss, Goodman, Wandersman (1993); Francisco, Paine, Fawcett (1993); Provan and Milward, (2001); Larson et al. (2002). The proposition is as follows:

- A collaborative community organization targeting the improvement of community health is effective when it is responsible for one or more of the following actions: efforts to improve the delivery of a specific service; the development of collaborative relationships; efforts to improve the health status of a particular community group; or efforts to alleviate a specific community health problem.

**Research Design**

The intent of this research is to describe the organizational attributes of CAHWF and then to evaluate the overall organizational effectiveness of CAHWF. For this purpose the researcher employed a single case design. To support this selection the following topics are covered in this section: the rationale for design selection; the unit of analysis; time
frame of study; data collection sources and methods; and the strategies and standards
employed to analyze and apply the findings.

**Rationale**

Without question one of the concerns with research of this nature is the absence of
ture experimental design. When the subject is a dynamic, evolving organization linked in
multiple and meaningful ways with other community organizations, the ability to sample
in an unbiased manner, control variables, or compare outcomes to like entities are
limited. In addition, the ability to demonstrate causality due to the cross-sectional nature
of the research design also poses limitations (Roussos and Fawcett, 2000).

Recognizing the research constraints described above, a single case study design is
appropriate when the research design is employed to explore in a holistic way a complex
organizational system that may be unique or at a minimum represents an organizational
model that is not fully understood and has not been previously well documented
(Yin,1994). More specifically, at the time the research for this report began in June, 2005
through the completion of the draft report in October 2007, the researcher did not find
any other detailed case studies of a health care conversion foundation serving as a lead
community organization for the improvement of community wide health. In fact through
fall 2007 there was only limited information on the common practices of health care
conversion foundations¹. As the research progressed through early fall 2007, GIH did
publish additional information on health care conversion foundation’s interaction with

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¹The only organization tracking health care conversion foundations is a nonprofit educational organization,
Grantmakers in Health (GIH). GIH completed seven surveys of health care conversion foundations
between 1996 and 2005. These surveys provided information on foundation organizational structure, board
structure, grant making practices and community involvement. Information on community input was
limited to traditional means of eliciting input – selection of board members, community advisory
committees, surveys, focus groups, public forums and consultations with academics and public health
officials.
community representatives\(^2\). The researcher believes the GIH survey findings on coalitions complements the in depth exploration completed by the researcher on the relationship between a conversion health foundation’s capacity as a community coalition builder and community grant maker. Further research on the value of coalition building by community health foundations may be expedited by expanding the researcher’s work to the cohort of community health foundations identified as fostering coalition activity.

Additionally the value of this research was enhanced because of the researcher’s prior experience with CAHWF. The researcher was afforded direct access to Foundation and community members instrumental in the development of CAHWF and its related community coalitions and partnerships. The researcher was also granted access to CAHWF source documents and secondary data sources of which not all were publicly available. The end result was a much richer analysis of this complex organization than could have been afforded by the use of other research designs.

**Unit of Analysis**

Although the organization under study has already been identified as a community health foundation, defining the unit of analysis is not a straight forward exercise. The unit of analysis for this case is best defined as a boundary spanning community organization that served in multiple capacities with community members and community organizations to collaboratively address multiple issues affecting community health. The analysis of CAHWF therefore not only focuses on the Foundations internal operations but

\(^2\) In October, 2007 subsequent to the completion of the researcher’s field work and draft report, Grantmakers in Health (GIH) published the result of a 2006 survey on health care conversion foundation strategies targeted at increasing community involvement – *Connecting to Community and Building Accountability*. GIH’s report for the first time acknowledged that health care conversion foundations “foster community coalitions as a way of increasing community involvement. The GIH survey report did not provide any detailed data on the manner in which these coalitions support foundation activities.
more importantly on the networked relationships established by the Foundation to advance its vision and mission.

**Time Frame of Study**

Carlisle Health & Wellness Foundation (CAHWF) was established in June, 2001 from the sale of Carlisle Hospital and Health Services, Inc and the transfer of income from related endowments and trusts. To assess the Foundation’s organizational development and intermediate effectiveness, CAHWF operations were reviewed and analyzed for a five year period beginning June 1 2001 and ending May 31 2006. Actual data collection through interviews, focus groups, document reviews, and review of secondary data sources was conducted from April 2007 –September 2007.

**Research Sources and Methods**

Data for the study was obtained from the following sources: key network stakeholders including CAHWF board members, CAHWF administrative staff, service providers, and community representatives. In addition information was retrieved from CAHWF source documents and CAHWF secondary data. Data was collected in four ways by completing focused interviews of key informants; conducting focus group sessions; reviewing source documents; and, reviewing secondary data.

**Key Informant Interviews**

Key informant interviews served as a critical source of information for this research study. To provide a complete explanation of this method, this segment of the paper is organized as follows: interview guide construction; key informant selection; key informant recruitment; and interview scheduling and completion.
Interview Guide Construction

The researcher developed a 19 question standardized open–ended interview guide to complete the key informant interviews. The entire interview guide is provided in Appendix B. The standardized interview guide was structured to gather information to address both research questions and their related propositions. The opening group of questions was designed to elicit interviewees’ general understanding of the purpose, structure and functions of CAHWF and to verify background information on each interviewee. Answers to these questions provided general support for research question one and its associated proposition. This group of questions is provided in Table 3-1.

Table 3-1 Understanding and Background Information Questions

<table>
<thead>
<tr>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>How would you define the purpose (vision/ mission) of CAHWF?</td>
</tr>
<tr>
<td>In your opinion what are the specific issues CAHWF attempts to address?</td>
</tr>
<tr>
<td>How is CAHWF structured as an organization and what activities does</td>
</tr>
<tr>
<td>CAHWF pursue to achieve their vision and mission?</td>
</tr>
<tr>
<td>In what roles have you participated in CAHWF activities (board member,</td>
</tr>
<tr>
<td>committee member, task force member)?</td>
</tr>
<tr>
<td>What organization do you represent in your participation with CAHWF?</td>
</tr>
</tbody>
</table>

A second group of questions specifically targeted CAHWF’s responsibilities as a coalition builder. These questions were designed to gain information required to answer research question one and its associated proposition. During the interview process the term partnership was replaced with the name of the specific collaborative activity in which the interviewee participated. This group of questions is provided in Table 3.2 below.
Table 3.2 CAHWF as a Coalition Builder Questions

To the best of your knowledge what were the reasons that (specific partnership) was formed?

Health care partnerships form for a variety of reasons. They form to exchange information among members; to help develop member capabilities; to help solve member’s problems; and to jointly act on common issues. Based on your experience with (specific partnership) please describe the specific purposes of (specific partnership).

Have you worked with other members of the (specific partnership) before joining (specific partnership)?

Is your participation with (specific partnership) voluntary in nature?

Are all of the individuals and groups necessary to achieve the stated purpose of the (specific partnership) represented?

Does (specific partnership) interact with other collaborative organizations which are not members of (specific partnership)?

All organizations grow and develop over time. Generally speaking, organizations emerge, grow, mature and decline. Briefly describe how (specific partnership) has evolved during your time as a member.

All organizations have rules that govern the scope of their activities. Please briefly describe how these rules, policies, and procedures serve to define your role and responsibilities as a member of the (specific partnership).

The responsibilities of a collaborative group leader can be challenging. Based on your experience with (specific partnership) please describe the responsibilities and actions of the (specific partnership) chairperson.

The final group of questions specifically targeted CAHWF’s effectiveness both as a grant maker and coalition builder during its first five years of operations. These questions were designed to gather information to adequately answer research question two and its related proposition. This group of questions is provided in Table 3.3 below.
Table 3.3 CAHWF Effectiveness Questions

In their traditional role as a funding source, how effective do believe CAHWF has been to date in addressing targeted community concerns?

In what specific ways has CAHWF been effective - process and outcomes / specific measures?

As a representative of (specific constituent) how effective do believe (specific partnership) has been to date in building the partnership as well as addressing targeted community concerns?

In what specific ways has (specific partnership) been effective?

When we discussed the membership composition of the (specific partnership) you stated that (restate groups described by the interviewee) are also members of (specific partnership). In your opinion, how effective do you think they believe the (specific partnership) has been to date in building the partnership and addressing targeted community concerns?

Key Informant Selection

The researcher purposefully selected 20 key informants to reflect key CAHWF internal as well as external stakeholder groups. The five stakeholder groups included representatives of CAHWF’s Board of Trustees, CAHWF’s administrative staff, the community, community service providers, and CAHWF grant recipients. In selecting key informants the researcher attempted not only to satisfactorily represent each of the stakeholder groups identified above but also select representatives who actively participated in multiple roles in the development and growth of the Foundation during its first five years of operations. The researcher relied on his experience as a participant–observer with the Foundation, resource documents, and recommendations solicited by the researcher from Foundation board and administrative staff to finalize the key informant list.
Selecting key informants that exclusively fit one stakeholder group proved to be extremely challenging because of the multiplicity of roles held by informants. The researcher used his best judgment in assigning key informants to stakeholder groups.

Provided below in Table 3.4 is the list of key informants interviewed by the researcher organized by stakeholder group and community organization that each was associated with at the time of the interview.

Table 3.4 CAHWF Key Informants

<table>
<thead>
<tr>
<th>Key Informant</th>
<th>Group</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Board of Trustees</td>
<td>Cumberland County Office of Aging and Community Serv</td>
</tr>
<tr>
<td>02</td>
<td>Board of Trustees</td>
<td>Manufacturers and Traders Trust Co.</td>
</tr>
<tr>
<td>03</td>
<td>Board of Trustees</td>
<td>H. S. Mowery &amp; Sons</td>
</tr>
<tr>
<td>04</td>
<td>Board of Trustees</td>
<td>Dickinson College</td>
</tr>
<tr>
<td>05</td>
<td>Administrative Staff</td>
<td>Carlisle Health &amp; Wellness Foundation</td>
</tr>
<tr>
<td>06</td>
<td>Administrative Staff</td>
<td>Carlisle Health &amp; Wellness Foundation</td>
</tr>
<tr>
<td>07</td>
<td>Administrative Staff</td>
<td>Carlisle Health &amp; Wellness Foundation</td>
</tr>
<tr>
<td>08</td>
<td>Community Rep</td>
<td>Cumberland County Housing and Redevelopment Auth.</td>
</tr>
<tr>
<td>09</td>
<td>Community Rep</td>
<td>The United Way of Carlisle and Cumberland County</td>
</tr>
<tr>
<td>10</td>
<td>Community Rep</td>
<td>Carlisle Area School District</td>
</tr>
<tr>
<td>11</td>
<td>Community Rep</td>
<td>Carlisle Regional Medical Center</td>
</tr>
<tr>
<td>12</td>
<td>Community Rep</td>
<td>Connect Synergy, Inc.</td>
</tr>
<tr>
<td>13</td>
<td>Service Provider</td>
<td>Cumberland – Perry Association for Retarded Citizens</td>
</tr>
<tr>
<td>14</td>
<td>Service Provider</td>
<td>Hospice of Central Pennsylvania</td>
</tr>
<tr>
<td>15</td>
<td>Service Provider</td>
<td>Domestic Services of Perry and Cumberland Counties</td>
</tr>
<tr>
<td>16</td>
<td>Service Provider</td>
<td>Cumberland-Perry MH/MR Program</td>
</tr>
<tr>
<td>17</td>
<td>Grant Recipient</td>
<td>Sadler Health Corporation</td>
</tr>
<tr>
<td>18</td>
<td>Grant Recipient</td>
<td>Hope Station</td>
</tr>
<tr>
<td>19</td>
<td>Grant Recipient</td>
<td>Big Spring School District</td>
</tr>
<tr>
<td>20</td>
<td>Grant Recipient</td>
<td>Substance Abuse Services, Inc. ( The RASE Project)</td>
</tr>
</tbody>
</table>

Key Informant Recruitment

The researcher contacted each key informant by electronic mail. The content of the electronic mail provided a brief explanation of the purpose and nature of the participation request. A formal letter of request was attached to the electronic mail by the researcher.
(see Appendix C). In addition an informed consent form was also attached to the electronic mail for review (see Appendix C). Key informants were asked to reply to the request by electronic mail. Nineteen of the twenty potential participants responded positively via electronic mail within four working days of the researcher’s initial request. The twentieth participant responded favorably after being contacted by the researcher by telephone a week after the initial request was electronically mailed.

Interview Scheduling and Completion

Utilizing the interview guide developed by the researcher, the researcher completed 20 key informant interviews between April 20, 2007 and June 4, 2007. Each of the interviews conducted by the researcher was a face–to–face interview. The interviews were scheduled on the date and time selected by the key informant. To ensure the completion of the interviews on their scheduled dates the researcher electronically mailed each interviewee within five working days of the scheduled interview a reminder with the date, time and location of the scheduled interview. At the beginning of each interview, the researcher reviewed the informed consent form with the key informant. Each key informant signed two copies of the consent prior to the beginning of the interview. The researcher and the key informant each retained one copy of the informed consent forms for their records.

Each of the key informant interviews was audiotape recorded. The key informant interviews ranged in length from 50 to 70 minutes. The researcher attributes the variance in interview lengths to the extent of each key informant’s involvement with CAHWF and to the level of operational detail provided by each key informant in response to the interview guide questions. Each of the audiotape recorded interviews was transcribed. Although the researcher informed the key informants that the interviews would be transcribed, there were
no requests by interviewees to review the transcribed record of their individual interviews for verification purposes.

**Focus Groups**

In addition to the 20 key informant interviews, the researcher conducted two focus group sessions. The focus group selection and recruitment processes were identical to the key informant selection and recruitment processes. There was one minor difference. The formal letter of request to participate in the research indicated that the participant was selected to participate in a focus group rather than being individually interviewed (see Appendix C). The end result of the selection and recruitment process was the formation of two five member groups comprised of a representative from each of the internal and external stakeholder groups identified by the researcher. Provided below in Table 3.5 is a listing of the members of each of the two focus groups. Each member of each focus group is identified by stakeholder group and community organization that each was associated with at the time of the interview.

Table 3.5 CAHWF Focus Group Membership

<table>
<thead>
<tr>
<th>Focus Group One</th>
<th>Group</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Board of Trustees</td>
<td>Kuhn Communications, Inc.</td>
</tr>
<tr>
<td>02</td>
<td>Administrative Staff</td>
<td>Carlisle Area Health &amp; Wellness Foundation</td>
</tr>
<tr>
<td>03</td>
<td>Community</td>
<td>Pennsylvania Dept. of Health</td>
</tr>
<tr>
<td>04</td>
<td>Service Provider</td>
<td>Cumberland County Drug and Alcohol Com.</td>
</tr>
<tr>
<td>05</td>
<td>Grant Recipient</td>
<td>YWCA - Carlisle</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus Group Two</th>
<th>Group</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>01</td>
<td>Board of Trustees</td>
<td>Retired Clergy</td>
</tr>
<tr>
<td>02</td>
<td>Administrative Staff</td>
<td>Carlisle Area Health &amp; Wellness Foundation</td>
</tr>
<tr>
<td>03</td>
<td>Community</td>
<td>Dickinson College</td>
</tr>
<tr>
<td>04</td>
<td>Service Provider</td>
<td>Perry Human Services</td>
</tr>
<tr>
<td>05</td>
<td>Grant Recipient</td>
<td>Bonnie Berk, Inc.</td>
</tr>
</tbody>
</table>
The researcher utilized the interview guide to complete the two focus group session. These focus group sessions were held on the Dickinson College campus on May 8, 2007 and May 15, 2007. The focus group sessions were scheduled on the date and time mutually agreed upon by focus group members. To ensure full participation on the scheduled dates, the researcher electronically mailed each focus group participant within five working days of the scheduled session a reminder with the date, time and location of the scheduled session. At the beginning of each session, the researcher reviewed the informed consent form with the focus group members. Each group member signed two copies of the consent prior to the beginning of the session. The researcher and each group member retained one copy of the informed consent forms for their records.

Each of the key focus group sessions was audiotape recorded. The first focus group session on May 8, 2007 lasted approximately 60 minutes. The second focus group session on May, 2007 lasted approximately 95 minutes. The researcher attributes the variance in interview lengths to the fact that two focus group members failed to attend the first focus group session on May 8, 2007. The researcher was not notified in advance by either member of their intent not to attend. One focus member who did not attend represented the CAHWF administrative staff. The second focus group member who did not attend represented the grant recipient stakeholder group. The researcher moved forward with the focus group session in deference to those focus group members in attendance. After the session, the researcher contacted the two focus group members who did not attend. Both were aware of the session but neither was able to attend because of unexpected work related circumstances. In fairness to these focus group members, the researcher did not
provide group members with a way of making contact in the event of an unexpected occurrence.

Each of the audiotape recorded focus group session was transcribed. Although the researcher informed the focus group members that the sessions would be transcribed, there were no requests by any group member in either group to review the transcribed record of their respective sessions for verification purposes.

**Source Documents and Secondary Data**

The researcher relied on source documents and to a lesser extent secondary data to support key informant and focus group findings. Source materials reviewed by the researcher included readily available public data as well as data controlled by CAHWF. The source material reviewed by the researcher is provided in Table 3.6 on page 69.

In its first five years of operations, CAHWF independently completed a key informant survey and outsourced two grantee surveys. The Key Informant Survey (KIS) was completed in spring 2006. CAHWF completed the survey to evaluate its effectiveness in meeting its mission, vision and goals. The grant applicant surveys were conducted in 2005 and 2006. These surveys were entitled Quality Improvement Surveys. Dr. Richard Wiscott of Shippensburg University developed the survey instrument. Dr. Jennifer Devlen of Dickinson College with the assistance of a student associate, Jessica Grinspan analyzed the 2005 survey results. Jennifer Grinspan analyzed the 2006 survey results. The purpose of the survey was the same as the KIS survey - to assess CAHWF’s success in meeting its vision, mission, values, and goals. The researcher used these secondary data sources to support key informant information, focus group findings, and source document data. The KIS and Quality Survey results are available in Appendix D.
<table>
<thead>
<tr>
<th>Table 3.6 Carlisle Area Health &amp; Wellness Foundation (CAHWF) Source Documents</th>
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</thead>
<tbody>
<tr>
<td><strong>Internet Resources:</strong></td>
</tr>
<tr>
<td>Carlisle Area Health &amp; Wellness Foundation Home Page</td>
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<tr>
<td><strong>Publications:</strong></td>
</tr>
<tr>
<td>Carlisle Area Air Quality Assessment Report 2006</td>
</tr>
<tr>
<td>Opportunities and Challenges: Behavioral Health Task Force Report 2005</td>
</tr>
<tr>
<td>Building a Better Continuum of Care: Continuum of Care Task Force Report 2002</td>
</tr>
<tr>
<td>Carlisle Area Health &amp; Wellness Foundation Annual Reports (2003-2007)</td>
</tr>
<tr>
<td>Branches: Carlisle Area Health &amp; Wellness Foundation Newsletter (2002-2007)</td>
</tr>
<tr>
<td><strong>Public Policy Recommendations:</strong></td>
</tr>
<tr>
<td>Air Quality Position Paper – March, 2007</td>
</tr>
<tr>
<td>Prescription Medication Position Paper – September, 2006</td>
</tr>
<tr>
<td>Nutrition Position Paper – December, 2005</td>
</tr>
<tr>
<td>Behavioral Health Position Paper - May, 2005</td>
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<tr>
<td>Tobacco Position Paper – May, 2005</td>
</tr>
<tr>
<td>Oral Health Position Paper – December, 2004</td>
</tr>
<tr>
<td><strong>CAHWF Policy and Procedure Manuals:</strong></td>
</tr>
<tr>
<td>Board of Trustees Orientation Manual</td>
</tr>
<tr>
<td>Employee Handbook</td>
</tr>
<tr>
<td>Computer Use Policy and Procedure Manual</td>
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<tr>
<td>Grant Making Policy and Procedure Manual</td>
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<tr>
<td><strong>CAHWF Grant Reports</strong>:</td>
</tr>
<tr>
<td>Grant Applications</td>
</tr>
<tr>
<td>Foundation Initiative Proposals</td>
</tr>
<tr>
<td>Grant Agreement Contract</td>
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<tr>
<td>Grant Six Month Interim Reports</td>
</tr>
<tr>
<td>Grant Final Reports</td>
</tr>
<tr>
<td>* The researcher reviewed in detail grant reports associated with grant projects documented in Chapter 4.</td>
</tr>
<tr>
<td><strong>CAHWF Meeting Minutes:</strong></td>
</tr>
<tr>
<td>Board of Trustees Meetings (2001-2006)</td>
</tr>
<tr>
<td>Grants Committee Meetings (2001-2006)</td>
</tr>
<tr>
<td>Planning Committee Meetings (2001-2006)</td>
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<tr>
<td>Behavioral Health Task Force Meetings (2003-2005)</td>
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<tr>
<td>Behavioral Health Implementation Team Meetings (2005-2006)</td>
</tr>
<tr>
<td>Carlisle Regional Advocates (for)Nutrition and Activity Meetings (2005-2006)</td>
</tr>
<tr>
<td>Wellness at Work Meetings (2005-2006)</td>
</tr>
</tbody>
</table>
Analysis and Application of the Findings

This study relied on the following methods to gather information pertinent to the research questions: key informant interviews, focus group sessions, source document reviews, and secondary data reviews. The researcher depended upon key informant interview results, focus group results and source document data to fully respond to the first question. Key informant, focus group, source document and secondary data sources were used to support the researcher’s response to the second question. The segment begins with a summary of techniques used to analyze the collected information. This is followed by a summary of the application of this information to the research questions and propositions within the context of the relevant research literature.

The researcher used several techniques to organize and analyze data gained from the sources listed above. The researcher completed content analysis of both the key informant interview data and the focus group data. The researcher completed this analysis by creating an Excel workbook for each source of data. The framework for the key informant data workbook is the researcher’s interview guide. The responses of the twenty key informants are documented by interview guide question. The researcher selected the key word or phrase used by each respondent for each question. The frequencies of the key words or phrases used by the respondents were automatically calculated.

The completion of the key informant interview analysis was challenging given the complexity of certain questions and the opened-ended nature of the interview process. This was especially true of two crucial CAHWF effectiveness interview guide questions. In two separate questions, the researcher asked key informants to describe how CAHWF had been effective in its capacities as a grant maker and as a coalition builder (see Table 3.3). Key
informants provided multiple responses for each question. In an effort to better manage the significant volume of data generated by each of these questions, the researcher grouped like responses into effectiveness themes. The researcher defined the themes. There are five themes in total for both questions. Three of these themes are related to CAHWF as a grant maker and two of the themes are related to CAHWF as a coalition builder.

As mentioned earlier, the researcher also completed content analysis of focus group data. The researcher constructed an Excel workbook in the same manner as the key informant work book and attempted to code the data in the same fashion. The researcher found abstracting focus group information more challenging than selecting individual interview data due to the multiple voices and stories intertwined within a focus group discussion. The focus group discussions significantly contributed to the researcher’s understanding of the rich and complex evolution of the Foundation over its first five years of growth. The researcher was able to capture key quotes from focus group participants that helped substantiate several of the findings on CAWHF’s effectiveness.

The researcher also depended on source documents to support the study’s findings. The researcher maintained detailed field notes of the source documents. The researcher analyzed this data in several ways. These included: creating a schematic diagram of CAHWF’s model of action; organizing source document information of CAHWF’s community networks and partnerships into groupings/categories; organizing key events in chronological order; linking CAHWF planning recommendations with grant approvals; preparing multi-year data displays of CAHWF’s grant allocations and multi-year displays of selected CAHWF project activities and outcomes.
The researcher also reviewed CAHWF independently generated secondary data (surveys). Selected information from these secondary data sources served to support the findings gathered from the primary data sources - interviews, focus group and source document review.

As first mentioned in the opening paragraph of this segment, the researcher depended upon key informant interview results, focus group results and source document data to fully respond to the first question. The first question and proposition are provided below.

**Q1. In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community?**

- The formation of networked organizations result from a recognition of the interdependence of groups; the growing complexity of the environment; the difficulty of social problems; and/or the limited availability of resources to address these complex, interrelated issues.

The researcher’s primary purpose in asking this question was to learn more about the purpose functions and structures of network organizations operating under the auspices of CAHWF. The interview question results garnered from interview guide questions on CAHWF’s capacity as a coalition builder were compared and contrasted to the relevant network theory and community partnership literature. Employing a triangulation of sources technique, the researcher used source documents to move from a conceptual understanding of these networks to an operational understanding of these collaborative efforts.

Interestingly, the interview guide did not contain questions on the CAHWF’s grant making functions and structures. Information on CAHWF’s grant making capacities was initially gathered from responses to questions on CAHWF’s effectiveness as a grant maker (see
These findings were compared and contrasted with the foundation literature. Findings on CAHWF as a grant maker were also supported by source document data. Key informant, focus group, source document and secondary data sources were used to support the response to the second question. The second question and proposition are provided below.

**Q2. In its first five years of existence how has the Carlisle Area Health and Wellness Foundation been effective?**

A collaborative community organization targeting the improvement of community health is effective when it is responsible for one or more of the following actions: efforts to improve the delivery of a specific service; the development of collaborative relationships; efforts to improve the health status of a particular community group; or efforts to alleviate a specific community health problem.

Responses to the interview guide questions that targeted CAHWF’s effectiveness as both a grant maker and as a coalition builder (see Table 3.3) served as the basis for identifying the effectiveness themes that are presented in Chapter 4. In Chapter 5 the findings were compared and contrasted with the effectiveness construct as presented in the community partnership and the foundation literatures. The researcher also referenced examples of the effectiveness literature in an attempt to more broadly explain the reason for CAHWF’s effectiveness in these first several years of operations. Again source documents were instrumental in providing historical quantitative data to support these findings. Focus group results were used when appropriate to strengthen the findings. Secondary data was included simply to support the data collected by the researcher.

Finally, it is important to note that the researcher took specific actions to help ensure the validity and reliability of the case study research. As already discussed in this segment, the researcher relied on multiple sources of evidence and triangulated these sources of
evidence to support the validity of the findings. Two CAHWF administrative staff members reviewed a draft case summary at the request of the researcher as a second measure to ensure validity. The staff members indicated that the draft accurately portrayed the purpose and actions of the Foundation in its first five years of operation.

To help guarantee the reliability of the study, the researcher maintained a case study data base. The data base included audiotapes of the key informant interviews and focus group sessions; the transcriptions of these events; copies of secondary data sources; copies of source documents; and detailed field notes.

**Study Limitations**

The limitations associated with the CAHWF study are those limitations routinely associated with case study research. The intent of the research was to describe the organizational attributes of CAHWF and associated measures of overall CAHWF organizational effectiveness. The study was exploratory in nature because of the dearth of information on health care conversion foundations serving as collaborative lead community agency focused on community health reform and because of the opportunity presented to the researcher given his history with the Foundation to complete the investigation with the total cooperation of the Foundation.

The first limitation of the study is that it cannot be stated with certainty that CAWHF’s reliance on partnering to achieve community health status objectives is unique among health care conversion foundations. The second limitation is that even in the event CAHWF offers a singular approach to improving the overall health and well being of community residents, this approach may not be easily transferable to other setting for a whole host of environmental factors (cultural/social/economic/geographical factors;
impetus for partnership formation; external resources; community control; previous collaboration) and organizational factors (functional and structural) present in the Carlisle community but possibly not present in other communities or in the same mix.

A third limitation of the study relates to the researcher’s experience as a participant with the Foundation. The strength of the participatory experience provided the researcher an “insider’s” sense of reality (Yin, 1994). Given the complexity of Foundation activities this insider’s knowledge facilitated the sense making process required to organize and analyze the significant volume of available information. Of course the major problem and potential limiter in this case relates to potential researcher bias. Having had a positive experience with the Foundation, the researcher may serve more as an advocate for the organization rather than as a neutral researcher. Efforts were taken by the researcher to address this potential bias. These efforts included interviewing a wide range of key stakeholders; using multiple sources of information; and, triangulating the sources of information to support all findings presented in the paper.
Chapter 4 Case Study Findings and Analysis

“CAHWF activities will include grants as well as collaborative efforts to change existing systems for the better”  Branches, Spring, 2004

Summary of Case Study Findings

As described in chapter three, The Carlisle Health & Wellness Foundation (CAHWF) represents a health care conversion foundation. During its first five years of operations CAHWF extended its activities beyond those of a traditional health foundation in its efforts to identify and resolve health care concerns within its service area. CAHWF’s efforts to define itself beyond the boundaries of a reactive health foundation are reflected in the comments of the CAHWF’s Director of Planning

“I feel privileged to be working as part of an organization and within a community that places such priority on the health and well-being of the community members. It is clear to me that in addition to the Foundation’s role as a funding source, the foundation plays an integral role in strengthening community relationships and the infrastructure of the social services network.”

CAHWF was selected as the case study organization because of the Foundation’s efforts to resolve community health concerns that reached beyond funding. As a community leader, CAHWF actively collaborated with other community stakeholders to address and resolve a set of difficult health related problems. Based on three years of participation in a voluntary capacity with CAHWF, the researcher believed that CAHWF’s selected course of collaborative action and the chosen methods of intervention to address targeted health concerns and at-risk populations mirrored the approach and actions of a community health partnership. Given these characteristics, it was anticipated that an

1 Branches is Carlisle Area Health & Wellness Foundation’s newsletter. It is published two times per year.
analysis of CAHWF would serve to complete research solely on community coalitions and related intermediate measures of coalition effectiveness. This initial assessment of CAHWF undervalued its primary responsibility as a community health foundation. With this realization came the opportunity to gain a deeper understanding of CAHWF by examining in detail its multiple capacities and the relationships between these capacities. Responses to two exploratory questions were worked on in order to complete the research. The first question asks how CAHWF interacted with community stakeholders in its first five years of operations. The purpose of this question is to gain a complete understanding of CAWHF’s organizational purpose, functions and structures as they relate to community stakeholders and to the overall welfare of the community. The second question designed to identify intermediate effectiveness measures asks how CAHWF was effective in its first five years of operation. The research completed disclosed information on CAHWF’s efforts to build and manage community health coalitions and it actions as a grant making community health foundation. Perhaps of more significance the research uncovered information on a complex multi-purpose organization capable of positively impacting community health in its first five years of operation.

Provided below is a brief summary of the research findings beginning with a description of CAHWF’s interactions with its stakeholders and concluding with an identification of measures of effectiveness.

In an expanded role, CAHWF interacted with stakeholders in three ways - by serving as a community organizer, community resource and community advocate. As a community organizer, CAHWF collaborated with other community members and
organizations through the formation of community coalitions to identify, prioritize and propose solutions to identified community health concerns. Although actions to address areas of concern were carried out through coalition activities fostered by CAHWF as a community organizer, the implementation of these actions in the majority of cases were driven by CAHWF as a community resource functioning as a grant making community health foundation. CAHWF routinely partnered with individual providers or small groups of providers to provide community health and health related services. In its first five years of operation the foundation approved $10.6 million in grants for community projects linked to recognized problem areas. Finally, as a community advocate, the foundation directly consulted with policy makers on health issues impacting the community and supported health policy change through the preparation and public dissemination of policy position papers. During its first five years of operations CAHWF predominantly interacted with its stakeholders in its capacities as a community organizer and community resource.

In response to the second research question, community stakeholders perceive CAHWF as effective in its first five years of operations. Identified measures of effectiveness are both process and goal oriented. Measures of effectiveness cited by stakeholders include: an increase in networking opportunities; completion of strategic and operational plans in a collaborative manner; increase in foundation and community organizations’ management capacities; maintenance of a disciplined mission driven approach to program funding; and, the addition of health and health related services within CAHWF’s service area.
The remainder of this chapter is arranged in three sections. The first two sections present the case findings and are organized around the two research questions. The final section provides an analysis of the research question findings.

The response to the first question begins with a general overview of CAHWF’s responsibilities as a community organizer and as a community resource at each step of the collaborative process employed by CAHWF to achieve its mission. A more detailed description of CAHWF’s capacity as an organizer follows the opening segment and includes its responsibilities for planning networks, network “work groups”, and a health promotion network. A detailed description of CAHWF’s capacity as a community resource follows the discussion on CAHWF’s organizing responsibilities. The description of CAWHF as a community resource includes information on grant allocations; the grant process; CAHWF’s interaction with grantees; and, examples of CAHWF funded projects. A summary integrating the dual responsibilities of the Foundation concludes the response to the first question.

Research question two reviews in detail each measure of effectiveness identified by community stakeholders. A summary explaining the relationships between these measures concludes the response to research question two.

In the final section of the chapter an analysis of the findings is provided based on an application of the relevant literature. The organization of this analysis parallels the chapter’s presentation of the case study findings. The section begins with a discussion of CAHWF as a community organizer. Included within this opening discussion is an analysis of the effectiveness measures closely associated with CAHWF’s organizing efforts. This is followed by a review of CAWHF as a community resource and its
resource related effectiveness measures. An analysis of the combined findings concludes
the section.

Given the richness and complexity of the case study findings, a brief explanation of
the relationships between the findings, data streams and research methods is provided
below. The explanation is divided into three sections that match the detailed descriptions
of CAHWF as a community organizer, CAHWF as a community resource, and
CAHWF’s measures of effectiveness.

Figure 4-1 depicts the relationship between the findings presented of CAHWF as a
community organizer and the data and methods used to support the findings. The findings
are primarily supported from data gathered through a review of source documents. A
richer understanding of the source document data is provided by key informant and focus
group documented responses obtained through key informant interviews and focus group
sessions.

Figure 4-1

![CAHWF as a Community Organizer](image)

Figure 4-2 shows the relationship between the findings presented of CAHWF as a
community resource and the data and methods used to support the findings. The findings
are primarily supported from data gathered through a review of source documents. Key informant documented responses obtained through key informant interviews provide a clearer understanding of the partnering relationship between CAHWF and its grantees.

Figure 4-2

Figure 4-2 outlines the relationship between identified measures of CAHWF’s effectiveness and the data and methods used to support the findings. The measures of effectiveness were initially identified through an analysis of documented key informant responses gathered through key informant interviews. For each measure multiple sources of data are triangulated to support the findings. In order of importance, data provided by documented responses obtained through focus group sessions or provided by a review of source documents followed by a review of secondary data sources routinely serve to support the initial key informant findings.

Figure 4.3
The Case Study Findings

CAHWF’s Role in the Community

Q1. In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community?

In its first five years of operations, CAHWF created opportunities to interact with stakeholders by embracing a collaborative community wide planning and implementation process designed to accomplish its complex and far-reaching mission. The basic steps of this collaborative community model of action include: assessment of community health needs; prioritization of health needs; development of strategic and operational plans; plan implementation; and, evaluation of outcomes. To carry out this course of action, the foundation broadened its role to serve in three capacities – community organizer, community resource, and community advocate. As community organizer, CAHWF first served as a lead-convening agency assembling community stakeholders into organizational networks. CAHWF then served as the network administrative organization for these groups and actively participated in network activities as well as follow-on network related activities. Functioning as a community organizer, CAHWF interrelated with stakeholders in all phases of the collaborative community-wide process with the exception of outcome evaluation. As a community resource, CAHWF served as a grant making institution with primary responsibilities for the implementation and evaluation steps of the collaborative process. In this role CAHWF reviewed and acted on grant requests submitted by service providers in response to community identified concerns. In a more assertive stance, CAHWF, through a pro-active grant request process, self
initiated funding of selected service providers to meet identified needs not addressed through the reactive grant request process. Finally, as a resource, CAHWF invested in projects and activities aimed at supporting community organizing efforts and building the capacity of community organizations. Third, the foundation served as a public policy advocate on health related issues. In addition to these three primary functions, CAHWF also participated as a member of numerous community collaborative organizations. A listing of these community organizations is provided in Table 4-1.

Table 4.1 CAHWF Community Memberships

| · Cumberland-Perry County Tobacco Control Coalition  
| · Cumberland-Perry County Substance Abuse Prevention Coalition  
| · Cumberland LINK: Aging and Disability Resource Center  
| · Harrisburg State Hospital Closure Advisory Committee  
| · United Way of the Capital Region  
| · Vision Council of Health  
| · United Way of Carlisle and Cumberland County Planning Committee  
| · United Way of Carlisle and Cumberland County Emerging Need Coalition  
| · Perry County Family Service Partnership Board  
| · Cumberland County Partnership for a Healthy Community |

Source: Carlisle Area Health & Wellness Foundation

In its first five years of existence, CAHWF primarily interacted with its stakeholders in its capacities as community organizer and community resource. As a community organizer CAHWF interrelated with stakeholders in three distinct ways. First, CAHWF created, managed and participated in broad based community organizational networks structured to identify and seek strategic and operational solutions to community health challenges. These collaborative networks were set up for defined periods of time and were often referred to as task forces. The initial collaborative effort (task force) focused on assessing community health status, and then identifying and prioritizing areas of
concern. Additional task forces were then convened to further investigate focus areas identified through the assessment process. For practical purposes, these broad based task forces dissolved after the completion of their respective planning reports.

Second, CAHWF interacted with follow-on working groups linked to the planning task forces described above. The work groups were charged with expediting task force recommendations. The work groups completed a broad range of activities in pursuit of this objective. These activities included completing further research on specific recommendations; identifying community organizations best suited to implement recommendations; and, in several instances collaborating with community organizations to implement recommendations.

Third, based on a planning task force recommendation, CAHWF created, and continues to manage and participate in a broad based community organizational network convened to facilitate health promotion initiatives. This grassroots network is charged with developing and implementing prevention, promotion and education initiatives aimed at positively influencing individual lifestyle choices and practices.

As a community resource, CAHWF served as both a reactive and pro-active grant maker. As a pro-active grant maker, CAHWF actively partnered with community providers to implement recommended strategies and actions not addressed through the reactive grant application process. As a funding partner, CAHWF routinely provided management expertise, administrative support and financial support to get these projects started. CAHWF also served as a sponsoring organization for both community organizing efforts (funding studies, retaining consultants, sponsoring meetings and extending
foundation staff resources) and capacity building initiatives (funding development of evaluation tools, offering training and informational sessions).

In an effort to incorporate the structural and functional aspects of CAHWF summarized to this point, a simple schematic integrating CAHWF’s model of collaborative community action and its community responsibilities is provided in Figure 4-4. As shown in the schematic, there is a fairly well defined separation between organizing and resource responsibilities with some overlap in the implementation step. Again it is important to note that this is a simple, linear representation of CAHWF’s responsibilities and actions. In reality this model evolved over the foundation’s first five years of operation. Funding decisions were being made after the completion of the community health status assessment but before the completion of task force planning recommendations. CAHWF, therefore, initially relied on the findings of the health status assessment report to aid in grant making decisions. The grant making decision process became more informed as planning task force recommendations became available in calendar years 2004 and 2005.
Figure 4-4  Model of Collaborative Community Action

ASSESSMENT

PRIORITIZATION

PLANNING

IMPLEMENTATION

EVALUATION

Community Organizer

Community Organizer

Community Organizer

Community Resource

Community Resource
Table E-1 in Appendix E provides a detailed chronology of CAHWF activities by organizational capacity and function during the first five years of the Foundation’s operations. Additional information on each of these initiatives is provided in the following two sections.

**CAHW as a Community Organizer**

At the time of its formation on June 19, 2001, CAHWF faced a number of significant governance and management issues. CAHWF’s governance responsibilities included organizing a Board of Trustees; establishing governance bylaws; developing well articulated vision and mission statements needed to set the new foundation’s direction; and, establishing grant making policy to ensure prudent oversight of the foundation’s assets. Operational responsibilities included locating suitable office space; furnishing the new space; selecting an executive director; and addressing issues related to on-going operations that became or would become CAHWF responsibilities as part of the conversion transaction. These ongoing operations included an assisted living facility, Cumberland Crossings and a nonprofit health clinic, the Sadler Clinic.

In the case of the Sadler Clinic, the new owners of the Carlisle Hospital, Carlisle HMA, Inc. agreed to support the clinic for a two-year period after the sale. At the end of the two-year period Carlisle HMA planned to relinquish responsibility for the center back to the community. CAHWF planned to assume responsibility for supporting the clinic at the end of the two-year period. Given these circumstances, the newly formed Board of Trustees felt a great urgency to resolve inherited operational issues and build Foundation management capacity because the community anticipated a judicious and equitable distribution of Foundation managed asset earnings as soon as possible.
By November 2002 all these issues were resolved with one exception. The assisted living facility, Cumberland Crossing, was not sold to Diakon Lutheran Services until October 2003. During this formative period the CAHWF Board of Trustees accomplished two important objectives that set the Foundation’s direction and influenced its actions. These were the recruitment of the foundation’s first executive director, Bets Clever, in September 2001 and the crafting of the vision and mission statements approved by the Board of Trustees in April 2002.

Prior to accepting the CAHWF position, Bets served as the United Way of Carlisle and Cumberland County’s Executive Director for 17 years. In her role as United Way Executive Director she developed a strong network of professional contacts across multiple sectors; participated in leadership roles in numerous community wide initiatives; worked closely with nonprofit managers to improve the performance of their nonprofits that spanned a broad range of health and human services; and evaluated the performance of these organizations.

Of course to fully exercise these skills, the execute director required a clear understanding of the newly formed foundation’s purpose. Interestingly, the purpose of the foundation began to take shape before the incorporation of the foundation. The foundation’s vision and mission are grounded in a series of deliberations immediately preceding and following the sale of Carlisle Hospital and Health Services, Inc. (CHHS) to Carlisle HMA, Inc. The first part of this narrative is best captured in the comments of a former CHHS trustee who transitioned onto the CAHWF Board of Trustees at the time of the non-profit community hospital sale.

“Yea, well, where I started out, it was on the hospital board. So I go all the way back to that. But, you know, for those of us who sat on that board
at that point, there was one meeting as we were trying to decide, should we sell this hospital or not? Where I think it became apparent – and this was after 18 months of studying this thing *ad nauseam* – where finally, and I think it was (board member), who said, just what is our fiduciary responsibility here? And it wasn’t to keep the hospital going at all costs. It was, as we saw it, it was to make sure that there was adequate health care in this community, in no matter what form that took. And I think that was probably a very defining moment because then everybody sort of got on board to say, okay, we can’t keep this hospital. We can’t own it. It’s not working. We can’t afford to renovate it. We can’t afford a new one. So we have to sell it and then with the proceeds we have got to (ensure adequate health care), that’s the part that we manage.”

There were challenges associated with this course of action. For example, what were the health and health related resources needed by the community after the closure of the non-profit community hospital? How should the newly forming Foundation honor its commitment to the community? In response to the first question, the CHHS Board of Trustees began efforts to organize a study of community health priorities in 2001 prior to the finalization of the hospital sale. The CAHWF Board of Trustees approved participation in a multi-organization funded health assessment study several months later in January 2002. The report was completed in May 2002. The purpose of the study and the process implemented to complete the study are best captured in the comments of a former CHHS trustee who transitioned onto the CAHWF Board of Trustees at the time of the non-profit community hospital sale and a community representative who served as a CAHWF volunteer and was elected to the CAHWF Board of Trustees in July, 2004. In response to explaining the purpose of the study, the former CHHS trustee stated

“And before the hospital divided, or sold, we knew that we wanted to do a Health Status Assessment. And I was the one that researched that one, because there seemed to me there were two camps. You could do a needs-assessment, or you could do a health status assessment. And to me and the rest of that little committee, it made more sense to do a health status so
you knew what you were dealing with than a bunch of people telling you what they thought you needed. So that’s what we did.”

In reflecting on the responsibility of the CAHWF Board of Trustees to determine community priorities, the CAHWF volunteer stated:

“This is not a group of people (CAHWF Board of Trustees) that are sitting at the table and saying well this is what we need so this is what we’re gonna fund. I really believe their efforts are sincere in going out into the community and finding out what does the community need -their priorities.”

In the end, the health assessment study reported on both documented health and health system concerns and perceived community needs. Supported by quantitative data, the final recommendations identified community health and health system concerns requiring action. These recommendations overlapped with the self reported concerns of community residents. Table E-2 in Appendix E provides a summary of Health Status Assessment findings by information source. Three areas of concern recognized by all three information sources listed in Table E-2 are mental health, access barriers to health care and obesity (as a factor related to chronic disease). Mental health and chronic disease became CAHWF targeted areas of concern. The reduction in barriers to care was targeted by CAWHF as a means to reducing the incidence of the two identified health problems.

This initial CAHWF lead effort was successful for several reasons. First and foremost the report recommendations significantly shaped CAHWF’s understanding of the extent of its anticipated commitment to the community – to provide “adequate health care in this community, in no matter what form that took.” Second, the assessment process and preliminary report findings served as the underlying rationale for development of the
Foundation’s vision and mission statements formulated and approved at the time of the study. CAHWF’s approved vision and mission tasked the Foundation with the challenging responsibility for creating and maintaining conditions conducive to community wide health and well being. To accomplish this mission would require the application of multiple innovative community based interventions. The vision and mission statements are provided in Table 4.2 below.

| Table 4.2  CAHWF Vision and Mission Statements |
|-----------------|----------------------------------------------------------------------------------------------------------------------------------|
| VISION          | Carlisle Area Health and Wellness foundation will be a leader and catalyst to ensure continuous improvement of health in our communities. |
| MISSION         | Carlisle Area Health and Wellness Foundation identifies and addresses healthcare needs and policies, promotes responsible health practices, and enhances access to and delivery of health services. |
| Source          | Carlisle Area Health &Wellness Foundation |

Third, predicated by the success of the health assessment process, the CAHWF Board of Trustees endorsed moving forward with a collaborative approach to resolving community health concerns. In its first five years of operation, CAHWF routinely relied on community partners to advance the Foundation’s mission. The commitment to active and meaningful community involvement continued to grow during the first few years of Foundation activity. Reliance on community stakeholders was formally recognized by the CAHWF Board of Trustees with their approval of the CAHWF strategic plan on May 10, 2005. Provided with a broad mandate to improve community health in concert with community stakeholders, Bets Clever’s experience proved invaluable as she managed the process of realizing the foundation’s vision and mission. The strategic plan is provided in Table 4.3 below.
Table 4.3 CAHWF Strategic Plan

Forge Partnerships with Providers
• Convene and plan with community stakeholders around specific issues.
• Provide funding that addresses identified needs.
• Research and promote best practices and evaluate CAHWF and grantees.
• Offer training and technical assistance to build the capacity of community organizations.

Connect with the Public
• Assess community needs.
• Educate the community about needs and solution.

Ensure Excellence in Governance
• Develop CAHWF capacity to achieve the vision, mission, and objectives.
• Practice excellent fiscal stewardship.

Source: Carlisle Health & Wellness Foundation

CAHWF Planning Networks

In its first three years of operation as a community organizer, CAHWF essentially addressed the assessment, prioritization and planning tasks of the collaborative community action model formulated by CAHWF. CAHWF partnered with community stakeholders (through the creation of temporary networks of community organizations) to define decision issues; gather and analyze information; develop alternative solutions or strategies; and, evaluate and select the “best” alternatives. Network activities that best exemplify these partnership actions and responsibilities include the Health Status Assessment Task Force (HSA), The Prevention and Education Task Force (PE), The Continuum of Care Task Force (CC) and the Behavioral Health Task Force (BHTF). The activity of each of these networks is summarized below. Further detailed information on each of these community planning networks is provided in Table E-3 in Appendix E.
As discussed, the Health Status Assessment Task Force (HSA) completed the critical first step of the planning process. This group’s efforts resulted in the identification of community health issues and concerns. Based on the report, the task force provided CAHWF with several opportunity areas to focus upon. These included disease and condition (including mental health, chronic disease management, and oral health); populations (at risk populations, the elderly, and working individuals and families); health system (access, capacity, and finance and delivery strategies); health education and promotion (instilling a sense of individual and shared responsibility for health); and, health policy and advocacy. The priority areas of concentration selected by CAHWF as a result of the assessment fundamentally mirrored the HSA recommendations. The priority focus areas were oral health; behavioral health (mental health and substance abuse); and chronic illness (asthma, cancer, cardiovascular disease, and diabetes). To address these areas CAHWF planned to concentrate its efforts on promoting individual and shared responsibility for health through prevention and education and/or providing access to and delivery of services to at risk populations (lower income, the elderly, and the under/uninsured).

The HSA report was a good first step. The report identified critical community health issues, promoted an approach to addressing identified health concerns, and prioritized community members in need of services. Continued collaborative planning activities were required however to further sharpen CAHWF’s focus.

Two major partnership activities were initiated within several months of each other and within six months of the completion of the Health Status Assessment Report. These were the Prevention and Education Task Force and the Continuum of Care Task Force.
The common objectives of these partnerships were to become better informed about HSA identified community concerns; to provide strategic direction; and, to build detailed plans of action to address these identified concerns. The specific areas of concern for each differed. The Prevention and Education Task Force investigated population health status issues and opportunities and the Continuum of Care Task force researched health system issues and opportunities.

The Prevention and Education Task Force studied each of the chronic illnesses identified in the HSA as well as substance abuse. At its conclusion, the Prevention and Education Task Force produced a report “A Framework for Health Promotion”. Employing the “Spectrum of Prevention” model 2 the report provided a plan consisting of six prevention strategies each accompanied with specific action steps to fulfill the recommended strategies. A detailed summary of the Prevention and Education Task Force strategic recommendations are provided in Table E-4 in Appendix E.

In contrast to learning more about specific illnesses and their associated causative factors, the Continuum of Care Task Force committed to identifying local health system issues and opportunities. The objectives of the task force included defining and assessing the existing regional health system; identifying manageable, yet important, system improvement strategies; and creating a working plan for identified system improvements. The final report of the task force “Building a Better Continuum of Care” included a plan identifying three strategic areas (capacity and workforce; barriers to service; health budget and policy) each with strategic themes and associated action steps. A detailed

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2 The Executive Director of the Prevention Institute, Mr. Larry Cohen, developed the “Spectrum of Prevention” model. The model is comprised of six levels of increasing scope beginning with a focus on individual capacity and ending with efforts to affect policies and laws.
summary of the Continuum of Care Task Force strategic recommendations is provided in Table E-5 in Appendix E.

The last major task force beginning more than a year after the completion of the HSA and prior to the completion of the Prevention and Education and Continuum of Care Task Forces was the Behavioral Health Task Force. Although the topics of mental health and substance abuse were partially addressed in the other task force activities, a decision to move forward with this specific activity resulted because of a perceived need to comprehensively address these dual health issues in a coordinated way. The partnership was tasked with defining the existing regional behavioral health system; recommending strategies and action steps to improve existing systems; and identify relevant stakeholders to carry out these recommendations. The Behavioral Health Task Force meetings, discussions, and recommendations were structured around three subject areas – prevention and wellness, clinical services and support services. The final report of the task force “Opportunities and Challenges” included a plan listing action steps associated with each of the three subject areas listed above. A detailed summary of the Behavioral Health Task Force recommendations is provided in Table E-6 in Appendix E.

CAHWF Working Groups

At the completion of their respective reports, the broad based planning task forces described above ceased meeting on a regular basis. CAHWF, however, extended the functioning of these task forces through the formation of working groups charged with expediting the implementation of task force recommendations. The work groups completed a broad range of activities to ensure implementation. These activities included completing further research on specific recommendations; identifying community
organizations best suited to implement recommendations; and, in several instances collaborating with community organizations to implement recommendations. A summary of these task force working groups is provided below. Further detailed information on these working groups is provided in Table E-7 in Appendix E.

Two working groups were convened by CAHWF as a result of Continuum of Care Task Force efforts. These working groups were the Prescription Coalition and the Enrollment Task Force. CAHWF provided administrative support for the working groups and foundation staff participated in both working groups.

The Prescription Coalition was assembled by CAHWF in response to the Continuum of Care Task Force recommendation to lower barriers to health care services by enhancing and developing an accessible and affordable prescription assistance strategy. The prescription Coalition’s work resulted in the approval of a proactive grant to the Sadler Health Center Corporation for the start up of the Healthy Community Rx Program.

The Enrollment Task Force was assembled to deal with barriers to health care services. Through an education and enrollment strategy, the group met with moderate success in assisting in the enrollment of eligible individuals not enrolled into Medicaid and CHIP programs. The task force collaborated with local school districts.

Efforts to execute other Continuum of Care recommendations were completed in the first five years of operations. The Enrollment Task Force and the Prescription Coalition are the only examples of working groups formed specifically to directly address the Continuum of Care Task Force recommendations.

As expressed by the Behavioral Health Task Force chairperson, task force members hoped that the completion of the behavioral health report would mark the first step in
continued community collaboration. According to the task force chair person in his letter prefacing the task force report, “We hope that under the auspices of CAHWF…an organizational network can be empowered to implement successful strategies that will benefit our behavioral health system as a whole. The network will be able to achieve strategic purposes not attainable by any single organization and to provide flexibility and responsiveness to the identified needs.” The Behavioral Health Task Force formed the Behavioral Health Implementation Team to begin the development of a reconstituted and redefined behavioral health network. The stated purpose of the implementation team was to facilitate the implementation of recommendations captured in the final Behavioral Health Task Force report, “Opportunities and Challenges”. Although the Behavioral Health Implementation Team Force acted on several modest initiatives immediately following the release of the report, there were no efforts by the implementation team to expand their role and act on more challenging recommendations (refer to Table E-7).

**CAHWF Health Promotion Network**

In April 2005 CAHWF launched its most ambitious attempt at convening and sustaining a community partnership. At that time CAHWF kicked off the Carlisle Regional Advocates for Nutrition and Activity (CRANA). The start up of this ongoing community network was in response to the Prevention and Education Task Force recommendation to “establish a broad based coalition to support and advocate health promotion.”

The effort also purposively coincided with a Pennsylvania state government community
partnership initiative administered through the Department of Health’s PANA program\(^3\).

CRANA is composed of school, employers, nonprofit agencies, and municipal and county representatives. The group is divided into three subcommittees – community, schools/youth and workplace. The division of the network into these three subcommittees by CAHWF was intended to simplify and structure community activities in ways that facilitate action by participating network members. The purpose of CRANA is best revealed in a quotation on the need for community collaboration contained in the Prevention and Education Task Force report “A Framework for Health Promotion”.

“These recommendations (strategies) are broad strokes…. While there are no suggested timelines submitted with these strategies, it is important to note that some of these strategies will take multiple years to implement, with further study and work by community partners.”

Using the Prevention and Education Task Force report as a starting point, CRANA’s purpose therefore was and remains to generate and implement innovative initiatives designed to change norms, individual behavior and institutional policies in order to encourage the practice of good health care and the responsibility of healthy lifestyle choices by each community member in all aspects of community life.

From April 2005 through 2006, representatives from two of the subcommittees (community and schools/youth) met on a quarterly basis. These meetings served as a forum for networking, information exchange, problem solving and brainstorming. The schools/youth subcommittee additionally met twice a year at networking dinners with school district representatives. These networking dinners typically contained an

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\(^3\) The Pennsylvania Advocates for Nutrition and Activity (PANA) was established by the Pennsylvania Department of Health and supported by funding from the Centers for Disease Control and Prevention. The mission of PANA is to build state-wide capacity to support and promote active lifestyles and health food choices through collaboration and communication.
educational component, information exchange and time for collaborative problem solving and/or project development. Although CRANA was structured to include a workplace subcommittee, this subcommittee was not activated at the inception of the partnership. This is because two months prior to the start up of CRANA in April 2005, CAHWF, in its role as community resource entered into a partnership agreement with the Carlisle Chamber of Commerce and seven local employers to collectively fund and manage a “Wellness at Work” pilot project. From its start up in February 2005 through 2006, the workplace group met separately on a quarterly basis to discuss project related progress. Based on the selection of a CRANA workplace subcommittee chair at the June 2, 2006 CRANA meeting, the long run intent of CRANA is to activate the workplace group as the pilot project concludes.

From April 2005 though the end of 2006, CRANA experienced some successes in championing health and wellness causes through the efforts of its community and schools/youth subgroups. CRANA initially focused on implementing Prevention and Education strategy recommendations aimed at disseminating information. As a first step, members representing the community and schools/youth subcommittees and CAHWF staff created an opportunity for community members to learn more about wellness. On November 18, 2005 CRANA sponsored a CAHWF funded public symposium featuring nationally known health and wellness experts as major presenters.

Additionally in 2006, members of the CRANA community group, a CAHWF staff member, and The Cumberland County Planning Commission partnered to produce a guide of Cumberland and Perry County’s public parks, trails and recreational areas that remains freely available to community residents. Funding for the publication of the guide
came from CAHWF as well as a $5,000 grant awarded by the State Department of Health through the PANA program.

During this time the school/youth subcommittee was also active. An example of successful problem solving initiated by CRANA through the school/youth subgroup concerned the state mandated school health program requirement to provide parents/guardians with their child’s BMI (body mass index) information. A CRANA partnership member recounted

“The school nurses had to send out, mandated by the state, a BMI…And so, I think a lot of them were overwhelmed with how they were going to gather the data, do the letter. What kind of repercussion is going to be created at home when a parent gets this letter? …We went to this networking dinner (school/youth dinner), and invited all the area school nurses. It was a lot of work on her end (CAHWF meeting facilitator). And then had two presenters and then, also not only was it a presentation, but then allow time for sharing and networking within the group in this community: Boiling Spring, Big Springs, Carlisle, and Cumberland Valley. And to me, what I saw was invaluable what they shared with each other. This is what I tried; this has worked. Oh, really? Can you give me, like, a website? Yea. And that was just phenomenal.” …

“So, all the school nurses were like up in arms like because parents, you telling the kid, you’re not the parents anything new but it’s a very sensitive subject. So, we’ve developed a whole initiative that when the BMI goes home, they have a resource guide and says it’s not just that your kid has a high BMI but here’s the resources we can help you with this, we’ve educated the school nurses, and that’s been very successful.”

As summarized above by a fellow CRANA member, CRANA followed through on the BMI issue. Throughout 2006 CRANA’s schools/youth group continued to search for ways to benefit local school districts. At the close of 2006, the schools/youth group

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4 The body mass index (BMI) is a unit of measure which incorporates a person’s height and weight in the calculation. Taking into consideration a person’s age and gender the measure is used as one way of determining an individual’s fatness or thinness.
planned to focus on the support of school district Wellness Councils. CRANA remains an active and grounded community partnership. As expressed by one CRANA member in describing her participation with in the network “I feel very fortunate to work on a grass routes level, because it (CRANA) is really grass routes”. The partnership continues to seek ways to stimulate community action in the areas of nutrition and activity through education, programming and problem solving. Further detailed information on CRANA is provided in Table E-8 in Appendix E.

In its efforts to serve as a community organizer, CAHW F became more than a reactive health foundation. CAHW F served as a community forum for information exchange, decision making, and planned action. Although CAHWF’s networking efforts lead to the implementation of health system improvements requiring limited financial resources, CAHW F’s greater contribution as a community organizer was its creation of a framework for community action then pursued more aggressively by CAHW F in its capacity as a community resource.

**CAHW F as a Community Resource**

As a community resource, CAHW F reviewed and acted on grant requests submitted by service providers responding to concerns identified by the community. In a more assertive stance, CAHW F, through a proactive grant process, funded selected service providers to meet identified needs not addressed through the traditional grant request process. Finally, CAHW F funded projects and activities that supported both community networking and community capacity building efforts. In it first five years of operation, all

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5 Wellness councils are formed by individual school districts to develop local wellness policy that promotes the health of students and addresses the growing problem of childhood obesity. The development of these policies is a federal requirement (Section 204 of Public law 108-265) for each local education agency participating in the National School Lunch Program and/or School Breakfast Program.
of CAHWF’s community resource responsibilities were instrumental in moving the organization toward its vision. This section of the paper focuses on CAHWF’s role as a grant maker with particular emphasis on its proactive funding decision and actions. CAHWF’s role as a proactive grant maker closely relates to the implementation and evaluation steps of the collaborative community model of action pursued by CAHWF.

**CAHWF Grant Awards**

CAHWF first awarded grants during fiscal year 2002-2003. For the five-year period (July 1, 2001 – June 30, 2006) total grants awarded were $10,609,484. During that time the Sadler Health Corporation received $5,451,259 or 51.4% of all grants awarded. A detailed summary of CAHWF’s grant awards by focus areas of community concern is provided in Table E-9 in Appendix E.

The commitment to the Sadler Clinic can be traced to the long-term support for the Sadler Clinic by CHHS prior to the hospital’s sale as well as the strong community support for the continuation of the clinic after the sale. From CAHWF’s perspective, Sadler Health Clinic served as an instrument to accomplish a key mission objective – most notably to address chronic illness and oral health by creating access to care for the under and uninsured. Funds awarded to the Sadler Clinic (renamed the Sadler Health Center at the time of its incorporation on October 25, 2002) were used to legally establish the entity; acquire capital assets; increase management capacity; fund operating shortfalls; and introduce new services.

**CAHWF Grant Processes**

CAHWF’s grants process evolved over the Foundation’s first five operating years. Initially CAHWF’s processed grants in a reactive manner basically receiving and
evaluating grant applications as submitted. The grant committee reviewed applications and submitted their recommendations to the Board of Trustees for final decisions on grant awards. This reactive approach to program funding shifted for three reasons. First, CAHWF realized that successfully meeting its mission objectives required a closer and more active relationship with its community service providers. Second, prior to any formal change in the grant making process, CAHWF demonstrated its ability to partner with a service provider to address an urgent community concern. Third, CAHWF acknowledged that social and environmental factors that influenced community health extended beyond the scope of those activities routinely funded by the Foundation. These changes in grant decision-making strategy were formally incorporated into the foundation’s policy and procedures through the board approved adoption of the proactive grants process November 1, 2003 and the healthy people grant guidelines on April 11, 2006.

The proactive grants process created a formal pathway for key stakeholders (board, community, board, staff, and task force members) to champion community initiatives. The policy requires that recommended initiatives/projects be initially reviewed by the planning committee. In the event of a successful planning committee review, the Board of Trustees may either accept or reject moving forward with the preparation and distribution of a RFP (request for proposal). If the Board of Trustees approves moving forward, Foundation staff members in collaboration with planning and grants committee members are responsible for carrying out the RFP process. The grants committee reviews responses to the RFP’s. The foundation board votes on awarding grants to RFP applicants.

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6 In response to a perceived need for community psychiatric services, CAHWF partnered with Adams–Hanover Counseling Services to establish a psychiatric practice in the Carlisle area. This partnership is discussed in greater detail later in the chapter when CAHWF pro-active grant initiatives are reviewed.
after reviewing the grants committee recommendations. Pragmatically speaking as a result of the approval of the proactive grant policy, foundation management staff members were able to move more aggressively in forming working partnerships to advance recommendations generated by CAHWF convened community collaborations.

The healthy people grant policy allowed applicants to submit grant requests that fell outside of the CAHWF focus areas but could be connected to public health and/or wellness as outlined in the Healthy People 2010 goals. The total annual Foundation funds reserved for these types of grants was $100,000. This change in policy occurred two months prior to the end of the five-year period being reviewed. It is noteworthy because it reflects the Board of Trustees understanding of the complexity of health and health care. Through this policy CAHWF could maintain the discipline of its focus areas while acknowledging the true complexities of health and health system models.

**The Role of CAHWF as an Active Partner with Grantees**

Over the five-year period under review, CAHWF management staff maintained an open and supportive relationship with grant applicants. For example, CAHWF staff routinely assisted service providers in completing CAHWF grant applications. This relationship with grant recipients intensified over time as CAHWF transitioned from a traditional “arms length” grant maker to a proactive grant maker actively partnering with community providers. CAHWF’s desire to move forward with “task force” recommendations in collaboration with community service providers accelerated this transition. Essentially, CAHWF moved beyond its traditional grant making

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7 The Department of Health and Human Services launched Healthy People 2010 in January, 2000. Healthy People 2010 is a comprehensive, nationwide health promotion and disease prevention agenda containing 467 objectives. These objectives are designed to help guide all Americans toward a more healthy life during the first decade of the 21st century.
responsibilities in three ways. First, CAHWF staff supported network related working
groups (Prescription Coalition, Behavioral Health Implementation Team) by originating
proactive grant requests in response to working group recommendations. Second,
CAHWF staff independently introduced grant requests using the proactive grant process
in response to community concerns not addressed through the reactive grant process
(Adams Hanover Counseling Service, Wellness at Work Program). Third, CAHWF
continued to support grant awardees throughout the original grant period and renewals. In
all of these instances CAHWF provided management and administrative support in
addition to the financial support required to move projects forward.

The value of CAHWF staff support to grant awardees is captured in this CAHWF
trustee’s comments on the grant process

“that is one of the things that is a real gift to the grantees is that they are
not just given money and are out there alone with it. The foundation has a
very dedicated, very capable staff of professionals who are there to answer
questions, there to work with folks, there to make suggestions and also to
connect them so there’s no duplication of services.” …

“They also are very approachable. If we’re having a problem or, God
forbid, we’re seeing that what we originally planned to do isn’t the way
that this program is going or something along those lines; we don’t have to
be afraid of saying, “help us.” Or, “I don’t understand what this is about.”
Or, you know, they aren’t that kind of organization where you have to be
afraid to talk to them. They’re very personable, very accessible. And
there’s never been a time when I had a question that it didn’t get answered
immediately, either through an email or a phone call.”

The value of the staff is also echoed by a grant recipient in the statement above.

CAHWF also signaled its interest in partnering with grant awardees in the way it
chose to evaluate program performance. CAHWF employs a logic model framework to
evaluate performance\textsuperscript{8}. By employing this model CAHWF serves as a good partner by requiring its grantees to clearly describe the rationale behind its programming and establish performance measurements linked to these underlying reasons. Through this process CAHWF not only helps build the management capacity of each grantee but also demonstrates trust in its partners’ abilities to establish performance measurements based on their professional expertise. In reflecting on the use of the logic model, a CAHWF trustee commented,

“Well, I think it’s again, you’re getting back to that area of partnership. For a lot of providers who come to us, they have not used that tool in the past. I think it helps them clarify the guts of their grant and also really question and take a look at what is it that they really want to accomplish and what are the resources and tools that they have in order to do that. I think this helps them with long-term sustainability, not just for the project that they’re presenting to us, but for other areas that they might work in within their organization down the road. That it really gives them a little more credibility.”

Examples of Proactive Grants

Table E-10 in Appendix E provides brief descriptions of CAHWF’s actions as a grant maker in partnership with service providers. These examples are representative of CAHWF’s actions and do not represent the entirety of the Foundation’s efforts during their first five years of activity. These examples demonstrate the connection between CAHWF’s planning activities and implementation steps; illustrate CAHWF’s proactive approach to change; and, provide some sense of the challenges associated with moving from plan to action in a collaborative manner. The examples are organized by task force

\textsuperscript{8} The term “logic model” is used in the field of evaluation to denote a model that defines the relationships between contextual factors and program inputs, processes, and outcomes. A well designed logic model communicates the underlying rationale about why a program is a good solution to a specified problem.
initiatives beginning with continuum of care then behavioral health, and closing with prevention and education.

In response to the Continuum of Care recommendation to “develop an accessible, affordable and appropriate prescription assistance strategy”, CAHWF approved a $200,000 proactive grant on October, 12, 2004 for the purpose of starting a prescription assistance program though the Sadler Health Center. This decision was informed by the work of the Prescription Coalition. Although approved in October 2004, the program did not begin operation until September 2005 due to the challenge of recruiting a pharmacist.

CAHWF’s first successful pro-active grant making effort was in the area of behavioral health and resulted from a successful internal campaign by CAHWF management to increase psychiatric capacity in the community. The need for community psychiatric services was identified in the Health Status Assessment Report. The need for these services intensified over time as concerns mounted over the lack of sufficient community psychiatric services. On December 9, 2003 the CAHWF Board of Trustees approved a three-year $350,000 grant award to start up a community psychiatric practice. CAHWF partnered with a nonprofit community based agency, the Adams-Hanover Counseling Services to accomplish this task. After the partners successfully completed an 18-month recruitment effort for a psychiatrist, the practice opened on October 1, 2005. As planned, in September 2007, the community psychiatric practice separated from Adams-Hanover Counseling Services and now operates as a free standing independent psychiatric practice, Carlisle Psychiatric Services.

Two other Foundation initiated proactive grants were awarded in response to the Behavioral Health Task force recommendation to initiate public education campaigns to
address stigma and wellness concepts. CAHWF, with the assistance of the Behavioral Health Implementation Team, partnered with the Carlisle Recovery Mobilization Effort, the RASE project, and the National Alliance on Mental Illness to fund and develop a speakers bureau. CAHWF also proactively partnered with Cumberland-Perry Substance Prevention Coalition (SAPC) to implement and support a multifaceted prevention campaign designed to increase public awareness and educate the community about current and local alcohol, tobacco, and other drug issues.

Started in February 2005, the Wellness at Work pilot project is a foundation initiative focused on promoting health within the work environment. The project is directly linked to the Prevention and Education Task Force level five strategy - to encourage and aid local institutions and organizations to adopt and promote healthier lifestyles for their constituents, especially at schools and work sites. CAHWF actively partnered with the Greater Carlisle Chamber of Commerce and seven area employers to select a consultant, The Susan P. Byrnes Health Education Center, to lead the endeavor. Wellness at Work programs were started at each of the participating employer’s work sites. Although each of the participants contributed to program costs, CAHWF was the primary funding source awarding grants of $56,612 on June 14, 2005 and $78,565 on June 20, 2006. Since its start up The Wellness at Work program added two local employers and remains an active project.

In response to the Prevention and Education Task Force recommendations to promote community education and create capacities and referral systems to help patients, CAHWF partnered with the Cumberland–Perry Tobacco Prevention Coalition to increase outreach efforts and to expand a smoking cessation program housed at the Sadler Health Center.
As a member of the Cumberland –Tobacco Prevention Coalition, Sadler Health Center received the grant award.

**Research Question One Summary**

CAHWF formed when the nonprofit Carlisle community hospital, Carlisle Hospital and Health Services (CHHS), was sold to a for profit hospital chain, HMA, Inc. in 2001. The Foundation initially formed to ensure that the health care needs of the community would not be jeopardized as a result of the conversion of the hospital to a for profit status under the management of a national firm. The final vision and mission statements approved by the CAHWF Board of Trustees entailed a community role for the newly formed Foundation that reached beyond simply maintaining the status quo. The Foundation was tasked with creating and maintaining social and environmental conditions that would lead to community wide health and well being. A model of collaborative action was chosen to accomplish this mission. To achieve its mission as a “leader and catalyst to ensure continuous improvement of health in our communities” CAHWF therefore expanded its role to comprise several capacities. These included capacities as a community organizer, community resource, and community advocate. During it’s the first five years of operations CAHWF predominantly interacted with its stakeholders in its capacities as a community organizer and community resource.

As a community organizer, CAHWF pursued a course of action in collaboration with other community stakeholders that began with an assessment of the community’s health status and finished with the initiation and subsequent evaluation of planned interventions. CAHWF convened and managed networks of community stakeholders in order to complete this course of action. The Health Status Assessment Task Force facilitated the
identification and prioritization of community health concerns. The Prevention and Education Task Force looked at ways to reduce the incidence and severity of major chronic illnesses impacting the community. The Behavioral Health Task Force sought solutions to mental health and substance abuse problems within the community. The Continuum of Care Task Force investigated ways to improve existing community systems of care.

The recommendations generated by these networks/partnerships of community stakeholders demonstrated an appreciation for the complexity of community health problems. The solutions offered in each case incorporated a holistic mix of social, educational, health service and/or health system responses. The Prevention and Education Task Force recommended the six tiered Spectrum of Prevention model to combat common causes of chronic illnesses. The Behavioral Health Task Force recommendations were organized into three categories – prevention and wellness, clinical services, and supportive services. The Continuum of Care Task Force recommended three focus areas for system improvement – capacity and workforce, barriers to care, and health budget and policy.

CHAWF led network related activity with community stakeholders to initiate plan recommendations. Work groups were formed to drive the implementation of task force recommendations. And, a new partnership was formed to facilitate the planning and implementation of health promotion and education activities.

In its capacity as a community resource, CAHWF supplemented the implementation efforts of CAHWF as a community organizer. For example CAHWF staff initiated proactive grant request for network projects such as the Prescription Coalition Task Force
Healthy RX program initiative at Seidle Health Center and the Behavioral Health Implementation Team Behavioral Health Speakers Bureau initiative. As a community resource CAHWF also directly partnered with community stakeholders to implement plan recommendations targeted at community health concerns. Examples of these partnerships include the Wellness at Work Program and the Adams-Hanover Counseling Service project.

In fact, all of the activities listed above are targeted at community health concerns identified by the Health Assessment Task Force and each of the actions linked to recommendations offered by the planning networks. In collaboration with community stakeholders, CAHWF identified and prioritized three community health problems (oral health, chronic illness, and behavioral health); planned community wide interventions; and initiated a wide range of actions (social, educational, health service or health system related) to address these problems.

**Measures of CAHWF’s Effectiveness**

**Q2. In its first five years of existence how has the Carlisle Area Health and Wellness Foundation been effective?**

Key stakeholders perceive CAHWF’s performance as effective over its first five years of operation. CAHWF’s effectiveness during this time largely may be attributed to its success at synthesizing its community organizing and community resource capabilities. Through CAHWF’s efforts, a broad array of community stakeholders reached consensus on areas of concern and on planned actions to remedy these concerns. CAHWF then successfully partnered with community organizations to implement initiatives targeted at these identified concerns. Initiatives implemented during this time prudently avoided the
most problematic health and health system coordination problems in favor of those that were challenging but achievable. Furthermore to ensure continued collaborative success, CAHWF concurrently worked at building management capacity within its own organization and those of community providers.

Stakeholders identified five measures of effectiveness exhibited by CAHWF during its first five years. These measures of effectiveness are both process and goal oriented. First, CAHWF’s efforts to convene and manage community organizational networks created an opportunity for community members who routinely did not interact to work together. Stakeholders considered this network building activity effective as a way of building, communication, understanding, trust and prospects for future collaboration. Second, the completion of strategic and operational plans allowed stakeholders to develop a shared understanding of issues, shape and prioritize recommendations, and produce community supported planning documents. Third, stakeholders considered CAHWF’s success in improving the Foundation’s own management capacity and supporting the management development of community organizations as an indicator of effectiveness. By concentrating on organizational development, CAHWF was able to “raise the bar” on individual organizational accountability and more broadly to strengthen the overall system of community funding and service delivery. Fourth, the maintenance of a disciplined mission driven approach to program funding (through reliance on focus area guidelines and task force recommendations) was recognized as a measure of effectiveness. By maintaining this focus CAHWF concentrated resources on commonly agreed areas of community concern; helped validate the planning process; demonstrated the Foundation’s trust and belief in its community partners; and consistently signaled the
Foundation’s funding interests to grantees. Fifth, stakeholders recognized the positive impact of CAHWF’s networking and funding efforts in supplementing existing services and introducing new services in response to community needs.

To support the findings summarized above, the response to the second research question is divided into two sections. The first section addresses key stakeholders overall perception of CAHWF effectiveness. The second section documents how CAHWF was effective in its first five years of operation.

**Stakeholders Perception of CAHWF’s Effectiveness**

To answer the second research question requires first knowing whether stakeholders consider CAHWF at all effective. To determine this answer requires some evaluation of the overall performance of the foundation and ideally the performance of the foundation in each of its key operational capacities as community organizer and community resource.

In spring, 2006 CAHWF management staff completed a Key Informant Survey. The survey was conducted to measure the quality of services provided by CAHWF toward the fulfillment of its mission, vision, values and goals. Sixty–nine respondents completed the survey. This secondary data source specifically demonstrates that those stakeholders who acknowledged a relationship with CAHWF consistently agree that the Foundation collaborated with community stakeholders; supported capacity development; funded identified needs; and impacted the community in a positive manner by promoting responsible health practices and improving individuals’ access to care. These findings are supported by data presented in Table 4-4.
| The Carlisle Health & Wellness Foundation is a catalyst that works towards improving the health in our community. | 4.13 | 4.24 |
| The CAHWF addresses the health care needs of the community. | 3.95 | 4.10 |
| The CAHWF addresses health care policies in the community. | 3.70 | 3.76 |
| The CAHWF promotes responsible health practices in the community. | 4.06 | 4.20 |
| The CAHWF helps to improve individuals’ access to health services in the community. | 3.92 | 4.14 |
| The CAHWF positively affects the delivery of health services in the community. | 4.03 | 4.16 |
| CAHWF convenes and plans with community stakeholders around specific issues. | 3.95 | 4.18 |
| CAHWF provides funding that addresses identified needs. | 4.12 | 4.34 |
| CAHWF offers training and technical assistance to build the capacity of community organizations. | 3.88 | 4.00 |
| CAHWF works to develop its capacity to achieve its vision, mission and objectives. | 3.97 | 4.02 |
| The CAHWF grant has enabled agencies to offer more services to region. | 4.31 | 4.43 |
| Our region has not changed as a result of CAHWF. | 3.35 | 3.32 |
| We gained knowledge as a region as a result of CAHWF. | 3.90 | 4.02 |
| CAHWF has made a positive impact on the community. | 4.08 | 4.19 |

**Scale**
1 = Strongly Disagree; 2 = Disagree; 3 = Neutral (no opinion); 4 = Agree; 5 = Strongly Agree
* Includes all respondents
** Excludes respondents who reported “no direct relationship” with CAHWF

Source: CAHWF Key Informant Survey 2006

Key Informant Survey and supporting documentation are provided in Appendix D.

These perceptions of effectiveness are also substantiated by the responses of key stakeholders’ interviewed by the researcher. Sixteen of the twenty key informants
interviewed by the researcher directly participated in network collaborative activities convened and managed by CAHWF. Each of the sixteen key respondents responded to interview questions concerning CAHWF as a community organizer. Four key informants refrained from addressing interview questions concerning CAHWF as a community organizer because they did not directly participate in any of the collaborative activities. In response to interview question 17, the key informants indicated that CAHWF was effective as a community organizer in convening and managing coalitions. These key informants also believed the coalitions contributed to alleviating identified community concerns as demonstrated in table 4.5.

<table>
<thead>
<tr>
<th>Table 4.5</th>
<th>Perceived Effectiveness of CAHWF as a Community Organizer in Building Coalitions and Addressing Community Concerns</th>
</tr>
</thead>
<tbody>
<tr>
<td>N= 20</td>
<td></td>
</tr>
<tr>
<td>Perceived Effectiveness</td>
<td></td>
</tr>
<tr>
<td>Very Effective</td>
<td>1</td>
</tr>
<tr>
<td>Effective</td>
<td>15</td>
</tr>
<tr>
<td>No Response (a)</td>
<td>4</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from key stakeholder’s interviews conducted by the researcher.

a – Four interviewed stakeholders did not directly participate in collaborative activities convened and managed by CAHWF.

The results of the key stakeholder interviews completed by the researcher shown in Table 4.6 also support CAHWF’s effectiveness as a community resource in addressing community concerns. Based on the responses to interview question 6, key informants
considered the results of CAHWF’s grant making decisions and actions as positively influencing the health and wellbeing of the community.

Table 4.6 Perceived Effectiveness of CAHWF as a Grant Maker in Addressing Community Concerns

<table>
<thead>
<tr>
<th>Perceived Effectiveness</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extremely Effective</td>
<td>1</td>
</tr>
<tr>
<td>Very Effective</td>
<td>6</td>
</tr>
<tr>
<td>Very Effective (base on available information)</td>
<td>1</td>
</tr>
<tr>
<td>Beginning to be Very Effective</td>
<td>1</td>
</tr>
<tr>
<td>Effective</td>
<td>5</td>
</tr>
<tr>
<td>Reasonably Effective</td>
<td>2</td>
</tr>
<tr>
<td>Moderately Effective</td>
<td>1</td>
</tr>
<tr>
<td>Effective in a Limited Way</td>
<td>1</td>
</tr>
<tr>
<td>Undecided</td>
<td>1</td>
</tr>
<tr>
<td>Do not Know</td>
<td>1</td>
</tr>
</tbody>
</table>

Source: Frequencies were calculated by the author from data drawn from key stakeholder interviews conducted by the researcher.

**Measures of Effectiveness**

Five measures of effectiveness were identified through the key stakeholder interviews and focus group responses. Source document data and secondary data help support these measurement themes. Key stakeholder interview information is captured in both Figure 14-10 and 14-11. The information in these figures represents the researcher’s best efforts to organize key stakeholder like responses into common themes. Based on interview question 18, two effectiveness measures closely associated with CAHWF as a community organizer include: network building and collaborative planning. Based on responses to interview question 7, as a community resource CAHWF effectiveness is measured in three ways. These measures include: management capacity building, disciplined funding and the addition of community health and health related services.
Network Building

As corroborated in Table 4.7, key stakeholders interviewed by the researcher identified network building as a measure of effectiveness. Networking was valued to a great extent because it encouraged continued collaboration.

Table 4.7 Ways in which CAHWF as a Community Organizer has been Effective Building Coalitions and Addressing Community Concerns (a)

<table>
<thead>
<tr>
<th>Network Development</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Resulted in exchange of information</td>
<td>2</td>
</tr>
<tr>
<td>Encouraged continued collaboration</td>
<td>5</td>
</tr>
<tr>
<td>Alerted participants of funding opportunities</td>
<td>2</td>
</tr>
<tr>
<td>Resulted in support for other collaborative community initiatives</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community Planning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Established community health care priorities</td>
<td>1</td>
</tr>
<tr>
<td>Opportunity for community involvement</td>
<td>4</td>
</tr>
<tr>
<td>Opportunity to seek solutions to common problems</td>
<td>1</td>
</tr>
<tr>
<td>Resulted in agreed upon recommendations</td>
<td>4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Effect of Community Planning</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Generated recommendations that were funded</td>
<td>3</td>
</tr>
<tr>
<td>Recommendations being implemented</td>
<td>2</td>
</tr>
<tr>
<td>Recommendations acted upon by individual members</td>
<td>1</td>
</tr>
</tbody>
</table>

| No Response (b)                                         | 4      |

Source: Frequencies were calculated by the author from data drawn from key stakeholders’ interviews conducted by the researcher.

a - Multiple responses permitted.
b - Four interviewed stakeholders did not directly participate in collaborative activities convened and managed by CAHWF.

CAHWF facilitated networking activity encouraged continued collaboration in several ways as evidenced in Table E-11 in Appendix E. First, it created opportunities for
community stakeholders to improve their understanding of community resources and activities. Second, it led to increased trust and cooperation among network participants. Third, it encouraged the strengthening of ties between participating organizations in more formal ways. Finally, in one instance county representatives’ participation in CAHWF network activity lead to improved medical care coordination. In this particular case the issue dealt with the failure of the county prison system to ensure a smooth hand off of inmates scheduled for release between health service providers for the ongoing medical care. The value of networking in this instance is best summarized by a senior CAHWF administrator in her comments on the role of CAHWF in connecting county representatives with Sadler Health Center managers

“…this community works on relationships, just being able to pick up the those phones and people know that you’re very reasonable to work with and that you’re looking for honest answers will make them respond … Here’s the person you need to call or I’ll help set that up. Credibility and reputation starts paying off in multiple ways. And that’s the networking effect. You know, we did this task force and I didn’t know RF (county administrator), now I know her, she knows us, well enough to know that yeh, if the foundation’s called, it’s serious. We get the right people in the room – we’ve got this system, you’ve got that system, there’s got to be a way to help them work together. Whereas Sadler didn’t have that relationship (with county administrators).”

CAHWF’s efforts to network Sadler Health Center with Cumberland County prison administrators resulted in an agreement between the two organizations. With the approval of each soon to be released prisoner requiring on going care, the county prison system enrolls the individual as a Sadler Health Center patient. As a result of the this process, these individuals upon release are already assigned to a medical practice and primary care provider and can more readily schedule on going care.
Collaborative Planning

Key stakeholders interviewed by the researcher identified two themes – community planning and effect of community planning – combined for reporting purposes as a measure of effectiveness related to CAHWF’s organizing responsibilities. Support for this observation is provided in Table 4.7. Stakeholders perceived collaborative planning as a measure of effectiveness because the planning process allowed stakeholders to develop a shared understanding of issues, shape and prioritize recommendations, and produce community supported documents that they anticipated would be utilized.

Given the nature of this measure, source document information gathered on the temporary planning networks (Continuum of Care Task Force, Prevention and Education Task Force, Behavioral Health Task Force) are used to further support this finding. These networks formed to address complex health and health system issues identified in the 2002 Health Status Assessment report. The primary responsibilities of the temporary planning networks included: researching prioritized community health issues; generating strategic and operational recommendations; and identifying lead community organizations to implement these recommendations. These temporary networks separated the planning function from implementation and evaluation responsibilities.

Each of the temporary networks (task forces) followed a similar evaluation and planning process as described in the CAHWF publication, Branches (Spring, 2004).

- Intensive study of the issue
- Examining issue’s impact on local health statistics
- Exploring existing or previous programs and identifying best practices; and
- Developing local strategies and identifying stakeholders (to implement strategies)

To provide further detail on this process, a schedule of network activities is provided for the Prevention and Education Task Force in Table E-12 in Appendix E and the
Behavioral Health Task Force in Table E-13 in Appendix E. After completing the first three steps of the task force process outlined above, these temporary networks employed a nominal group process⁹ to reach consensus on final recommendations. In two of the task forces (Continuum of Care and Behavioral Health) CAHWF relied on professional facilitators to manage the task force process. A service provider who participated in the Behavioral Health Task Force provides an overall sense of the task force process including selection of final recommendations in her comment.

“In the earlier meetings they usually had some kind of speaker about a particular area of interest and we would discuss that. But then as we got towards the end, and it was like ‘okay, we’re pulling together what have we learned, what are our recommendations going to be’, there was a group process where generally there would be a discussion but also a person from the foundation would be listing, outlining the ideas that were brought forward and we would all be given a certain number of little colored dots and we would choose which of those we were most in favor of or that resonate best with us and we would put our dots up there as our vote. Then we would go and collate all of that, give that feedback back to us and we would give them feedback and so it came together.”

A senior CAWHF staff member in her comments about CAHWF as a network administrator offers further support for the validity of this collaborative process when she stated, “You don’t (CAHWF) determine the outcome, but you manage the process to make sure the outcomes are good and legitimate.”

Three key planning reports resulted from the work of the temporary task forces. The Continuum of Care Task Force produced the “Building a Better Continuum” report. The

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⁹ Nominal group process is a structured process used to solve problems or to generate ideas. The process takes place in a face-to-face non-threatening group situation. A well facilitated nominal group process ensures balanced input from all group participants and maximum use of participants’ knowledge and expertise. The results of a well facilitated nominal process include group consensus, prioritization of issues, and decisions on alternative courses of action.
Prevention and Education Task Force produced the “A Framework for Health Promotion” report. The Behavioral Health Task Force produced the “Opportunities and Challenges” report. Each of these reports were presented to the CAHWF Board of Trustees for review and published in their entirety without modifications. The reports were made publicly available to the community. As will be discussed in greater detail in the segment on disciplined funding, CAHWF relied on recommendations in all three reports to guide grant making decisions. CAHWF’s use of collaborative planning and the outcomes of these planning endeavors are further supported in the 2005 Key Informant Survey. As indicated in Table 4.4 survey respondents agreed that CAHWF met its goal of convening and planning with stakeholders and addressing identified needs.

**Management Capacity**

Table 4.8 on page 122 identifies two management capacity related themes. These are “grant application and review process” and “support for service providers”. The first theme relates to CAHWF’s investment in its core functional area of grant management. The second theme addresses CAHWF’s attempts to increase the management capabilities of community service organizations. A common belief held by CAHWF helps bridge the two themes. In brief, management capacity is believed to serve as a measure of effectiveness because better-managed community organizations (including CAHWF) are considered more capable of collaboratively achieving common community objectives. This belief serves as the underlying rationale for two of CAHWF’s stated strategic objectives provided in Figure 4-6 – to “develop CAHWF capacity to achieve the vision, mission and objectives” and to “offer training and technical assistance to build the capacity of community organizations”.

121
Table 4.8  Ways in which CAHWF as a Grant Maker has been Effective in Addressing Community Concerns (a)

<table>
<thead>
<tr>
<th>N=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Grant Application and Review Process</strong></td>
</tr>
<tr>
<td>Strength of application and review process                          2</td>
</tr>
<tr>
<td>Effort to promote provider collaboration                             1</td>
</tr>
<tr>
<td>Skill and experience of CAHWF staff                                  6</td>
</tr>
<tr>
<td>Knowledge of CAHWF grant committee                                   1</td>
</tr>
<tr>
<td>Capability of CAHWF Board of Trustees                                1</td>
</tr>
<tr>
<td><strong>Grant Decision Making</strong></td>
</tr>
<tr>
<td>Grants awards linked to focus areas                                  5</td>
</tr>
<tr>
<td><strong>Support for Service Providers</strong></td>
</tr>
<tr>
<td>Effort to improve grantee management capacity                        6</td>
</tr>
<tr>
<td>Willingness to fund “overhead” costs                                 1</td>
</tr>
<tr>
<td><strong>Effect of Grant Awards</strong></td>
</tr>
<tr>
<td>Addition of new service/ increase in existing services               7</td>
</tr>
<tr>
<td><strong>Other Responses</strong></td>
</tr>
<tr>
<td>No quantifiable measures                                             2</td>
</tr>
</tbody>
</table>

*Source: Frequencies were calculated by the author from data drawn from key stakeholders’ interviews conducted by the researcher.*

a - Multiple responses permitted.

Responses grouped under the first theme “grant application and review process” in Table 4.8 reflect stakeholders’ recognition of CAHWF’s organizational competency in its core grant making function. In response to a question on the effectiveness of CAHWF as a grant maker in addressing community concerns, a CAHWF Board of Trustees member immediately cited the effectiveness of the grant process. He stated,

“…all of those (grant) policies and (grant) practices are in place at the Foundation. And when you add all of those up, the initial review of the applications, what the projected outcomes are gonna be, how it’s evaluated and how it’s monitored, I’m of the opinion that there’s probably few, if
any organizations that could compete with the effectiveness of the money that is being spent by the Foundation.”

This same individual believed a critically important aspect of the process related to the quality of the management staff and board members. Commenting on the roles of the management and board members in this process, he stated,

“They (the CAHWF management staff) come with a great deal of experience. Secondly the diversity and the experience of the people (grant committee members) that are reviewing the grants, I think is particularly noteworthy. And you combine that with the expertise of the staff – you’ve got a great combination… you also have a Board that I think has a tremendous amount of expertise and knowledge and commitment to making sure that the dollars are being spent as effectively as possible. So you’ve got a three-tiered process that I think really defines the effectiveness (grant making) as well.”

The strength of it grants management process reflecting the Foundation’s growing management capacity is also supported by the results of CAHWF Quality Improvement Survey Report (2005), a grantee survey contracted for by CAHWF in 2005( The entire survey report is available in Appendix D) .Selected results of this secondary data source are shown in table 4.9 on page 124. Grant applicants agree that CAHWF is an efficient and effective grant maker. Based on these findings the Foundation has a well established process; provides appropriate training to grant applicants; and, holds grantees accountable for program outcomes.
The grant management process valued by community stakeholders did not simply happen. Specific management actions were taken over the five-year period to continually improve this core function. The Board of Trustees approved the first grant policy and procedures in July, 2002. The Board of Trustees continually reviewed the grant process in an effort to improve the Foundation’s responsiveness to community needs and organizations. Examples of these efforts include approval of the proactive grant making process in November, 2003 and approval of the healthy people grant process in April, 2006. A related management action that supported this process included the installation in July, 2002 of a computer based financial software system specifically written for foundation applications. Finally, a Board of Trustees approved Director of Planning
position was filled on January 17, 2005. The addition of this position strengthened the linkage between CAHWF planning efforts and grant decisions.

CAHWF’s effectiveness in providing support for service providers is related to CAHWF staff’s abilities to work closely with these service providers throughout the grant process from application to program evaluation. CAHWF work with service providers helped improve service providers’ skills, knowledge and abilities as documented in the CAHWF Quality Survey Reports in 2005 and 2006. A listing of these benefits as provided from these secondary data sources are in Table 4.10 below.

<table>
<thead>
<tr>
<th>Table 4.10</th>
<th>CAHWF 2005, 2006 Quality Improvement Survey Report - Specific Skills, Knowledge, Abilities Acquired by Grant Recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(2006 Survey)</strong></td>
<td>Specific skills, knowledge, and abilities obtained as a result of the CAHWF grant:</td>
</tr>
<tr>
<td>• Learned more from an exercise physiologist and expanded enjoyable and safe activity for children</td>
<td></td>
</tr>
<tr>
<td>• Improved grant writing skills (3)</td>
<td></td>
</tr>
<tr>
<td>• Increased collaborative partnerships (2)</td>
<td></td>
</tr>
<tr>
<td>• Better understanding of the importance of outcomes planning (5)</td>
<td></td>
</tr>
<tr>
<td>• Allowed participation in continuing education programs</td>
<td></td>
</tr>
<tr>
<td>• Opportunity to offer more staff training to maintain quality of service</td>
<td></td>
</tr>
<tr>
<td>• Much better understanding of the population in the Greater Carlisle Area</td>
<td></td>
</tr>
<tr>
<td>• Evaluation skills in regard to services delivered to families and the community</td>
<td></td>
</tr>
<tr>
<td>• Better understanding of the adult population and their needs</td>
<td></td>
</tr>
<tr>
<td>• Increased awareness of Medicare system and rising costs of prescriptions and how this impacts senior citizens and low-income individuals in the community</td>
<td></td>
</tr>
<tr>
<td>• More comfortable with developing outcomes and relating them to goals/objective</td>
<td></td>
</tr>
<tr>
<td>• Able to focus on no-show rates and obstacles for appointment compliance</td>
<td></td>
</tr>
<tr>
<td>• Developed systems to track statistics</td>
<td></td>
</tr>
<tr>
<td>• Innovation in service offerings</td>
<td></td>
</tr>
<tr>
<td><strong>(2005 Survey)</strong></td>
<td>Specific skills, knowledge, and abilities obtained as a result of the CAHWF grant:</td>
</tr>
<tr>
<td>• Writing skills (3)</td>
<td></td>
</tr>
<tr>
<td>• Communication skills</td>
<td></td>
</tr>
<tr>
<td>• Outcome measurement; using a program logic model (4)</td>
<td></td>
</tr>
<tr>
<td>• Marketing knowledge (2)</td>
<td></td>
</tr>
<tr>
<td>• Organization skills (2)</td>
<td></td>
</tr>
</tbody>
</table>

As noted in the secondary data survey results above and documented throughout key informant interviews and source documents, CAHWF’s effectiveness in building management capacity was primarily linked to CAHWF staff efforts in assisting grant applicants with the required logic model segment of the grant application and evaluation processes. Service providers considered CAHWF’s initial effort to improve outcome measurement capabilities within each organization as effective. Service providers believed acquiring this competency better positioned them to be selected as grant awardees by CAHWF and/or other grant making institutions. And, providers believed increasing this management skill improved their ability to better serve their clients. A grant recipient best summed up management capacity benefits gained through the grant making process when she made the following comment about grant reporting requirements,

“They’ve (CAHWF) shown us how to do it (document performance). So that all the grants, or proposals, that I write now have, use the same tools that the Carlisle Health and Wellness Foundation is using. So I’m already ahead of the game. As a result of working with them, I know how to do those things now for other organizations, you know, other places that I might write proposals for…. And not only does it show them that we’re doing what we say we’re doing, but it also shows us how effective the methods are that we’re using to do the things that we’re doing.”

This same sentiment regarding reporting requirements was echoed by a grant recipient in her six month interim progress report to CAHWF when she wrote, “While one would think the logic models only used in evaluation, we have found it equally helpful for planning, managing programs, and setting goals.”

Realizing the importance of building management capacity in all potential CAHWF community organization partners, CAHWF explored other ways to provide training and
assistance that extended beyond the grant management process. CAWHF’s effort to formally offer training and technical assistance to build the capacity of community organizations first began in 2004 with a key CAHWF capacity building initiative undertaken in partnership with the United Way of Carlisle and Cumberland County, and the United Way of the Capital Region. The final product of this initiative was the development of a logic model based outcome measurement tool for non-profit organizations. Training on how to use this evaluation instrument was offered to community service providers. In fact, during this five-year period CAHWF also routinely provided training opportunities on topics other than outcome measurement such as financial management, grant writing, and lobbying at a minimal cost to all community service organizations. A schedule of these programs is provided in Table 4.11 below.

<table>
<thead>
<tr>
<th>Grant Writing Workshop</th>
<th>Outcomes Measurement (Part 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 19,2004</td>
<td>November 16,2004</td>
</tr>
<tr>
<td></td>
<td>December 14,2004</td>
</tr>
<tr>
<td>Worry Free Advocacy</td>
<td>Outcomes Measurement (Part 3)</td>
</tr>
<tr>
<td>October 13,2004</td>
<td>May 3, 2005</td>
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<tr>
<td>October 19,2004</td>
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<tr>
<td>September 26,2006</td>
<td>Basic Financial Training</td>
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<td></td>
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<tr>
<td>Outcomes Measurement (Part 1)</td>
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<tr>
<td>September 21,2004</td>
<td>October 26,2005</td>
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<tr>
<td>October 26, 2004</td>
<td>April 06, 2006</td>
</tr>
<tr>
<td>May 18, 2005</td>
<td>September 28, 2006</td>
</tr>
</tbody>
</table>

Source: Carlisle Area Health & Wellness Foundation

Finally, in 2006, CAHWF provided selected CAHWF partners a significant capacity building opportunity. Invited community providers were offered the chance to complete a
CAHWF funded “standard of excellence” program offered by the Pennsylvania Association for Non-Profit Organizations (PANO)\textsuperscript{10}

**Funding in a Disciplined Manner**

In reflecting on funding decisions made by CAHWF, a community service provider commented “When I look at the list of grantees that they put in their annual report and the newsletters and what kind of projects. They are very consistent in the primary concern areas they have identified.” A community representative remarked on the role of the grant committee in achieving the consistency noted above when he stated, “I think the grants committee has done a really, really good work both in saying yes, and in saying no.” CAHWF purposely attempted to allocate its financial resources in focus areas identified in the HSA survey. And within those focus areas, CAHWF implemented a number of recommendations offered by each of the major planning initiatives (Prevention and Education, Behavioral Health, and Continuum of Care). The deliberate intent of CAHWF to act within the established collaborative planning framework is noted in CAHWF’s 2005 annual report. In the executive director’s letter to the community she stated, “We employed a management strategy that linked our vision with funding efforts that measure our ability to be a catalyst for health care improvements. Staff and board members strive to align our programs with the needs highlighted by our task forces.”

As gathered from the executive director’s statement, funding in a disciplined manner serves as a measure of effectiveness because it conveys three messages to community stakeholders about CAHWF. First CAHWF is aware of critical community health concerns. Second, the Foundation has knowledge of those interventions required to

\textsuperscript{10} PANO is a state wide membership organization serving the charitable non-profit sector. The “standards of excellence” program offered by PANO is a certification program designed to expand management capacity and through certification demonstrate the organization’s credibility to community stakeholders.
alleviate these concerns. Third, CAHWF has the will to concentrate funding on targeted areas of concern for the duration required to achieve and measure results. A related message that strengthens community stakeholders’ support for this measure is encapsulated in the last sentence of the executive director’s statement. From the perspective of community stakeholders, CAHWF’s efforts to “align” program funding with task force findings demonstrated the foundation’s effort to honor decisions made in partnership with community organizations. CAHWF stakeholders recognized this effort and considered funding in a disciplined manner a measure of effectiveness as evidenced Table 4.8 on page 122.

Table E-9 in Appendix E further substantiates the perception of community stakeholders. As outlined in the table, grants were exclusively awarded in the three focus areas (oral health, chronic illness, and behavioral health) with the exception of grants awarded for academic scholarships captured in the general mission category. Within the focus areas, CAHWF purposely implemented recommendations offered by each of the major planning initiatives (Behavioral Health, Prevention and Education, and Continuum of Care). This effort to act on task force recommendations is documented in Tables E-14, E-15, and E-16 in Appendix E. In reviewing the tables representing grant awards linked to task force recommendations, it is apparent that a significant number of the grant awards were issued prior to the completion of the reports. As stated earlier, funding decisions were being made after the completion of the health status assessment but before the completion of task force planning recommendations. CAHWF, therefore, initially

11 On May 10, 2005 The CAHWF Board of Trustees approved a strategic outcomes matrix. A measure of strategic success approved by the Board of Trustees as a component of the outcomes matrix included evidence each year of significant support for at least two recommendations from each of the planning networks – Continuum of Care, Behavioral Health Task Force, and Prevention and Education.
relied on the findings of the health status assessment report to aid in grant making decisions.

The grant making decision process became more informed as planning task force recommendations became available in calendar years 2004 and 2005. Evidence of these more deliberate grant making efforts is substantiated in the Tables E-14, E-15, and E-16 in Appendix E.

For example it is evident by reviewing Table E-14 that in the behavioral health arena, there was a ramping up of public education initiatives to address stigma and wellness concepts and an increase in the initiatives to strengthen and expand school and community-based child and adolescent programs after the release of the task force report. At the same time grants to support clinical capacity within the community were renewed without cutbacks in support.

CAHWF also supported prevention and education programs targeted in the Prevention and Education Task Force recommendations as depicted in Table E-16. Notable initiatives enacted in response to Prevention and Education Task Force recommendations include the Wellness at Work program directed at changing organizational practice; the Tobacco Cessation program designed to increase community capacity; and, the multiple grade school programs such as the Success by Six Program aimed at promoting community education.

Of the multiple Continuum of Care funded recommendations listed in Table E-15, the most significant initiative that post dates the release of the task force recommendations is the Healthy Rx program. In general, the linkage between task force recommendations and grant awards may be indirectly ascertained by reviewing the pattern of CAHWF’s grant
renewal decisions. In brief, programming in place prior to task force reports that coincided with task force recommendations available at the time of grant renewal were routinely renewed.

**Community Health and Health Related Services**

In its first five years of activity CAHWF took actions to make improvements in each of its identified areas of concern. More specifically CAHWF addressed each of the task force recommendations in a planned way with the exception of the Continuum of Care recommendation to establish a better/different connection among and between the provider community for the purpose of improving health care coordination. For the most part CAHWF partnered with a single provider or small group of providers during this period to fashion responses to challenging but resolvable service shortfalls, gaps and barriers. These collaborations typically resulted in the increased availability of health and health related services. The increase in service availability serves as a measure of effectiveness because it illustrates CAHWF’s commitment to satisfy unmet health care needs and create opportunities for health improvement.

The sense of achievement in tackling immediate community needs is illustrated in the CAHWF executive director response to an interview question on the effectiveness of CAHWF as a community resource. She stated,

“but where we’ve been extremely effective I think is when you can point to two psychiatric practices that are now here that weren’t: maybe a new agency. I think bringing nurse family partnership to town. Those things that I think are fundamentally just not more of the same but critically needed health care – organizations that were missing. That and prevention - the preventative piece. Getting a conversation around nutrition, activity, and tobacco that’s been lacking in the community.”
The increase and/or addition of services is further revealed as a measure of effectiveness in the individual interview data collected by the researcher as evidenced in Table 4.8 on page 122. Additionally it is supported in the secondary data. As shown in Table 4.4 on page 114 respondents to the CAHWF Key Informant Survey agreed that the foundation positively impacted the community. As documented in secondary data in Table 4.12 below, grant recipients who responded to the 2005 and 2006 CAHWF Quality Survey Reports believed the additional funding positively impacted the community by allowing them to increase the number of clients served and offer more services to clients.

<table>
<thead>
<tr>
<th>Table 4.12 2005,2006 Quality Improvement Survey Report – Selected Grant recipient Responses</th>
<th>2006 Survey</th>
<th>2005 Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>This CAHWF grant has allowed us to increase the number of clients we serve.</td>
<td>4.43</td>
<td>4.28</td>
</tr>
<tr>
<td>The CAHWF grant has allowed us to expand our service area.</td>
<td>3.27</td>
<td>3.43</td>
</tr>
<tr>
<td>The CAHWF grant has enabled us to offer more services to our clients.</td>
<td>4.55</td>
<td>4.31</td>
</tr>
<tr>
<td>Our organization has not changed as a result of receiving this CAHWF grant.</td>
<td>1.91</td>
<td>2.24</td>
</tr>
<tr>
<td>This CAHWF grant has helped us to be a more effective organization.</td>
<td>4.09</td>
<td>3.83</td>
</tr>
<tr>
<td>This CAHWF grant has enabled us to make a positive impact on the community.</td>
<td>4.70</td>
<td>4.34</td>
</tr>
</tbody>
</table>

**Scale**
1 = Strongly Disagree; 2 = Disagree; 3 = Neutral (no opinion); 4 = Agree; 5 = Strongly Agree

Source: CAHWF Quality Improvement Survey Report 2005
CAHWF Quality Improvement Survey Report 2006

The perception that there was an increase in existing services and the addition of new services into the community in the first five years of CAHWF’s operation is also supported by source document data collected by CAHWF for grant evaluation purposes.
Examples documenting the increase in services are provided below. These examples were chosen because each matched with at least two of the following criteria. These are: the initiative linked directly to both focus areas and task force recommendations; CAHWF provided significant financial support over several years; and, the initiative is an example of a the expansion of existing community clinical services and/or the introduction of new prevention/promotion services. Information on each of the initiatives is organized by focus area and related task force recommendation/s.

The Sadler Health Center and the Health Rx program provide services that relate directly to CAHWF’s chronic disease focus by providing services to those who either are under or uninsured. Both of these initiatives further connect to the Continuum of Care Task Force recommendations to enhance access to care and in the case of the Healthy Rx program to provide prescription medication assistance. Table E-15 in Appendix E documents the growth in Sadler Health Center’s capacity over a four year period extending one year past CAHWF’s fifth year of operation. During the first five years of CAHWF’s operation, CAHWF’s investment in the Sadler Health Center resulted in a 216% increase in total medical and dental services when comparing 2005-2006 activity to 2003-2004 base year activity. During this same time period 94% of those receiving care were either uninsured or relied on Medical Assistance for health insurance coverage. The introduction of the Healthy Rx Program to Sadler Health Center also had immediate impact as shown in Table E-17 in Appendix E. An impressive statistic is the 68% growth of the program in number of patients served in the second nine months of the program compared to the first nine months of 2005-2006.

\[12\] In this example and in several others the most recent data available is provided to demonstrate CAHWF’s continued impact on service provision within its service area.
The Adams/Hanover Counseling Services and the Northwestern/Stevens Center initiatives support CAHWF’s attempt to reduce the incidence of mental illness and substance abuse. These initiatives are directly tied to the Behavioral Health Task Force clinical recommendation to increase the availability of qualified psychiatrists and other allied professionals in the service area. The impact of these two programs is provided on Table E-18 in Appendix E. The impact of the Adams/Hanover Counseling Services initiative is not remarkable based on patient services provided. The significance of this project relates to the success in recruiting a community psychiatrist into a private practice setting in the Carlisle service area – a service area that historically has not been successful in recruiting or retaining psychiatrists. In contrast the Northwestern/Stevens Center initiative immediately affected service capacity as evidenced by the total number of services provided by the psychiatric team over the two year period reported (5595 in 2005-2006 and 5259 in 2006-2007).

Both the Wellness at Work and Tobacco Cessation programs were initiated to respond to chronic diseases concerns by employing a prevention and education strategy. Each of these programs directly ties to a Prevention and Education Task Force recommendation. Table E-19 in Appendix E details the activities of these programs. The Wellness at Work program allowed local employers to promote healthier lifestyles for their employees. The significance of the reported data is not necessarily captured in the weight and activity program participation rates but in the program exposure and behavioral change data. 71% of the combined employees at the seven organizations attended a health promotion presentation. Based on this exposure participants reported a 15% increase in intent to change behavior. The Tobacco Cessation program generated additional service capacity.
in the community to aid residents with tobacco addiction. The effect of this program goes beyond capacity building. Clients completing the program are reporting a six month quit rate in excess of 50%.

**Research Question Two Summary**

Stakeholders acknowledged CAHWF’s effectiveness not only for the resources it provided to the community but as importantly how it decided to allocate these resources. CAHWF intentionally selected a complex and far reaching mission to ensure community health improvement. To accomplish this mission CAHWF with the support of other community organizations led an effort to assess the community’s health status. With a clearer understanding of community concerns, CAHWF then served as a forum for the exchange of knowledge, information and ideas among a broad array of community stakeholders. These networking opportunities supported the development of stronger personal and professional relationships among participants and resulted in the production of community supported recommendations targeted at identified concerns. To make sure CAHWF funds were used in the best way, the Foundation invested in community capacity building and relied on community generated recommendations to guide funding decisions. These actions focused around three health care problems (oral health, chronic illness, and behavioral health) cumulatively resulted in the addition of clinical services and the development of programming that reduced health care services shortfalls, reduced barriers to care, and created opportunities for health improvement.

**The Case Study Analysis**

The analysis of the case study findings is based on an application of the relevant literature. The organization of this analysis parallels the chapter’s presentation of the case
study findings. The section begins with a discussion of CAHWF as a community organizer and its related effectiveness measures. This is followed by a review of CAWHF as a community resource and its resource related effectiveness measures. An analysis of the combined findings concludes the section. Key points of the analysis are provided at the beginning of each topic (community organizer, community resource, effectiveness).

**CAHWF as a Community Organizer**

*Key Points*

- The scope of CAHWF’s vision and mission, its collaborative course of action, methods of intervention, and goals reflect a community partnership approach to community health improvement.
- CAHWF pursued a “model of community partnership action” in its efforts to achieve its vision and mission.
- CAHWF relied on community coalitions convened by the Foundation to complete each step of the “model of community partnership action” through the plan initiation step.
- CAHWF relied upon a collaborative structure resembling an outreach network as defined in the network literature and as a decentralized action partnership as described within the community health partnership literature to complete the assessment, prioritization and planning steps of the “model of community partnership action”.
- CAHWF relied upon a second type of community collaborative structure that exhibited attributes of a developmental network as defined in the network literature and as a facilitating partnership as described within the community health partnership literature to complete both planning and plan initiation steps of the “model of community partnership action”.
- Measures of effectiveness associated with CAHWF’s activities as a community organizer include effectiveness indicators identified in the community health partnership literature. These are an increase in networking opportunities and completion of strategic and operational plans in a collaborative manner.

As community organizer, CAHWF served as a lead-convening agency assembling community stakeholders into network organizations. CAHWF then served as the network administrative organization for these groups; actively participated in network activities; and facilitated and participated in working groups that represented follow-on network related activities. Based on an application of the relevant literature, an analysis of CAHWF in its capacity as a community organizer is provided in this section of the
Purpose, Philosophy, Goals

Community health partnerships form to address multi-dimensional problems. In this case partnerships convene to reverse society’s waning ability to maintain community wide health and well being for its members (Roussos and Fawcett, 2000). A partnership’s response to these “wicked” problems requires an understanding of the multiple factors that influence both individual and community health. These main influences include the environment, lifestyle, heredity, and medical care (Shi and Singh, 2004). The effects of each of these factors on health are complex and not fully understood. This complexity is magnified when considering the health outcomes generated by the interaction of these four broad health related factors. Given the challenges associate with these multi layered problems, the efforts of the entire community are required to create conditions that will promote and sustain community wide health and well being.

The value of partnership collaboration is captured in the network and community health partnership literature. Rupert Chisholm (1998) stated that the networking of autonomous organizations offers great promise in addressing difficult multi-dimensional problems because these multi- organizational entities have the potential of meeting goals that cannot be reached if each autonomous member organization acted separately and independently. Roussos and Fawcett (2000) reiterate Rupert Chisholm’s reasoning for network formation in their discussion on the purpose of community health partnerships. Roussos and Fawcett (2000) provide three underlying reasons for the formation of these
partnerships. First, given the determinants of health a single organization working alone cannot remedy health related problems. Second, the opportunity for organizations representing a diversity of community interests to work together will allow for the formation of a common community purpose and goals. Third, the diversity of partnership membership will help ensure the development of creative and accepted solutions.

In the short run community health partnerships solutions focus on meeting realistic goals. These goals may include either one or a combination of the following: the alleviation of a community health issue; response to the needs of a group within the community; the development of the partnership; and/or improvements to community and health delivery infrastructure. These intermediate successes are seen as a way of building community support for the resolution of more difficult system issues (Sofaer et al., 2003).

During its first five years of operation, CAHWF purpose, philosophy and goals reflected those documented in the community health partnership literature. The very nature of CAHWF’s purpose “to ensure the ongoing improvement of health in our communities” demonstrates a commitment to creating the conditions necessary to promote and sustain community wide health and well being. The creation of community coalitions to assess, prioritize, plan and initiate plans to address community health concerns reflects CAHWF’s belief in the value of collaboration. Finally those actions taken by CAHWF mirror the intermediate goals of community health partnerships. CAHWF focused on three community health problems – oral health, chronic illness, and behavioral health. In seeking solutions to remedy these health problems CAHWF consistently prioritized the needs of at-risk community members. And, the solutions employed by CAHWF involved multiple approaches including efforts to improve
existing community and health service delivery systems. The purpose and philosophy of CAHWF are best disclosed in the following statement from CAHWF’s home page:

The Carlisle Area Health & Wellness Foundation is helping to Grow a Healthy Community in many ways, but we do not do it alone. We work with local healthcare agencies, government officials, schools, businesses, individuals and many others to improve the wellbeing of our area.”

Selecting a Course of Action

CAHWF selected a community health partnership model of action to complement its far-reaching mission statement to address both health and health care system concerns. The chosen approach represents an adaptation of Frances Dunn Butterfoss, Robert Goodman, and Abraham Wandersman’s “model of community partnership action” (1993). This model outlines the functions of a single health coalition through four stages of development – formation, implementation, maintenance, and outcomes. In this model, the formation stage represents the period during which the lead agency convenes stakeholders representing multiple sectors of the community. Several key activities occur during the implementation stage. These include completion of the community health assessment; prioritization of community health concerns and needs; development of community-wide intervention plans; and initiation of interventions. Efforts to maintain the coalition and its planned activities take place during the maintenance stage. Evaluations of the impact of planned interventions occur during the outcomes stage. Themes common to CAHWF’s approach to achieve its mission and the “model of community partnership action” include: the convening of key stakeholders; an initial assessment of community health; an active and participative planning process;
implementation of plan recommendations; efforts to maintain coalition activities; and, the evaluation of program activities.

In its capacity as a community organizer, CAHWF participated in each of the activities listed above through the initiation of plan recommendations. During the implementation stage, multiple coalitions under the auspices of CAHWF were convened to achieve those tasks assigned to this stage of development. CAHWF initially convened a group of community organizations to facilitate the completion of the 2002 Health Status Assessment (HSA) Report. Upon completing the health status assessment, CAHWF served as the lead convening entity for several community health coalitions focused on developing responses to prioritized areas of concern identified in the 2002 HSA Report. These coalitions included the following: Prevention and Education Task Force, Behavioral Health Task Force, and the Continuum of Care Task Force. These coalitions successfully developed community-wide intervention plans to address identified community concerns. Second, CAHWF attempted to maintain the momentum of coalition activities by winding up the work of the planning coalitions and in their place constituting smaller more focused work groups (Behavioral Health Implementation Team, Prescription Coalition, and Enrollment Task Force) or creating a new health partnership (CRANA) to facilitate the implementation of partnership recommendations. As identified in Figure 4-4 on page 86 and discussed further in the next section, CAHWF’s activities as a community organizer primarily centered on the assessment, prioritization and planning activities of the “model of community partnership action”. As a community organizer, CAHWF attempted to implement initiatives recommended by the planning coalitions. These implementation efforts varied in success. The most notable
success during this period was the start up of the Health Rx Program at Seidle Health Corporation resulting from the work of the Prescription Coalition - a work group formed after the completion of the Continuum of Care Task Force activities.

**Organizing Community Stakeholders**

Given CAHWF’s plan of action, it was essential for the Foundation to develop an organizational structure flexible enough to create forums for community wide interaction as well as form traditional partnerships for targeted interventions. To drive the community wide collaborative process endorsed by the CAHWF Board of Trustees, the foundation management staff early on set up inter-organizational structures designed to expedite collective planning and implementation activities. A significant aspect of CAWHF’s interaction with its stakeholders therefore involved the creation and management of temporary and on-going networks/partnerships. These formed to identify, prioritize, plan and act on complex health and health system issues. The primary responsibilities of the temporary planning networks/partnerships (Health Status Assessment Task Force, Prevention and Education Task Force, Behavioral Health Task Force, Continuum of Care Task Force) included: identifying and prioritizing community health concerns; researching prioritized community health issues; generating strategic and operational recommendations; and identifying lead community organizations to implement these recommendations. These temporary entities clearly separated the planning function from implementation and evaluation responsibilities. Based on a planning recommendation, the ongoing network/partnership (CRANA) convened for the purpose of developing and implementing prevention and education initiatives.
These organizational structures exhibit characteristics of network organizations as defined by Rupert Chisholm (1998). They also display properties of community health partnerships as presented by Stergio Roussos and Stephen Fawcett (2000). In several instances, the network attributes identified by Rupert Chisholm (1998) and the community health partnership characteristics described by Stergio Roussos and Stephen Fawcett (2000) mirror and/or complement each other. To support this position the four organizational features recognized by Rupert Chisholm (1998) to distinguish network organizations from other inter-organizational forms are briefly summarized below. Community health partnership characteristics are incorporated into the summary of network features when appropriate.

The first distinguishing network characteristic identified by Chisholm (1998) and discussed earlier in the paper focuses on the purpose of network formation. Member organizations develop networks to better understand and manage complex, ambiguous issues. Stergio Roussos and Stephen Fawcett (2000) identify this as a reason for community health partnership formation further suggesting that partnership members should represent the community in order to better advance the development of supportable solutions. CAHWF believed that no single organization alone could resolve complex and challenging health related issues. This is evidenced by efforts to ensure that the community was accurately represented in all network initiatives and that community representatives contributed to network outcomes. The Behavioral Health Care Task Force chairperson, commenting on the composition of the task force, remarked

“
We wanted to get people from the political arena as well as service providers as well as other knowledgeable people and a couple that didn’t have much experience in the field at all. So we had a really broad based, diverse group.”
As stated by the Continuum of Care Task Force chairperson on the recruitment of service providers into the network

“…we wanted to get the players. We wanted all the players and some people from our board and from their boards. But we wanted to get a group together who would take a look at this thing and work on it together.”

This emphasis on working together relates to the second distinguishing characteristic of both network organizations and community health partnerships. Essentially, to accomplish network tasks requires collaboration among community organizations united by a shared vision. This sentiment is captured in the comments on the functioning of CRANA offered by two focus group participants.

“Well, I think what it is that we all have the same vision and we’re all there. It’s not about our egos. You know, we all have the intention to create a health community and you know create resources and so forth and I think that is the key (first participant).”

“It’s a very powerful opportunity to make a difference and I think people consider that important (second participant).”

The third network characteristic centers on the member working relationship. Within these organizations members serve in a voluntary capacity. The member organizations are also loosely coupled. CAHWF relied on volunteers to populate the numerous coalitions convened to address challenging community health issues. In many instances these participants knew each other as a result of either prior professional interaction in their specific service areas or as members of other inter-organizational networks.

Finally, an important network feature concerns organizational control. In these settings, network members mutually control the network and its activities. Within the defined purpose of each CAHWF convened network, members controlled network
proceedings in three ways. First network members collectively agreed on the structure of the network and the format of meetings. Second, although network facilitators did not specify formal roles for representatives or rules for conducting meetings, members were encouraged to participate in an open, inclusive and democratic manner. As stated by the Behavioral Health Task force chair

“I’ll point out about the Behavioral Health Task Force is that we were very careful to make sure that no particular service or need dominated the conversation. And if you think about group dynamics, when you get some people that are passionate about the program or service they’re delivering versus somebody who is reluctant participant in terms of speaking up, they just may be timid; we wanted to make sure there was as much equal input as we could.”

This open and inclusive environment was also maintained at CRANA network meetings. In commenting on the network facilitator’s interaction with network members for the purpose of generating new initiatives, a CRANA participant stated,

“…there are enough people involved, that come from different fields, different concerns, and so when (CAHWF facilitator) say, okay, what are some ideas? What’s our next topic? Somebody always has something.”

Not only is there a sense that CRANA participants had a voice in the process but their issues and concerns were given consideration based on these comments by a CRANA participant, “.. and the (CAHWF facilitator) very much does rely on the CRANA to give her feedback, like what we feel is important. What we see happening.”

Third, key decisions were made in a comprehensive and transparent way. For example a nominal group process was applied to reach consensus on planning recommendations generated by all three planning networks/partnerships. Members of each of these
collaborative groups also reviewed and commented on drafts of the planning reports prior to final publication. These reports were then made publicly available.

The classification of network organizations extends beyond the general attributes ascribed to these organizations by Chisholm (1998). These networks are further defined along a continuum ranging from loosely formed interactions to structured and interdependent collaborations focused on system change (Milward and Provan, 2000; Agranoff, 2003). Of the multiple ways of defining network organizations, the researcher found Robert Agranoff’s value added approach most appealing. Robert Agranoff classifies inter-organizational networks based on four network activities. These activities include exchange, capacity, strategy and decision. Agranoff defines four separate network models based on the cumulative number of activities performed by each network model ranging from a single activity within a network to the presence of all four activities within one network. This framework was established by Agranoff to identify and analyze inter-governmental networks but can be applied to other network settings. As addressed in the literature review, community health partnerships as defined by Romana Hasnain-Wynia et al. (2001) exhibit characteristics common to inter-organizational networks as described by Robert Agranoff. Within limitations given the type of organizations being described (intergovernmental networks vs. community partnerships), Robert Agranoff’s models and the community health partnership models offered by Romana Hasnan-Wynia and her colleagues may be cross-walked. A more detailed explanation and comparison of the two sets of models is presented in Appendix F.

In combination, these models may be used to classify a significant portion but not all of CAHWF’s network/partnership activities. Employing Robert Agranoff’s (2003) value
added network typology, CAHWF’s network activities exhibit characteristics of both developmental and outreach network models. From the perspective of community health partnerships as defined by Romana Hasnan-Wynia and her colleagues (2001), CAHWF network activities exhibit characteristics of both facilitating and decentralized action partnership models. More specifically, CAHWF’s health promotion network (CRANA) exhibits developmental network characteristics and most closely resembles a facilitating community health partnership. The temporary networks created by CAHWF for assessment and planning purposes (Health Status Assessment Task Force, Prevention and Education Task Force, Behavioral Health Task Force, Continuum of Care Task Force) display characteristics of outreach networks and are most closely related to decentralized action community health partnerships. The application of more than one community health partnership model by CAHWF in its role as community organizer is not unusual given the complexity and reach of CAHWF’s mission. In their description of community health partnership models Romana Hasnain-Wynia et al. (2001) acknowledges that partnerships models are not necessarily mutually exclusive and that a combination of partnership models may be used in response to the types of initiatives and goals targeted. In this instance CAHWF first employed a decentralized action partnership model for the purpose of reaching consensus on planning recommendations targeted at identified focus areas. As a consequence of the planning process CAHWF then formed a facilitating partnership for “brainstorming” and implementing prevention and education initiatives aimed at combating causative factors directly associated with chronic disease – a CAHWF focus area.
Measuring Effectiveness

CAHWF stakeholders identified five measures of effectiveness related to CAHWF’s overall efforts. Measures of effectiveness cited by stakeholders include: an increase in networking opportunities; completion of strategic and operational plans in a collaborative manner; increase in foundation and community organizations’ management capacities; maintenance of a disciplined mission driven approach to program funding; and, the addition of health and health related services within CAHWF’s service area.

Two of the five identified measures of effectiveness are related to CAHWF’s actions as a community organizer. These are networking and collaborative planning. These indicators are consistent with measures of effectiveness identified in the community health partnership literature. Lasker, Weiss and Miller (2001), Provan and Milward, (2001) and Shosanna Shofaer et al. (2003) all recognize the networking opportunities as a measure of coalition effectiveness. Francisco, Paine, Fawcett (1993), Butterfoss, Goodman, Wandersman (1996) and Zakocs and Edwards (2006) recognize the production of community planning documents as a measure of community coalition effectiveness.

CAHWF as a Community Resource

Key Points

- CAHWF partnered with community organizations and provided these organizations with a variety of resources including funding in order to complete the final steps of the “model of community partnership action” – plan initiation and plan evaluation.

- CAHWF’s effectiveness as a community resource is indicated by measures identified in the foundation literature - management capacity building, disciplined funding and the addition of programs and services.

As a community resource, CAHWF processed grant requests submitted by service providers responding to concerns identified by the community. In a more assertive stance,
CAHWF proactively funded selected service providers to meet identified needs not addressed through the traditional grant request process. CAHWF also funded projects and activities that supported both community networking and community capacity building efforts. Based on an application of the relevant literature an analysis of CAHWF in its capacity as a community resource is provided in this section of the chapter. The chapter section is organized as follows: the rationale for partnership; selecting a course of action; relating to grantees; and, measuring effectiveness.

**The Rationale for Partnership**

Theorists and researchers have advocated for a more assertive stance on the part of foundations in resolving a host of social and environmental problems (Porter and Kramer 1999; Regenstreif, Langston, Rieder, 2004; Ostrower, 2006). More specifically, Porter and Kramer (1999) believe that foundations should embrace a leadership role in an effort to affect positive social change. To accomplish this transition, a foundation must first select in what sector it plans to operate and in what ways it plans to improve the identified social condition. To initiate change, a foundation must actively partner with grantees sharing the same purpose. These selected grantees must have the capability or potential capability of generating positive outcomes from their actions. In a partnership relationship the grantee brings the required expertise to address the problem or the ability to adapt new approaches to the resolution of problems. As a partner, the foundation creates an environment for grantees to investigate new approaches and sufficient management and financial capacity to sustain support for programs that prove effective.
Selecting a Course of Action

As community organizer, CAHWF maintained coalition activities for the purpose of initiating plan recommendations through the establishment of working groups and the creation of a new coalition. CAHWF efforts as a community resource linked to these initiatives. CAHWF staff supported network related working groups (Prescription Coalition, Behavioral Health Implementation Team) by originating proactive grant requests in response to working group recommendations. As a community resource, CAHWF also financially supported CRANA initiated programming.

As a community resource CAHWF’s proactive efforts went beyond linking with ongoing coalition efforts to initiate programs in two ways. First, CAHWF helped build the management capacity of community organizations. Second, guided by the established planning framework, CAHWF directly drove the implementation of recommended initiatives in collaboration with community service organizations and evaluated the performance of these service organizations. These efforts were notable. Examples of these efforts include the Adams Hanover Counseling Service and the Wellness at Work projects.

Relating to Grantees

As inferred above CAHWF became an increasingly proactive partner with its grantees. As advocated in the foundation literature (Porter and Kramer, 1999; Regenstreif, Langston, Rieder, 2004; The Center for Effective Philanthropy, 2002; Grantmakers for Effective Organizations, 2006, Ostrower, 2006), CAHWF provided resources and support that extended beyond funding in its efforts to initiate and maintain planning recommendations. The following quotation from Michael Porter on the role of
foundations in creating community value best exemplifies CAHWF’s growing role as a grant maker during the first five years of Foundation operations.

“Foundations can become fully engaged partners, providing advice, management assistance, and access to professional service firms, clout, and a host of other non-cash resources. Improving the performance of grant recipients often requires foundations to work closely with grantees. It also requires the willingness to engage for the long term. Foundations are capable of both.” (Porter and Kramer, 1999, p 124)

CAHWF developed this type of relationship with a number of grant recipients (Adams Hanover Counseling Service, The RASE Project, and Hope Station). The relationship with the Sadler Health Corporation (SHC) however is one example that may best illustrate the type of partnership described above. In each of its first five years of operation CAHWF funded Sadler Health Center Corporation. CAHWF’s involvement during this time went beyond simply funding the center’s capital and operating requirements. Sadler assisted in the incorporation process; helped recruit the SHC’s Board of Trustees chairperson and the SHC executive director; served in a management consulting role for the executive director; collaborated with SHC to introduce new services (Health Rx, Tobacco Cessation); and created opportunities for SHC to increase its management capacity through participation in the PANO “Standards for Excellence” program. The positive results of this partnership are evident. These include increased availability of primary care for underserved populations within the community; increased access to pharmaceuticals for community members; and the addition of a tobacco cessation program aimed at eliminating one of the major causes of population morbidity and mortality.
Measuring Effectiveness

CAHWF stakeholders identified five measures of effectiveness related to CAHWF’s overall efforts. Three of the five identified effectiveness measures are associated with CAHWF’s actions as a community resource. These are management capacity building, disciplined funding and addition of programs and services. These measures of effectiveness are widely recognized in the foundation literature. Porter and Kramer (1999), The Center for Effective Philanthropy (2002), Grantmakers for Effective Organizations (2006), and Ostrower (2006) recognize capacity building efforts as a measure of effectiveness. Disciplined funding is recognized as an effectiveness indicator by Porter and Kramer, 1999; The Center for Effective Philanthropy, 2002, Regenstreif, Langston, Rieder, 2004, and Grantmakers for Effective Organizations, 2006. A number of the same sources (The Center for Effective Philanthropy, 2002; Regenstreif, Langston, Rieder, 2004) specifically recognize the addition of programs and services as an effectiveness measures.

CAHWF in its capacity as a community resource is closely associated with management capacity building for at least two reasons. First CAHWF expected a higher level of grantee accountability. The grant application requirement to develop a logic model for evaluation purposes is evidence of this expectation. Second, CAHWF invested in the development of management training programs (outcome measurement) and routinely provided management training at minimal expense to community organizations.

With regard to disciplined funding, CAHWF routinely based grant approval decisions on the fit between the grant request and identified areas of community concern. This
ability to remain within the targeted focus areas increased as CAHWF became more active in initiating proactive grants based on specific planning recommendations. Finally, although there was some recognition by community stakeholders of CAHWF’s impact on community health as a community organizer, stakeholders firmly believed CAHWF major contribution to community health resulted from its actions as a community resource. There are several reasons for this assessment. First, CAHWF was publicly associated with high visibility, high impact community projects funded by the Foundation in partnership with a single or small group of providers. Second, community actions undertaken by the CAWHF community partnership convened to implement health promotion and education initiatives (CRANA) were modest in comparison to the high visibility, high impact projects funded by CAHWF. As will be noted in the next section, the combined actions of CAWHF as a community organizer and resource were both essential in generating positive responses to community health concerns.

**CAHWF as a Blended Organization**

*Key Points*

- The Carlisle Area Health & Wellness Foundation (CAHWF) is a multidimensional organization consisting of community partnership and foundation attributes.

- The Carlisle Area Health & Wellness Foundation (CAHWF) in its expanded role invested in strengthening community collaboration and organizational capacities; and in a focused and disciplined manner reduced health care services shortfalls; reduced barriers to care; and, created opportunities for health improvement.

Within the first year of its formation, CAHWF committed to ensuring the ongoing improvement of community health within its defined service area. CAHWF’s underlying rationale for collaboration, its selected course of action, its choice of organizational structures and identified measures of effectiveness are represented in aspects of the inter-
organizational network, community health partnership, and foundation literatures. The ability to apply facets of these multiple literatures to CAHWF is related to the hybrid nature of the organization.

Briefly stated, CAHWF relied upon a model of community partnership action to identify and prioritize community health care concerns; develop plans; and, follow through on planning recommendations. In order to successfully execute this plan in the first several years of its existence, CAHWF expanded its role to include organizing as well as resource capacities. As a community organizer, CAHWF relied upon network organizations defined within the context of health care reform as community health partnerships to complete specific steps of the model of community partnership action. To complete the assessment, prioritization and planning steps of the model of community partnership action, CAHWF relied upon a collaborative structure resembling an outreach network as defined in the network literature and as a decentralized action partnership within the community health partnership literature. CAHWF relied upon a second type of community collaborative that exhibited attributes of a developmental network as defined in the network literature and as a facilitating partnership within the community health partnership literature to complete both planning and implementation steps of the action model. Both of CAHWF’s networking initiatives experienced moderate to good success. The Foundation’s growing reputation as a community health catalyst however was more clearly recognized in its capacity as a community resource. Relying on information from the health status assessment and subsequent planning documents, CAHWF proactively partnered with community organizations to implement targeted initiatives while
concurrently working at management capacity building within its own organization and those of community providers.

Overall, community stakeholders perceived CAHWF’s first five years of operation as effective. Stakeholders cited five measures of effectiveness. These include networking, community planning, capacity building, disciplined funding, and the addition of programs and services. These measures of effectiveness are noted in both the community partnership and the foundation literature. These effectiveness measures complement each other because each recognizes a critical building block of the model of community partnership action. Effectiveness measures associated with CAHWF as a community organizer include networking and community planning. The three effectiveness measures associated with CAHWF as a community resource include capacity building, disciplined funding, and the addition of programs and services.

These combined measures of effectiveness not only relate to the community partnership literature and foundation literature but tie to a broader interpretation of organizational effectiveness provided by Richard Hall (1977) that is partially based on the work of Charles Perrow (1961). Richard Hall (1977, p 95) begins his discussion of organizational effectiveness by stating there “are no single models or prescriptions for effectiveness”. Hall instead presents a pragmatic description of organizational effectiveness that captures aspects of a number of established organizational effectiveness models (goal, system resource, contingency, multiple constituency). Essentially organizational effectiveness may best be understood by all organizational stakeholders in term of the achievement of operative goals set by key decision makers. In this instance operative goals refer to the specific content of official goals. Operative goals in contrast
to official goals serve as the benchmarks by which organizations make decisions and measure their progress. Operative goals may accurately represent official goals or may differ in purpose and intent (Perrow, 1961). In order to maximize its effectiveness (achievement of operative goals) Hall further states that an organization must remain flexible in terms of organizational structure and processes in order to better shape the external environment to its advantage or reactively respond to changes in its external environment (Hall, 1977).

In the case of CAHWF, its operative goals and official goals were in alignment. More specifically, CAHWF’s broad goals are captured in its mission statement. These include the following: identifying and addressing health care needs; promoting responsible health practice; and enhancing access to and delivery of health services. The identified health needs were identified as oral health, chronic illness, and behavioral health. These goals were partially achieved in very tangible ways. CAHWF was instrumental in improving access to primary care for the community’s underserved residents (The Enrollment Task Force, The Sadler Health Center Primary Medical Care and Dental Care Services) and by providing this access impacting oral health and chronic illness concerns. CAHWF proactively supported health promotion and prevention programs (Tobacco Cessation Program, Wellness at Work Program). And, CAHWF addressed a significant gap in mental health services in its community (Northwestern Human Services, Adams Hanover Counseling Services). These efforts were recognized by stakeholders as a measure of effectiveness defined in this paper as the addition of services and programs.

To maximize effectiveness (achievement of operative goals), CAHWF actively managed its organizational structures and processes. As discussed above CAHWF
created temporary community networks for assessment and planning purposes. The work of these networks initially allowed for the articulation of an informed mission statement by CAHWF key decision makers. These networks also set the stage for community action by identifying areas of concern and developing plans to address these concerns. Because no health promotion community coalition existed within CAHWF’s service area to take on one of CAHWF’s biggest concerns, CAHWF created an ongoing network to facilitate the development and implementation of prevention and promotion activities and services. On going efforts were made to improve the management capacity of both CAHWF and its partnering organizations to ensure mutual discipline and accountability in the use of precious community resources. And, procedures were put in place that allowed CAHWF to partner with community service organizations in a more expedient way. The impacts of these actions were recognized by stakeholders and captured in the four remaining measures of effectiveness – networking, community planning, capacity building, and disciplined funding.

In summary, the broader model of organizational effectiveness offered by Richard Hall additionally supports the researcher’s position that CAHWF’s success in its first five years of operations is related to the integration of its community organizing and resource capacities. The successful adaptation of CAHWF’s structures and processes resulted in the achievement of its operative goals. CAHWF’s initiatives reduced health care services shortfalls and barriers to care through the addition of clinical services; and, created opportunities for health improvement through the establishment of education, prevention and promotion programs all in an effort to remedy three community health problems (oral health, chronic illness, and behavioral health).
Chapter Five – Conclusions and Implications

The objectives of this closing chapter are three-fold. First, following a brief summary of the purpose of the research, a discussion on the contributions of the research to community health foundation and community partnership theories and models is provided. This first section is followed by a discussion on the practical applications of these contributions to community health foundation management. Some suggestions for further research are then presented followed by concluding remarks.

This research centered on the examination of Carlisle Area Health and Wellness Foundation (CAHWF), a community health foundation focused on broad based community health improvement. CAHWF was initially selected as the case study organization for several reasons. To begin with the Foundation’s purpose was and remains to serve as a catalyst for continuous community health improvement. Second, CAHWF supported a collaborative approach to problem solving since its inception despite the fact there was limited legal obligation on the part of the Foundation to actively seek community input or involvement. Third, during its first five years of operations, CAHWF served as the lead convening organization and administrator for several community health collaborations while concurrently maintaining its core responsibility as a grant maker. The Foundation’s responsibilities as a convening organization and as a grant maker offered an interesting opportunity to explore one organizational approach dedicated to community health improvement that links community health partnership and community foundation principles and practices.

In the end the research process revealed a dense and intricate organization that served the community as a convener, administrator, facilitator, advisor and grant maker in order
to advance the cause of improved community health. For research purposes this variety of responsibilities was reduced to three groupings – community organizer, community resource, and community advocate. In its first five years of operation, CAHWF predominantly served in the capacities of community organizer and community resource. In both capacities CAHWF relied on a model of community partnership action to achieve its goals and objectives.

From a community organizing perspective, the research provided information on community partnership characteristics and related partnership effectiveness measures. From a community resource perspective, the research provided information on foundation characteristics and related foundation effectiveness measures. The true value of the research however results from the integration of these findings. CAHWF’s success in its first five years of operations is based on the inextricable linkage between CAHWF’s actions as a community organizer and community resource.

**Contributions to Community Health Foundation and Community Partnership Theories and Models**

As outlined in Chapter One, an exploratory study of CAHWF offered two related opportunities to add to the existing body of knowledge on community health reform. These were in the areas of community health foundation and community partnership theories and practices. More specifically, by completing the case study of the Carlisle Health and Wellness Foundation, the researcher exploited an opportunity to contribute to a community foundation topic that has not been fully investigated – the role of a community health foundation as a collaborative community leader. An integration of inter-organizational relationship, community health partnership, and foundation literatures were relied upon to describe CAHWF’s organizational purpose, functions and
structures and to identify intermediate measures of foundation effectiveness. The key contributions of the case study research are provided below.

Key Contributions

- The purpose, functions and structures of a community health foundation serving as a lead community organization for health improvement are described for the first time (based on a review of existing literature) through the integration of inter-organizational relationship, community partnership and foundation theories and models.

- Measures of effectiveness associated with this specific community health foundation serving as a lead community organization for health improvement are identified.

- In the analysis of CAHWF as a community organizer, the community health partnership literature and the IOR literature are successfully linked and provide insight into the relationship between measures of effectiveness and community partnership models.

- An organizational model of the Carlisle Health & Wellness Foundation (CAHWF) in its role as a lead community organization is presented as an “Engaged Community Health Foundation”.

CAHWF as a Lead Community Organization for Health Improvement

As summarized in Chapter One, foundation research to date has primarily focused on the relationship between foundations and their grant recipients (Porter and Kramer, 1999, The Center for Effective Philanthropy, 2002; Regenstreif, Langston, and Reider, 2004; Grantmakers for Effective Organizations, 2006; Ostrower, 2006a). As a result of this research there is a growing body of knowledge on successful foundation practices as these practices relate to foundation grantees. The role of foundations serving more broadly as leaders for community betterment however is just beginning to be explored (Ostrower, 2006b, 2007). More specifically, it is believed that a community foundation may be more effective in advancing the welfare of its community by taking on a role as community leader (Ostrower, 2007). From an organizational theory perspective, there is a
gap in the literature on how a community foundation can best accomplish its transition to this broadened community role.

In its first five years of operations, CAHWF successfully positioned itself as a lead community organization focused on sustaining conditions required to promote community wide health and well being. The case study findings and analysis contribute to the body of knowledge on community foundations by describing a transitional path to community leadership for one type of community foundation, a community health foundation. This is accomplished by describing the purpose, functions and structures of CAHWF through the integration of inter-organizational relationship, community partnership and foundation theories and models.

As stated above, CAHWF dedicated itself to improve community health within its defined service area in the role of community leader. CAHWF’s purpose reflected objectives typically associated with the mission of a community health partnership (Roussos and Fawcett, 2000). To accomplish this mission CAHWF adopted a collaborative philosophy reflected in both the organizational network (Chisholm, 1998) and community partnership (Roussos and Fawcett, 2000) literatures. Relying on an underlying collaborative belief system, CAHWF selected a course of action advocated in the community partnership literature (Butterfoss, Goodman, Wandersman, 1993). CAHWF expanded its community role to include functional capacities as both a community organizer and community resource in order to implement its selected course of action.

As a community organizer, CAHWF relied upon network organizational structures to complete specific steps of the model of community partnership action. To complete the
assessment, prioritization and planning steps of the model of community partnership action, CAHWF employed an outreach network (Agranoff, 2003) as defined in the network literature and as a decentralized action partnership within the community health partnership literature (Hasnan–Wynia et al., 2001). CAHWF utilized a developmental network as defined in the network literature and as a facilitating partnership within the community health partnership literature to complete both planning and implementation steps of the action model.

In its capacity as a community resource, CAHWF actively participated in the implementation and evaluation steps of the model of community partnership action. CAHWF adopted a partnering approach toward foundation grant recipients espoused in the foundation literature (Porter and Kramer, 1999) to implement and evaluate the progress of targeted community health initiatives identified during the planning step of the model of community partnership action.

CAHWF’s transition into the role of a lead community health improvement organization is best attributed to its ability to blend organizational characteristics of community partnerships and foundations as defined in the three streams of literature cited above to achieve the following: community consensus on identified community health concerns; agreement with community stakeholders on community actions to address these concerns; and, implementation of agreed upon actions in a collaborative manner.

**CAHWF’s Measures of Effectiveness**

Five measures of effectiveness are associated with CAHWF in its expanded role as community organizer and community resource. These measures include network building, collaborative planning, management capacity building, disciplined funding, and
the addition of health and health related services. These measures of effectiveness are noted in either the community partnership or the foundation literature or in one instance in both literatures. Effectiveness measures associated with CAHWF as a community organizer include networking (Lasker, Weiss and Miller 2001; Provan and Milward, 2001; Shosanna Shofaer et al. 2003) and collaborative planning (Francisco, Paine, Fawcett 1993; Butterfoss, Goodman, Wandersman 1996; Zakocs and Edwards 2006). The three effectiveness measures associated with CAHWF as a community resource include management capacity building (Porter and Kramer 1999; The Center for Effective Philanthropy, 2002; Grantmakers for Effective Organizations, 2006; Ostrower, 2006), disciplined funding (Porter and Kramer, 1999; The Center for Effective Philanthropy, 2002; Regenstreif, Langston, Rieder, 2004; Grantmakers for Effective Organizations, 2006), and the addition of health and health related services (The Center for Effective Philanthropy, 2002; Regenstreif, Langston, Rieder, 2004). In the community health partnership literature the effectiveness measure associated with the addition of health and health related services is also identified as an effectiveness measure (Sofaer et al. 2003; Butterfoss et al. (1993); Francisco, Paine, Fawcett (1993); Provan and Milward, (2001); Larson et al. (2002). In this case study research this measure was not strongly related to CAHWF’s community organizing activities. The possible reason for this is discussed in the next section.

The Relationship between the IOR and the Community Partnership Literature

As related in Chapter 1, the study of CAHWF created the opportunity to model and assess the effectiveness of community health foundation lead coalitions through the integration of an IOR conceptual framework in the case study analysis. Based on the case
study findings and analysis, CAHWF employed community collaboratives to complete the model of community partnership action. These organizational structures exhibited characteristics common to both network organizations as defined by Rupert Chisholm (1998) and community health partnerships as presented by Stergio Roussos and Stephen Fawcett (2000). Additionally, in an analysis of the case study findings it was demonstrated that CAHWF developed and managed different types of community collaboratives. A value-added network typology developed by Robert Agranoff (2003) was used to identify these different organizational structures. Further, the characteristics of these value added network types were linked to models of community health partnership developed by Romana Hasnan–Wynia (2001) and her colleagues.

CAHWF relied upon a collaborative structure resembling an outreach network as defined in the network literature (Agranoff, 2003) and within the community health partnership literature as a decentralized action partnership (Hasnan-Wynia et al., 2001) to complete the assessment, prioritization and planning steps of the model of community partnership action. CAHWF relied upon a second type of community collaborative that exhibited attributes of a developmental network (Agranoff, 2003) and as a facilitating partnership (Hasnan-Wynia et al., 2001) to complete both planning and implementation steps of the action model. CAHWF Stakeholders identified two key effectiveness measures associated with these community networks/partnerships – network building and collaborative planning.

Given the myriad of effectiveness measures associated with community coalition activity (Zakocs and Edwards, 2006; Roussos and Fawcett, 2000), why are these the only two measures recognized by key CAHWF stakeholders? A probable explanation for this
relates to the type of partnerships convened and managed by CAHWF. The predominant partnership model organized by CAHWF exhibited characteristics of a decentralized action partnership (Hasnian-Wynia et al., 2001). From a value added network perspective (Agranoff, 2003) decentralized action partnerships are organized for three purposes (information exchange, capacity building, development of coordinated strategies). CAHWF decentralized action partnerships (Prevention and Education, Continuum of Care, and Behavioral Task Forces) were convened specifically to generate community supported recommendations to address community health concerns. Their purpose was not to assertively move forward with implementation of recommendations. As observed by Romana Hasnain-Wynia and her colleagues, planning coalitions such as the Prevention and Education, Continuum of Care, and Behavioral Task Forces do not routinely receive recognition for taking actions that result in positive community health improvements. “The community, and more often, external evaluators and financial supporters, do not see the behind –the –scenes work of the partnership and attribute all actions and achievements to the individual implementing organizations” (Hasnian-Wynia et al. 2001, p32).

The relationship between the predominant community partnership model employed by CAHWF and the associated measures of effectiveness assigned to these partnerships by CAHWF stakeholders provides some insight into the failure to reach consensus on common listings of partnership effectiveness measures. Simply stated, partnership measures of effectiveness may be related to the purpose and type of community health partnership being studied. The recognition in the community health partnership literature of multiple measures may be associated with the fact that these effectiveness measures
were drawn from a review of a broad array of community partnership models ranging from facilitating to centralized action partnerships at varying times of their organizational development. In contrast the effectiveness measures related to CAHWF as a community organizer are associated to a great extent with a coalition model that exhibited characteristics of a decentralized action partnership. Further analysis on the relationship between community partnership models and measures of effectiveness using a value added approach was beyond the scope of this case study but worthy of future research.

**CAHWF as an “Engaged Community Health Foundation”**

Although defined as a health care conversion foundation, during its first five years of operations CAHWF more closely approximated a blended organization featuring characteristics of a community health partnership and a community foundation. The researcher has developed a definition and attributes of this blended organization in order to synthesize the learning gained from the intensive review of CAHWF. This model may be used for other research opportunities detailed later in the paper in the discussion on future research trajectories. In an effort to remain consistent with the presentation of the findings, the attributes of an “Engaged Community Health Foundation” are organized by foundation capacity. Included within this description are community advocate attributes of an “Engaged Community Health Foundation”. Although recognized but not pursued in this research, this capacity is included in order to present a full and accurate description of CAHWF and more generally that of an engaged foundation. CAHWF grew its capacity as a community advocate late into the five year period under review. The CAHWF Board of Trustees approved the formation of a public policy committee in 2004. The committee met for the first time on September 15, 2004. Since its formation, the public policy committee
has approved six public policy position papers prepared by either CAHWF staff or
CAHWF public policy committee members for public dissemination. CAHWF sponsored
two legislative forums for interested community members. The first forum was held on
May 12, 2005 and the second forum on May 10, 2007. Additionally CAHWF
commissioned an air quality report for the Carlisle area published in November 2006 that
served as the basis for the Foundation’s policy position on air quality. The definition and
attributes of this blended organization including its capacity as a community advocate are
provided in Table 5.1.

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CAHWF prepared positions papers include the following: air quality position paper –
March, 2007; prescription medication position paper – September, 2006; nutrition
position paper – December, 2005; tobacco position paper – May, 2005; behavioral health
position paper - May, 2005; oral health position paper – December, 2004
Table 5.1 Definition and Attributes of an Engaged Community Health Foundation

Definition
An “Engaged Community Health Foundation” is a blended organization (with both community partnership and community foundation attributes) capable and committed to leading community health and health care system improvement efforts.

Attributes
The attributes of an “Engaged Community Health Foundation” are presented below by organizational capacity – community organizer, community resource, and community advocate.

Community Organizer – Engaged Community Health Foundations
- pursue a model of community partnership action and serve as a focal community health care organization actively involved in every stage of community health improvement from health status assessment to program implementation and evaluation.
- serve as convener and administrator of community networks to facilitate collaboration at each stage of the community partnership action plan.
- support and participate in existing community networks to facilitate collaboration at each stage of the community partnership action plan

Community Resource - Engaged Community Health Foundations
- are proactive in funding planned initiatives at the level of intensity and over the requisite time to generate positive health outcomes
- are proactive in funding emerging community health improvement opportunities or conversely emerging threats that would diminish community health status
- serve as an engaged and equal partner with grant recipients sharing administrative and management resources in addition to financial resources
- invest in projects and activities aimed at supporting community organizing efforts and building the capacity of community organizations
- are proactive in funding health policy projects

Community Advocate - Engaged Community Health Foundations
- internally formulate and publicly disseminate health policy position papers
- directly engage with health policy makers and create opportunities for their stakeholders to engage with health policy makers
Practical Applications of the Research Contributions

Beyond the effort to contribute to theory, case study research findings ideally should add value by benefiting those directly working in the field. Although the lessons learned are based on one case study of a health care conversion foundation, it is the hope of the researcher that the application of these lessons might be relevant for private as well as public foundations organized for the purpose of improving community health. More specifically, it is the hope of the researcher that the results of the case study may assist foundation board members and managers interested in expanding their foundation’s community role by:

- providing a pathway for transitioning from a community health foundation to an “engaged community health foundation”;
- providing measures of effectiveness to assess a community foundation’s progress in achieving a community leadership role as an “engaged community health foundation”.

Pathway for Transition

The case study findings initially provide foundation leaders with a preferred course of action for expanding their organizations’ role in the community. Through the application of the model of community partnership action, a foundation can position itself as a focal community health care organization actively involved in every stage of community health improvement from health status assessment to program implementation and evaluation. The analysis of the case study findings also identifies inter-organizational structures for each stage of the action model. Foundation management can facilitate each stage of the action plan as appropriate through the use of multiple forms of inter-organizational
relationships ranging from network organizations to traditional partnerships. The effective use of collaborative decision making throughout the model of community partnership action process helps initially ensure an accurate identification of targeted health concerns and the achievement of desired intermediate outcomes.

In the long run, an “engaged community health foundation” strengthens its position to affect health policy and programming by serving as a forum for community collaboration. By sustaining and nurturing these networks and partnerships, the foundation will maintain its ability to accurately assess community health concerns and respond in appropriate and timely ways. Second, through the maintenance of collaborative structures the foundation will be able to generate innovative responses to existing and emerging community health concerns. Finally, early successes resulting from collaborative action may build sufficient social capital to resolve increasingly more difficult health and health system problems.

**Measures of Effectiveness**

To assess progress in achieving community leadership status, foundation leaders can monitor five measures of effectiveness. It is suggested that foundations initially monitor their efforts to create networking opportunities for the purpose of developing stronger personal and professional relationships among community stakeholders. The formation of networks should then lead to measurable outcomes. In the completion of the first steps of the model for community partnership action, network efforts should result in the assessment of community health status and the production of community recommendations targeted at identified concerns. These network outcomes can serve as a measure of effectiveness. The implementation of community initiatives requires
sufficient community capacity to act on recommendations and the continued support of community stakeholders to sustain the effort. Actions taken by the foundation to support community capacity building and to adhere to community generated recommendations to guide funding decisions can serve as indicators of effectiveness in these areas. Finally the actions of foundation networks and partnerships should cumulatively result in community health improvement measured in either the degree of program activity targeted at identified community health concerns or in the outcomes generated by these programs.

**Suggestions for Further Research**

- Suggested research topics on community health foundations and on the relationship between community health foundations and community health care reform efforts include the following: the community health foundation’s role as policy advocate; community health foundation types; community health foundation life cycle; community health foundation impact on community health; and, comparison of community health foundations to other community organizational models designed to positively impact community health.

In general, the goal of community health foundation research is to uncover ways in which community resources may best be coordinated and allocated to ensure ongoing and sustainable community health improvement. With this in mind, several organizational research possibilities may be pursued as a result of this initial study. First, additional research may be directed toward the role of the community health foundation as a public policy advocate. For example how can public policy advocacy efforts initiated by community health foundations create opportunities for community health improvement by influencing community policy and practice across multiple sectors? Second, because this research represents a single case study, one suggestion is to expand this work by completing a cross-sectional study of a representative sampling of conversion health foundations. The research questions could focus on conversion health foundations’ roles as
change agents for improving community health. A sample question could focus on identifying each foundation’s vision, mission and chosen course of action /strategy. In relating this data to the CAHWF findings the researcher could determine whether CAHWF’s collaborative actions are standard practice pursued by other health care conversion foundations or if they represent a distinctly different way of meeting community needs? In the event there are varying paths followed by these foundations to achieve their visions, it may be possible to develop a typology of conversion health foundations around community capacities (organizer, resource, and advocate). On-going research could possibly concentrate on organizational effectiveness determinants and effectiveness measures for each type of foundation.

A single case longitudinal study of CAHWF is also possible for the purpose of exploring changes in CAHWF’s community role over time in an attempt to seek out a possible community health foundation life cycle model. A series of questions could be posed on this topic. Will CAWHF maintain its responsibilities as community organizer, community resource and community advocate? If so, how will CAHWF’s community role change over time (relationship among varying capacities)?

Initial research on CAHWF’s impact on the community is also possible. One area of research may be measuring the impact of CAHWF’s prevention and education initiatives on institutional practice and community population behavior. A more challenging research initiative could focus on the relationship between intermediate program results and long term community health outcomes. Although methodologically demanding, a broader study involving health care conversion foundations similar in purpose and action to CAHWF could explore the same set of community impact questions.
Finally, assuming the possibility of establishing a health care conversion foundation typology, an interesting research effort could focus on the relative effectiveness of efforts by varying forms of community health organizations to address specific community health concerns. A representative sample of organizations might include a reactive community health foundation, a blended organization featuring community foundation and partnership features such as CAHWF and a stand-alone community health partnership.

**Closing Remarks**

Throughout the second half of the twentieth century and into the first decade of this century, repeated national and state health reform initiatives have been proposed and some attempted to address access, cost and quality concerns. The results of these efforts are not encouraging. Due in part to limited reform successes at the federal and state levels, reliance has grown on multi-sector community level led health reform initiatives to address immediate community health concerns. As a result of the devolution of health care reform responsibility from the federal to state level and ultimately to the local community level, community health foundations have an opportunity to extend beyond their core responsibility of grant making. Within this environment, health foundations are positioned to serve as catalysts for collaborative change in pursuit of sustainable solutions to inherent health and health system problems.

The challenge for a community health foundation committed to taking a lead community role often involves selecting the best path toward legitimately achieving and maintaining this new community status. From its beginning as a conversion health foundation, CAHWF accepted the challenge of serving as a community leader and catalyst for change. CAHWF established itself as a community health care leader within the first
five years of its existence. CAHWF achieved this status by proactively creating community partnerships; mobilizing community stakeholders within these structures ranging in form from networks to dyadic relationships; and sustaining meaningful community action that resulted in measurable increases in health care activity that often benefited the Carlisle area’s most vulnerable community members.

In closing, unraveling the multiple responsibilities of CAHWF and determining the relationships between these responsibilities was demanding for the researcher but in the end rewarding. CAHWF offers one example of a community health foundation that creates social value – a community health foundation that skillfully weaved itself into the fabric of the communities it served and continues to serve by expertly integrating its abilities as a community organizer and community resource.
Appendix B: Key Informant and Focus Group Standardized Interview Guide

Summary:

This interview guide is developed for the completion of a standardized open-ended interview. It is designed to be administered to individual key stakeholders or small groups of key stakeholders (3–5 participants) of the Carlisle Health and Wellness Foundation. The objectives of the interview include the following: to better understand the organizational characteristics of CAHWF and to document stakeholder’s perception of the organization’s effectiveness.

The interview questions are designed to address each of the objectives listed above. The purpose and type of each question is included with each question. Depending on the roles of the interviewee with CAHWF, part or all of the interview questions will be completed. More specifically, questions on organizational characteristics and effectiveness are separately structured for the traditional and proactive funding roles of the foundation and the network administration role of the foundation.

Today I would like to learn more about CAHWF and get your thoughts on the effectiveness of the organization to date. I plan to start by asking general questions about CAHWF followed by more specific questions concerning your professional relationship with the foundation.

Purpose: Introduction
Type: Prefatory Statement

Introductory Questions

Q1. How would you define the purpose (vision/mission) of CAHWF?
   Purpose: Definition of CAHWF
   Type: Knowledge

Q2. In your opinion what are the specific issues CAHWF attempts to address?

Q3. How is CAHWF structured as an organization and what activities does CAHWF pursue to achieve their vision and mission?
   Purpose: Definition of CAHWF
   Type: Knowledge

Q4. In what roles have you participated in CAHWF activities (board member, committee member, task force member)?
   Purpose: Definition of CAHWF
   Type: Knowledge

Q5. What organization do you represent in your participation with CAHWF?
   Purpose: Definition of CAHWF
   Type: Background (probing)
Organizational Characteristics (Structure and Process)

Traditional/ Proactive Funding Role

I do not plan to ask questions on the formal structure of the foundation. Sufficient information on the structure and processes are documented in the foundation’s source documents.

Organizational Effectiveness

Traditional/ Proactive Funding Role

These next several questions are very important to this research. You may find them somewhat difficult to answer. Please feel free to respond to these questions in ways that make sense to you.

Purpose: Effectiveness of CAHWF Funding

Type: Attention Getting Prefatory Statement

Q6. In their traditional role as a funding source, how effective do believe CAHWF has been to date in addressing targeted community concerns?

Purpose: Effectiveness of CAHWF Funding

Type: Opinion

Q7. In what specific ways has CAHWF been effective (process and outcomes)/specific measures?

Purpose: Effectiveness of CAHWF Funding

Type: Opinion (probing)

Before we begin the final section of the interview in which I will ask you to comment on CAHWF’s community health partnership role, I want to make sure I clearly understand your thoughts on CAHWF’s effectiveness as a funding source for community health initiatives (summarize interview to this point). Before I move on, are there any other comments you would like to make on CAHWF’s effectiveness?

Purpose: CAHWF summary

Type: Summarizing Transition

Organizational Characteristics (Structure and Process)

Community Health Partnership Role

Q8. To the best of your knowledge what were the reasons that (specific partnership) was formed?

Purpose: Community health partnership formation

Type: Knowledge

Q9. Health care partnerships form for a variety of reasons. They form to exchange information among members; to help develop member capabilities; to help solve member’s problems; and to jointly act on common issues. Based on your experience with (specific partnership) please describe the specific purposes of (specific partnership).
Purpose: Community health partnership formation
Type: Illustrative/ Experience

Q10. Have you worked with other members of the (specific partnership) before joining (specific partnership)?
Purpose: Community health partnership composition
Type: Knowledge

Q11. Is your participation with (specific partnership) voluntary in nature?
Purpose: Community health partnership composition
Type: Knowledge

Q12. Are all of the individuals and groups necessary to achieve stated purpose of the (specific partnership) represented?
Purpose: Community health partnership composition
Type: Knowledge (probing)

Q13. Does (specific partnership) interact with other collaborative organizations which are not part of (specific partnership)?
Purpose: Community health partnership composition
Type: Opinion

Q14. All organizations grow and develop over time. Generally speaking, organizations emerge, grow, mature and decline. Briefly describe how (specific partnership) has evolved during your time as a member.
Purpose: Community health partnership development
Type: Illustrative/ Opinion

Q15. All organizations have rules which govern the scope of their activities. Please briefly how these rules, policies, and procedures serve to define your role and responsibilities as a member of the (specific partnership).
Purpose: Community health partnership governance
Type: Experience

Q16. The responsibilities of a collaborative group leader can be challenging. Based on your experience with (specific partnership) please describe the responsibilities and actions of the (specific partnership) chairperson.
Purpose: Community health partnership management
Type: Experience

Before we begin the next section of the interview in which I will ask you to assess (specific partnership) effectiveness, I want to make sure I clearly understand your description of (specific partnership) (summarize interview to this point). Before I move on, Are there any other comments you would like to make to describe (specific partnership)?
Purpose: (specific partnership) summary
Type: Summarizing Transition
Organizational Effectiveness
Community Health Partnership Role

These next several questions are very important to this research. You may find them somewhat difficult to answer. Please feel free to respond to these questions in ways that make sense to you.

Purpose: Effectiveness of (specific partnership)
Type: Attention Getting Prefatory Statement

Let me begin by saying that researchers believe collaborative organizations are considered effective when all of the key participants believe that the outcomes of the partnership provide benefit.

Purpose: Effectiveness of (specific partnership)
Type: Prefatory Statement

Q17. As a representative of (specific constituent) how effective do you believe (specific partnership) has been to date in building the partnership as well as addressing targeted community concerns?

Purpose: Effectiveness of (specific partnership)
Type: Opinion

Q18. In what specific ways has (specific partnership) been effective?

Purpose: Effectiveness of (specific partnership)
Type: Opinion (probing)

Q19. When we discussed the membership composition of the (specific partnership) you stated that (restate groups described by the interviewee) are also members of (specific partnership). In your opinion, how effective do you think they believe the (specific partnership) has been to date in building the partnership and addressing targeted community concerns?

Purpose: Effectiveness of (specific partnership)
Type: Opinion

Generalize the groupings – community representative (public managers, funding sources, consumers, and general public), service providers, consumers, foundation representatives

Before concluding the interview, I want to make sure I clearly understand your description of (specific partnership) effectiveness measures (summarize interview to this point). Are there any other comments you would like to make to describe (specific partnership) effectiveness?

Purpose: (specific partnership) summary
Thank you for your honest and candid responses to these interview questions. This information will be extremely helpful to me as I complete the research on CAHWF.
Appendix C: Key Informant and Focus Group Recruitment and Informed Consent Documents

Recruiting Material for Key Informant Participants

The following message will be sent to potential participants in the case study research.

Dear ____________:

My name is David Sarcone. I am a doctoral student at Penn State University- Harrisburg. With the permission of the CAHWF Board of Trustees I plan to conduct research on the foundation. The research objectives are to answer the following questions: Q1 In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community? Q2 In its first five years of existence how has the Carlisle Area Health & Wellness Foundation been effective?

The purpose of this note is to ask your permission to meet with you to discuss the research topics described above. The interview process will take approximately 60 minutes. I have attached the informed consent form associated with this study for your review.

Please let me know your decision on participating by responding to this note. If you plan to participate in this study, I will contact you to schedule an appointment.

Thank you for considering this request.

Dave Sarcone
Dear _____________:

My name is David Sarcone. I am a doctoral student at Penn State University- Harrisburg. With the permission of the CAHWF Board of Trustees I plan to conduct research on the foundation. The research objectives are to answer the following questions: Q1 In its first five years of operation, how did the Carlisle Health & Wellness Foundation interact with stakeholders for the purpose of meeting its vision to grow a health community? Q2 In its first five years of existence how has the Carlisle Area Health & Wellness Foundation been effective?

At this time I am attempting to recruit individuals who have worked with CAHWF to voluntarily participate in a focus group. The focus group session will take approximately 90 minutes. The findings of the focus group will be used to complete dissertation research required to complete my doctoral degree from Penn State University – Harrisburg. I have attached the informed consent form associated with participating in the focus group for your review.

Please let me know your decision on participating by responding to this note. If you plan to participate in this study, I will contact you to schedule the focus group session.

Thank you for considering this request.

Dave Sarcone
Informed Consent Form for Social Science Research
The Pennsylvania State University

Title of Project: Intermediate Measures of Effectiveness: A Case Study of a Community Health Foundation

Principal Investigator: David Sarcone, Graduate Student
55 South Pin Oak Drive
Boiling Springs, PA 17007
(717) 245-1261
sarconed@dickinson.edu

Advisor: James Ziegenfuss, Ph.D.
School of Public Affairs
Penn State- Harrisburg
77 West Harrisburg Pike
Middletown, PA 17057
(717)-948-6053
jtz1@psu.edu

1. **Purpose of the Study:** The purpose of this research study is to first explore how community health partnerships organize for the purpose of improving overall community health status, and second to explore how partnership members measure the effectiveness of these endeavors.

2. **Procedures to be followed:** You will be asked individually or as part of a focus group to reply to a maximum of 27 questions in an interview conducted by the principal investigator. The interview will be recorded.

3. **Duration/Time:** It will take about 60 to 90 minutes to complete the interview.

4. **Statement of Confidentiality:** Your participation in this research is confidential. Only the person in charge, will know your identity. For those participating in a focus group, it is expected that if you speak about the contents of the focus group outside the group, your comments will not include the identification of statements by specific focus group members. The data will be stored and secured at the principal investigator’s office in a locked desk drawer. The principal investigator will be the only person with access to the data. The tape of the recorded interview will be destroyed in 2008. In the event of a publication or presentation resulting from the research, no personally identifiable information will be shared.

5. **Right to Ask Questions:** Please contact the principal investigator, David Sarcone (717) 245-1261 with questions or concerns about this study.

6. **Voluntary Participation:** Your decision to be in this research is voluntary. You can stop at any time. You do not have to answer any questions you do not want to answer. Refusal to take part in or withdrawing from this study will involve no penalty or loss of benefits you would receive otherwise.

You must be 18 years of age or older to consent to take part in this research study. If you agree to take part in this research study and the information outlined above, please sign your name and indicate the date below. You will be given a copy of this form for your records.

_____________________________________________  ___________________
Participant Signature  Date

_____________________________________________  ___________________
Person Obtaining Consent  Date
Appendix D: CAHW F Secondary Data

Carlisle Area Health & Wellness Foundation
2006 KEY INFORMANT SURVEY SUMMARY

During Spring of 2006, the Carlisle Area Health & Wellness Foundation distributed a Key Informant Survey (KIS) throughout the service region through a large mailing and distribution at various public places. This was done to as part of our strategic plan to help assess and measure the quality of services provided by the Carlisle Area Health & Wellness Foundation (CAHW F) toward the fulfillment of its mission, vision, values and goals. We plan to repeat this effort to gain insight from key informants every three years.

Demographics
Sixty-nine total respondents completed the questionnaire. Of them, 27 were female, 23 were male, and 19 chose not to record their genders. Five respondents were between the ages of 20 and 35, 12 were between 36 and 50, 20 were between 51 and 65, 20 were 65 or older, and 12 did not list their ages.

Relationship with CAHW F during the past three years:
- 17 volunteered with the Foundation: 10 as a committee member, 2 as a task force member, and 5 as both.
- 9 volunteered with a grant recipient
- 15 attended a CAHW F event
- 11 were a healthcare provider
- 17 had no direct relationship
- 9 marked “other”: on committees with CAHW F staff, community partners, etc.
- 10 did not specify a relationship

They live in:
- 44 Central Cumberland County (Carlisle)
- 6 Perry County
- 4 Western Cumberland County (Newville—Shippensburg)
- 2 Marked both of the above
- 0 Eastern Franklin County (Shippensburg)
- 1 Upper Adams County
- 8 “Other”: Dauphin County, or other areas outside of our region
- 4 Did not specify a county

Ethnicity:
- 1 was Asian
- 2 were black
- 0 were Hispanic
- 0 were Native American
- 59 were white
- 9 did not specify an ethnicity

Findings
Exclusion of the (17) respondents who reported “no direct relationship” with CAHW F yields slightly higher scores, possibly because the no-relationship sample often marked “neutral” (score of 3), which brought the overall scores down. Following is a comparison
of respondents, both overall and excluding those with no direct relationship to CAHWF. Summated Scores:
1 = Strongly disagree    4 = Agree
2 = Disagree            5 = Strongly Agree
3 = Neutral (no opinion)

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<tr>
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<th>Without Exclusion</th>
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<tbody>
<tr>
<td><strong>Vision:</strong> being a leader/catalyst for health improvement in our community</td>
<td>4.05</td>
<td>4.18</td>
</tr>
<tr>
<td><strong>Mission:</strong> addressing health care needs, policies, promoting responsible practices, improving access and delivery of health care services in the community</td>
<td>3.93</td>
<td>4.07</td>
</tr>
<tr>
<td><strong>Values:</strong> health education, empowering individuals/organizations, excellence, integrity, equity, fairness, responsiveness, and openness</td>
<td>3.92</td>
<td>4.12</td>
</tr>
<tr>
<td><strong>Goals:</strong> convening/planning with stakeholders, addressing identified needs, promoting best practices, evaluation of grantees, self-evaluation, capacity-building, fiscal stewardship</td>
<td>3.92</td>
<td>4.08</td>
</tr>
<tr>
<td><strong>Satisfaction/ Outcomes:</strong> website format, user-friendliness, information, staff, change agent, knowledge gain, and positive impact</td>
<td>3.88</td>
<td>3.99</td>
</tr>
<tr>
<td><strong>Grant Focus Areas:</strong> improving oral health, advancing mental health access/services, advancing substance abuse access/services, managing chronic diseases, reaching at-risk populations, and promoting individual/shared responsibility for health via prevention/education</td>
<td>4.00</td>
<td>4.09</td>
</tr>
</tbody>
</table>
**Responses to Open-Ended Questions**

Some of the common themes that emerged from the open-ended questions include:
- Develop more visibility/public relations/community education
- Provide access to quality healthcare/dental care
- Had positive experiences with Foundation staff
- Noted Sadler Health Center importance (re: continued funding)
- Expressed concerns with CRMC and our relationship with them
- Desire to see expansion of service area
- Appreciate various collaborations/initiatives such as CHIP enrollment, Medicare Part D, Wellness at Work and psychiatric services

When asked about important issues we should fund beyond the key focus areas, the following emerged: STDs, HIV, family violence, air/water pollution, OB/GYN services, basic needs, the elderly, oral health care, and more work on nutrition and activity.

**Summary**

The results of the KIS very closely mirror the most recent CAHWF applicant survey, which shows a consistency of “better than average” satisfaction with CAHWF’s performance. The most negative feedback appears to come from one very disgruntled respondent, based on the similar phrasings in the open-ended questions section.

We believe that it is appropriate to separate out the responses of those who have no relationship with the Foundation in the findings to provide a better comparison with the data from our applicant survey, so that we are comparing “apples to apples,” i.e., those who are familiar with the work of the Carlisle Area Health & Wellness Foundation.

The entire Key Informant report is available for review by Planning Committee and Board members. Please contact Cliff Deardorff, Director of Planning, for a copy.
KEY INFORMANT SURVEY
Note: Must be received by May 15, 2006

Carlisle Area Health & Wellness Foundation
Quality Improvement Survey

This survey contains questions designed to measure the quality of service provided by the Carlisle Area Health & Wellness Foundation toward fulfillment of its mission, values, and goals. There are questions that will require you to provide a numerical rating and questions that are open-ended to allow you to provide more detailed responses. It should only take about ten minutes to complete.

Your honest and detailed responses are greatly appreciated and will help to improve our ability to plan, fund, and manage our work on behalf of our community. All of your answers are completely anonymous and confidential.

Attention grant applicants: Since you recently received our Quality Improvement Survey of Applicants you do not need to complete this one.

THANK YOU FOR COMPLETING THIS SURVEY.
SIMPLY FOLD, TAPE AND RETURN (NO STAPLES, PLEASE)
NO POSTAGE IS NECESSARY

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<tr>
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<th>Without Exclusion</th>
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<tbody>
<tr>
<td>I. Vision</td>
<td></td>
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</table>
| Using the scale provided at the right, please circle the appropriate response to the following statements. | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree |
<p>| A. The Carlisle Health &amp; Wellness Foundation is a leader that helps to ensure the continuous improvement of health in our community. | 3.97 | 4.12 |
| B. The Carlisle Health &amp; Wellness Foundation is a catalyst that works towards improving the health in our community. | 4.13 | 4.24 |</p>
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<th>With Exclusion</th>
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</table>
| **II.** | **Mission** | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree |
| | Using the scale provided at the right, please circle the appropriate response to the following statements. | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree |
| A. | The CAHWF addresses the health care needs of the community. | 3.95 | 4.10 |
| B. | The CAHWF addresses health care policies in the community. | 3.70 | 3.76 |
| C. | The CAHWF promotes responsible health practices in the community. | 4.06 | 4.20 |
| D. | The CAHWF helps to improve individuals’ access to health services in the community. | 3.92 | 4.14 |
| E. | The CAHWF positively affects the delivery of health services in the community. | 4.03 | 4.16 |
|   | **Values** | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree |
| | Using the scale provided at the right, please circle the appropriate response to the following statements. | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral (no opinion)  
4 = Agree  
5 = Strongly Agree |
<p>| A. | Health education is an important value to CAHWF. | 4.26 | 4.46 |
| B. | CAHWF works to empower individuals. | 3.55 | 3.82 |
| C. | CAHWF works to empower organizations. | 3.83 | 4.06 |</p>
<table>
<thead>
<tr>
<th></th>
<th>CAHWF is committed to excellence.</th>
<th>4.05</th>
<th>4.22</th>
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<tbody>
<tr>
<td>E</td>
<td>CAHWF is committed to integrity.</td>
<td>4.11</td>
<td>4.30</td>
</tr>
<tr>
<td>F</td>
<td>CAHWF is committed to treating all applicants equally. (equity)</td>
<td>3.85</td>
<td>4.00</td>
</tr>
<tr>
<td>G</td>
<td>CAHWF is committed to treating all applicants fairly.</td>
<td>4.06</td>
<td>4.20</td>
</tr>
<tr>
<td>H</td>
<td>CAHWF is responsive to grantee needs.</td>
<td>3.89</td>
<td>4.06</td>
</tr>
<tr>
<td>I</td>
<td>CAHWF is practicing good stewardship of its funds.</td>
<td>3.91</td>
<td>4.16</td>
</tr>
<tr>
<td>J</td>
<td>CAHWF displays openness in organizational transactions and communications.</td>
<td>3.73</td>
<td>3.92</td>
</tr>
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<thead>
<tr>
<th>IV.</th>
<th>Goals</th>
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<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
</tr>
<tr>
<td>A.</td>
<td>CAHWF convenes and plans with community stakeholders around specific issues.</td>
</tr>
</tbody>
</table>
|    | 1 = Strongly Disagree  
|    | 2 = Disagree  
|    | 3 = Neutral (no opinion)  
|    | 4 = Agree  
<p>|    | 5 = Strongly Agree |
|    | Without Exclusion | With Exclusion |
|    | 3.95 | 4.18 |
| B. | CAHWF provides funding that addresses identified needs. | 4.12 | 4.34 |
| C. | CAHWF grant processes promote best practices. | 3.84 | 4.04 |
| D. | CAHWF evaluates grantees. | 4.05 | 4.20 |
| E. | CAHWF evaluates itself and its processes. | 3.69 | 3.68 |
| F. | CAHWF offers training and technical assistance to build the | 3.88 | 4.00 |</p>
<table>
<thead>
<tr>
<th></th>
<th>capacity of community organizations.</th>
<th></th>
<th></th>
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<tbody>
<tr>
<td>G.</td>
<td>Community assessment is a clear goal of CAHWF.</td>
<td>4.03</td>
<td>4.20</td>
</tr>
<tr>
<td>H.</td>
<td>CAHWF educates the community about needs and solutions.</td>
<td>3.73</td>
<td>3.88</td>
</tr>
<tr>
<td>I.</td>
<td>CAHWF works to develop its capacity to achieve its vision, mission and objectives.</td>
<td>3.97</td>
<td>4.02</td>
</tr>
<tr>
<td>J.</td>
<td>CAHWF practices excellent fiscal stewardship.</td>
<td>3.91</td>
<td>4.08</td>
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<thead>
<tr>
<th>V.</th>
<th>Satisfaction and Outcomes</th>
<th>Without Exclusion</th>
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<tbody>
<tr>
<td></td>
<td>Satisfactory and Outcomes</td>
<td>1 = Strongly Disagree</td>
<td>1 = Strongly Disagree</td>
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<td></td>
<td>Using the scale provided at the right, please circle your level of satisfaction with the following items.</td>
<td>2 = Disagree</td>
<td>2 = Disagree</td>
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<td></td>
<td>3 = Neutral (no opinion)</td>
<td>3 = Neutral (no opinion)</td>
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<td></td>
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<td>4 = Agree</td>
<td>4 = Agree</td>
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<tr>
<td></td>
<td></td>
<td>5 = Strongly Agree</td>
<td>5 = Strongly Agree</td>
</tr>
<tr>
<td>A.</td>
<td>Website format and user friendliness (cahwf.org)</td>
<td>3.63</td>
<td>3.72</td>
</tr>
<tr>
<td>B.</td>
<td>Website information</td>
<td>3.72</td>
<td>3.80</td>
</tr>
<tr>
<td>C.</td>
<td>CAHWF staff</td>
<td>4.17</td>
<td>4.35</td>
</tr>
<tr>
<td>D.</td>
<td>Training provided</td>
<td>3.75</td>
<td>3.90</td>
</tr>
<tr>
<td>E.</td>
<td>Overall satisfaction with CAHWF</td>
<td>4.00</td>
<td>4.23</td>
</tr>
<tr>
<td>F.</td>
<td>The CAHWF grant has enabled agencies to offer more services to region.</td>
<td>4.31</td>
<td>4.43</td>
</tr>
<tr>
<td>G.</td>
<td>Our region has not changed as a result of CAHWF.</td>
<td>3.35</td>
<td>3.32</td>
</tr>
</tbody>
</table>
H. We gained knowledge as a region as a result of CAHWF.  

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<tr>
<td>3.90</td>
<td>4.02</td>
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I. CAHWF has made a positive impact on the community.  

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<tr>
<td>4.08</td>
<td>4.19</td>
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<tr>
<th>VI. Grant Focus Areas</th>
<th>Without Exclusion</th>
<th>With Exclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please rate the importance of CAHWF focus areas for the community at large using the scale provided at the right.</td>
<td>1 = Strongly Disagree 2 = Disagree 3 = Neutral (no opinion) 4 = Agree 5 = Strongly Agree</td>
<td>1 = Strongly Disagree 2 = Disagree 3 = Neutral (no opinion) 4 = Agree 5 = Strongly Agree</td>
</tr>
<tr>
<td>A. Improving oral health</td>
<td>3.79</td>
<td>3.88</td>
</tr>
<tr>
<td>B. Advancing mental health access and services</td>
<td>4.22</td>
<td>4.24</td>
</tr>
<tr>
<td>C. Advancing substance abuse access and services</td>
<td>4.00</td>
<td>4.02</td>
</tr>
<tr>
<td>D. Managing chronic diseases</td>
<td>3.72</td>
<td>3.90</td>
</tr>
<tr>
<td>E. Reaching at-risk populations such as elderly, lower income, and the under- and uninsured</td>
<td>4.28</td>
<td>4.38</td>
</tr>
<tr>
<td>F. Promoting individual and shared responsibility for health via prevention and education</td>
<td>4.04</td>
<td>4.16</td>
</tr>
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</table>
EXECUTIVE SUMMARY
From its inception, the Carlisle Area Health and Wellness Foundation has been committed to evaluation – not only of grantees, but also of itself. The following report presents the results of the Foundation’s first annual survey of grant applicants. In 2004, Dr. Richard Wiscott of Shippensburg University was asked to develop a questionnaire for grant applicants to evaluate the Foundation’s success in achieving our Mission, Vision and Values and to assess how well we serve our grant applicants.

The respondents overwhelmingly rated the Foundation above average in the survey. In general, respondents – whether funded or not – were complimentary about the Foundation’s staff and the support that was provided throughout the grant process. The comments about staff were quite positive and show that our efforts to build relationships and to be helpful and fair are succeeding.

The greatest amount of criticism from survey respondents was related to the forms and process that we use. A number of respondents complained that the outcome measurement, reports and site visits took away time and resources from serving those in need. We have tried to make our forms accessible and easy to use, and have revised the paperwork, schedule and process several times in the past 3 years. This may be an issue that will never be completely solved, but we will keep trying.

A number of comments and suggestions indicate misconceptions or lack of knowledge about the Foundation and its processes. This underscores the need to continue our efforts to inform the community about CAHWF through our website, public speaking, media coverage and publications, as well as ongoing interaction with grantees. This insight and other information from the survey will be used to improve our grant making process in the coming year. It is anticipated that this or a similar survey will be given to applicants annually.

Background and Process
The survey was sent to all agencies that applied for funding between June 2003 and December 2004, including both those that were approved and those that were declined. The questions were developed by breaking the Foundation’s Mission, Vision and Values into their component parts and then asking applicants to rate the Foundation’s achievements in each of these areas.

In January 2005, 75 surveys were sent out – 45 to agencies that were funded, and 30 to agencies that had been declined. If an agency had applied for more than one specific program, a survey was sent for each separate grant submission. In an effort to maintain confidentiality and impartiality, respondents mailed completed questionnaires to a Dickinson College mail box and the results were collated and analyzed by student Jessica
Grinspan ‘05. Oversight for the project was provided by Professor Jennifer Devlen in the college’s Psychology Department.
The data from this survey will be discussed by the Grants Committee and staff in an effort to improve and refine our grant making.

Interpreting the results

<table>
<thead>
<tr>
<th>Application decision</th>
<th>Total surveys sent</th>
<th># returned</th>
<th>% returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
<td>30</td>
<td>9</td>
<td>23%</td>
</tr>
<tr>
<td>Funded</td>
<td>45</td>
<td>30</td>
<td>77%</td>
</tr>
<tr>
<td>Overall</td>
<td>75</td>
<td>39</td>
<td>52%</td>
</tr>
</tbody>
</table>

Respondents varied in size and area served, as well as the amount of their grant(s). Both Prof. Devlen and Ms. Grinspan felt that the mix of respondents and responses provides a valid picture of how the Foundation is viewed by those who have had direct dealings with our policies and staff. The following summary is based on Ms. Grinspan’s excellent and thorough work. Raw data and statistical calculations are available for folks who enjoy that sort of thing.

The numbers in the right-hand column note the average of the responses for each of the groups who were surveyed. For example, in item I.A, the average response of those who were funded was 4.47 (on a 1-5 scale) in support of the statement that “The Carlisle Health and Wellness Foundation is a leader that helps to ensure the continuous improvement of health in our community.” Among those who applied but were not funded, there was a slightly lower agreement with this statement (average 4.0).

Bulleted suggestions following each summary include representative comments that were submitted and numbers in parentheses indicates that the same comment was made by that number of respondents. For example, if a comment is followed by (3), it means that three separate respondents made similar statements. In some areas I have added notes in italics to provide additional info or clarifications.

<table>
<thead>
<tr>
<th>I. Vision</th>
</tr>
</thead>
</table>
| Using the scale provided at the right, please circle the appropriate response to the following statements. | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral  
4 = Agree  
5 = Strongly Agree |
| A  The Carlisle Health and Wellness Foundation is a leader that helps to ensure the continuous improvement of health in our community. | Funded 4.47  
Declined 4.0 |
| B  The Carlisle Health and Wellness Foundation is a catalyst that works towards improving the health in our community. | Funded 4.43  
Declined 3.89 |
| Summated score for Vision | Funded 4.45  
Declined 3.94 |
Respondents in both the Funding and Declined groups agreed that the Foundation is a leader and catalyst working toward improving health in the community, though those respondents who had received funding agreed significantly more strongly than those who had not.

Suggestions:
- Be available for questions and assistance
- Continue to inform the community of the Foundation’s activities and involve more community stakeholders in planning activities (4)
- Continue an open line of communication available to local hospitals, involved agencies, and the public
- Expand training and workshops for the public, not just professionals. (2) *Our trainings are almost always open to the public and we offer regular community programs.*
- Be active in approaching agencies and asking them how CAHWF can be involved in improving the health of its clients (2)
- Expand focus areas

<table>
<thead>
<tr>
<th>II.</th>
<th>Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Neutral</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
</table>
| A | The CAHWF addresses the health care needs of the community. | Funded 4.3  
Declined 3.78 |
| B | The CAHWF addresses health care policies in the community. | Funded 3.89  
Declined 3.25 |
| C | The CAHWF promotes responsible health practices in the community. | Funded 4.14  
Declined 4 |
| D | The CAHWF helps to improve individuals’ access to health services in the community. | Funded 4.13  
Declined 4.33 |
| E | The CAHWF impacts the delivery of health services in the community. | Funded 4.28  
Declined 4.44 |
|   | Summated score for Mission | Funded 4.12  
Declined 3.90 |

Respondents in both the Funding and Declined groups generally agreed that CAHWF’s activities are consistent with its mission. The somewhat weaker response on item B underscores the need for the activities of our recently created Public Policy Committee.
and the Foundation’s other policy efforts. It is also interesting to note that respondents in the “no-funding” group agreed with items D and E. more strongly than those who were funded.

Suggestions:
- Make site visits, conduct client surveys on services, and educate healthcare service agents (2) *We conduct regular site visits on all significant grants and provide 2-3 education opportunities per year.*
- Make application process less burdensome after initial approval. *Have revised & simplified grants process, especially for renewals, and continue to seek improvements.*
- Survey providers in the service area and grant recipients on a frequent basis (3)
- Address funding concerns more aggressively
- Include victim service professionals in behavioral health initiatives

<table>
<thead>
<tr>
<th>III.</th>
<th>Values</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
</tr>
<tr>
<td>A</td>
<td>Health education is an important value to the CAHWF.</td>
</tr>
<tr>
<td>B</td>
<td>The CAHWF works to empower individuals.</td>
</tr>
<tr>
<td>C</td>
<td>The CAHWF works to empower organizations.</td>
</tr>
<tr>
<td>D</td>
<td>The CAHWF is committed to excellence.</td>
</tr>
<tr>
<td>E</td>
<td>The CAHWF is responsive to grantee needs.</td>
</tr>
<tr>
<td>F</td>
<td>Helping organizations achieve their goals is an important value to the CAHWF. (stewardship)</td>
</tr>
<tr>
<td>G</td>
<td>The CAHWF displays openness in all business transactions and communications.</td>
</tr>
<tr>
<td></td>
<td>Summated score for Values</td>
</tr>
<tr>
<td></td>
<td>1 = Not at All Evident</td>
</tr>
<tr>
<td></td>
<td>2 = Sometimes Evident</td>
</tr>
<tr>
<td></td>
<td>3 = Mostly Evident</td>
</tr>
<tr>
<td></td>
<td>4 = Always Evident</td>
</tr>
<tr>
<td>A</td>
<td>Funded 3.61</td>
</tr>
<tr>
<td></td>
<td>Declined 3.33</td>
</tr>
<tr>
<td>B</td>
<td>Funded 3.04</td>
</tr>
<tr>
<td></td>
<td>Declined 2.56</td>
</tr>
<tr>
<td>C</td>
<td>Funded 3.41</td>
</tr>
<tr>
<td></td>
<td>Declined 2.89</td>
</tr>
<tr>
<td>D</td>
<td>Funded 3.83</td>
</tr>
<tr>
<td></td>
<td>Declined 3.44</td>
</tr>
<tr>
<td>E</td>
<td>Funded 3.66</td>
</tr>
<tr>
<td></td>
<td>Declined 3.38</td>
</tr>
<tr>
<td>F</td>
<td>Funded 3.55</td>
</tr>
<tr>
<td></td>
<td>Declined 2.78</td>
</tr>
<tr>
<td>G</td>
<td>Funded 3.59</td>
</tr>
<tr>
<td></td>
<td>Declined 3</td>
</tr>
<tr>
<td>Summated score for Values</td>
<td>Funded 3.52</td>
</tr>
<tr>
<td></td>
<td>Declined 3.20</td>
</tr>
</tbody>
</table>
Both the Funded and Declined groups were likely to rate the CAHWF’s commitment to its values as mostly or always evident, with no significant difference in the average overall rating between the groups. The significant difference between Funded and Declined responses on item F is of note.

Suggestions:
- Focus on helping viable, well-run organizations increase their capacity to improve and deliver health-related services. *Several trainings are offered each year at little or no cost to participants.*
- Consider expanding educational opportunities and facilitating roundtable discussions with area providers. *(2) This is being done.*
- Vary board members to include health and human service workers, not just administrators. *Current board has six frontline health/human service professionals.*
- Simplify the grant process. *Revised in 2004 and ongoing.*
- Be more specific about why grants are denied. *We try to be informative without getting into specific details. Our goal is to provide general info that will help the agency with any future applications while not usurping the Board and Grants Committee’s prerogative to decline funding.*

<table>
<thead>
<tr>
<th>IV.</th>
<th>Goals</th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Neutral</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>The CAHWF grant process promotes best practices.</td>
<td>Funded 4.33</td>
<td>Declined 4.25</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>On-going assessment is a clear goal of the CAHWF.</td>
<td>Funded 4.60</td>
<td>Declined 4.63</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>The CAHWF uses an educational approach in communications.</td>
<td>Funded 4.17</td>
<td>Declined 4.0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>The CAHWF is an effective and efficient funding partner.</td>
<td>Funded 4.30</td>
<td>Declined 3.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>The CAHWF monitors and evaluates grantee processes.</td>
<td>Funded 4.57</td>
<td>Declined 4.13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>The CAHWF monitors and evaluates grantee outcomes.</td>
<td>Funded 4.60</td>
<td>Declined 3.75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>The CAHWF has well-developed policies and procedures for its grantees.</td>
<td>Funded 4.33</td>
<td>Declined 3.38</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The CAHWF provides appropriate training to its grantees.

**Funded**: 4.37  
**Declined**: 4.0

The CAHWF provides on-going technical assistance to its grantees.

**Funded**: 4.20  
**Declined**: 2.88

Overall, the CAHWF has well-defined goals that guide the grant making process.

**Funded**: 4.43  
**Declined**: 3.75

**Summated score for Goals**

**Funded**: 4.38  
**Declined**: 3.95

Respondents from both groups (Funded and Declined) were likely to Agree or to Strongly Agree that CAHWF achieves its goals in serving grantees, with respondents who received funding particularly likely to agree strongly. We were pleased top see such high marks in items B, E and F, reflecting our emphasis on outcomes and evaluation. The low average among Declined agencies for item I may reflect that they did not receive any assistance because they did not receive a grant.

Suggestions:

- Extend the time of grant from one year to two. *This is now done with certain grantees that have a good track record with CAHWF, and is likely to expand over time.*
- Consider holding pre-proposal conferences. *We encourage (and prefer) agencies to speak with us before submitting a grant.*
- Establish a complete set of guidelines for the proposal request. *Available in hard copy and on our website.*
- Offer samples of acceptable grants to those new to grant-writing process. *Done upon request.*
- Be clear about the reasons that grants are declined. *See previous section (III).*
- Do not over-monitor projects; CAHWF appears to think effectiveness & efficiency are the same (4)

### V. Satisfaction

Using the scale provided at the right, please circle your level of satisfaction with the following items.

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
</table>
| **A** | The grant application process | **Funded**: 5.99  
**Declined**: 5.44 |
| **B** | Information, guidelines and forms on website | **Funded**: 5.80  
**Declined**: 6.0 |
| **C** | Common Funding Application (if you were required to complete) | **Funded**: 5.62  
**Declined**: 5.25 |

1 = Extremely Dissatisfied  
2 = Dissatisfied  
3 = Somewhat Dissatisfied  
4 = Neutral  
5 = Somewhat Satisfied  
6 = Satisfied  
7 = Extremely Satisfied
<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Funded</th>
<th>Declined</th>
</tr>
</thead>
<tbody>
<tr>
<td>D</td>
<td>Program logic model / outcome measurement tool</td>
<td>5.50</td>
<td>5.22</td>
</tr>
<tr>
<td>E</td>
<td>Terms of your Grant Contract Agreement</td>
<td>6.0</td>
<td>5.14</td>
</tr>
<tr>
<td>F</td>
<td>On-going support through the funding period</td>
<td>6.14</td>
<td>5.0</td>
</tr>
<tr>
<td>G</td>
<td>CAHWF staff</td>
<td>6.62</td>
<td>5.88</td>
</tr>
<tr>
<td>H</td>
<td>Site visits scope and quality</td>
<td>5.24</td>
<td>5.0</td>
</tr>
<tr>
<td>I</td>
<td>Training materials provided</td>
<td>5.32</td>
<td>4.58</td>
</tr>
<tr>
<td>J</td>
<td>Technical assistance provided</td>
<td>5.96</td>
<td>4.86</td>
</tr>
<tr>
<td>K</td>
<td>Evaluation of proposed or final grant outcomes</td>
<td>5.83</td>
<td>5.14</td>
</tr>
<tr>
<td>L</td>
<td>Interim Report process, if applicable</td>
<td>5.58</td>
<td>5.0</td>
</tr>
<tr>
<td>M</td>
<td>The final report process, if applicable</td>
<td>5.65</td>
<td>5.17</td>
</tr>
<tr>
<td>N</td>
<td>Overall satisfaction with CAHWF</td>
<td>6.21</td>
<td>5.58</td>
</tr>
<tr>
<td></td>
<td>Summated score for Satisfaction</td>
<td>5.98</td>
<td>5.14</td>
</tr>
</tbody>
</table>

Respondents who received funding generally rated themselves more ‘satisfied’ with the CAHWF grant process than those who were declined (likely to rate themselves ‘somewhat satisfied’). Note the high satisfaction among those funded on items F and G, relating to staff support. Satisfaction with the grant process and materials was less enthusiastic.

Positive experiences in conjunction with the CAHWF grant process:
- Timely reply to proposal (2)
- Supportive and accessible staff and directors (17)
- Ease and speed of application with friendly follow-up
- Clear explanation of why proposal was rejected
- Informative meetings, training sessions, and networking opportunities
Negative experiences in conjunction with the CAHWF grant process:

- Cumbersome, labor-intensive application in comparison to others. (3) *Our application is the standard one for foundations and United Ways in this area. It was greatly revised & simplified in 2004 and improvement is ongoing as identified.*
- Tendency to micro-manage (3)
- Outcome measurement is confusing & difficult (2)
- Our grant was denied due to “lack of need,” which was an incorrect judgment

<table>
<thead>
<tr>
<th>VI.</th>
<th>Outcomes</th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Neutral</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>This CAHWF grant has allowed us to increase the number of clients we serve.</td>
<td>Funded 4.28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>The CAHWF grant has allowed us to expand our service area.</td>
<td>Funded 3.43</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>The CAHWF grant has enabled us to offer more services to our clients.</td>
<td>Funded 4.31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Our organization has not changed as a result of receiving this CAHWF grant.</td>
<td>Funded 2.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>This CAHWF grant has helped us to be a more effective organization.</td>
<td>Funded 3.83</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Training and or technical assistance received in conjunction with this CAHWF grant has improved the skills of our staff.</td>
<td>Funded 3.61</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G</td>
<td>We gained knowledge as a result of this CAHWF grant.</td>
<td>Funded 4.11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H</td>
<td>This CAHWF grant has enabled us to make a positive impact on the community.</td>
<td>Funded 4.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Summated score for Outcomes</td>
<td>Funded 3.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Respondents who received funding from the CAHWF were likely to agree, though not strongly, that the CAHWF grant had improved their organization. [Note that the low response to item D. actually means that the organization has changed as a result of the CAHWF grant.]

Specific ways the CAHWF grant has improved organizations and their ability to serve clients:
- Expanded and improved quality of service, outcome measurement (4)
- Allowed organization to provide services in rural areas
- Increased use of a pool by physically-challenged individuals and senior citizens
- Improved accessibility; increased clients (7)
- Allowed organization to focus on programming and communication
- Improved visibility of organization
- Allowed organization to hire needed staff; to grow in size and function (2)
- Allowed organization to learn about the grant-writing process
- Allowed for quicker turnaround time to purchase prescriptions
- Allowed organization to network in the community
- Limit on overhead was impetus to be more organized and professional

Specific skills, knowledge, and abilities obtained as a result of the CAHWF grant:
- Writing skills (3)
- Communication skills
- Outcome measurement; using a program logic model (4)
- Marketing knowledge (2)
- Organization skills (2)

Ways the CAHWF grant has allowed organizations to impact the community as a whole:
- Food provided is of better quality
- Perry County families are receiving improved family-based services
- Organization has been able to expand its reach in the community, including minorities (4)
- Encouraged individuals to advocate for their own health
- Allowed organization’s support group to carry out its goals and objectives instead of being a fundraising machine

<table>
<thead>
<tr>
<th>VII.</th>
<th>Grant Focus Areas</th>
<th>Please rate the importance of CAHWF grant focus areas for the community at large using the scale provided at the right.</th>
<th>1 = Not at all Important</th>
<th>2 = Somewhat Important</th>
<th>3 = Important</th>
<th>4 = Very Important</th>
<th>5 = Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Improving oral health</td>
<td>Funded 3.78 Declined 2.88</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Advancing mental health access and services</td>
<td>Funded 4.43 Declined 4.13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Advancing substance abuse access and services</td>
<td>Funded 4.25 Declined 3.75</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Managing chronic diseases</td>
<td>Funded 4.36 Declined 4.0</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Reaching at-risk populations such as elder, lower income, and the under- and uninsured</td>
<td>Funded 4.75 Declined 4.50</td>
<td></td>
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</tr>
</tbody>
</table>
Both the Funded and Declined groups were likely to consider CAHWF grant focus areas ‘very important’ or ‘extremely important.’ There was no significant difference in ratings of importance between the groups. Note that the lowest “Importance” rating was for oral health; this may reflect the lack of community recognition of the oral health needs in our area.

Other health and wellness areas suggested as important for the CAHWF to focus on:
- Teen pregnancy prevention; promotion of healthy sexual lifestyle
- Parenting skills and education
- Dental/mental health & substance abuse in Perry County (2). *This is high on our list – we have funded several PC substance abuse programs. Oral health is a bigger challenge, but we are working on it.*
- Prenatal health (2)
- Mental health for the elderly
- Violence prevention and intervention (4)
- Lack of transportation for persons needing services
- Low-cost pharmaceuticals. *We are funding the Healthy Community Prescriptions initiative and several other Rx assistance grants.*
- Obesity in children. *YMCA Fit for Life addresses this issue as well as Carlisle Regional Advocates for Nutrition & Activity (CRANA).*
- I think [CAHWF has] hit on the major ones

VIII. Other Comments

A. Is there anything else you would like the staff at the CAHWF to know to help improve the quality of the services provided?
- Maintain open-door policy
- Decrease paperwork and oversight and let organizations focus on helping people
- Perhaps the Foundation could publish a grantee directory with a synopsis of each organization receiving a grant; the directory could be located at clinics, therapy locations, etc. *Annual Reports, website and newsletters offer this info.*
- HealthE Mail and the grantee lunch are good
- Keep up the good work

IX. To help us analyze this information, please answer the following demographic questions:

<table>
<thead>
<tr>
<th>Funded (# responding)</th>
<th>Declined (# responding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td></td>
</tr>
<tr>
<td>What is the size of your organization in terms of annual budget? (check one)</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>11</td>
</tr>
<tr>
<td></td>
<td>Question</td>
</tr>
<tr>
<td>---</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>B</td>
<td>What geographic area(s) do you serve? (check all that apply)</td>
</tr>
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<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>What was the size of your grant from CAHWF? (check one)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>What role does the person completing this survey have? (check all that apply)</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>How many grants has your organization received from the CAHWF since 2002? [Note that four of nine in the Declined group did receive a grant at some point.]</td>
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</table>

201
EXECUTIVE SUMMARY
From its inception, the Carlisle Area Health & Wellness Foundation has been committed to evaluation – not only of grantees, but also of itself. The following report presents the results of the Foundation’s second annual survey of grant applicants.

The respondents overwhelmingly rated the Foundation above average in the survey. In general, respondents – whether funded or not – were complimentary about the Foundation’s staff and the support that was provided throughout the grant process. The comments about staff were quite positive and show that our efforts to build relationships and to be helpful and fair are succeeding.

Although rated higher in almost all categories than the previous survey, the responses related to the grants forms and process still elicit a lower satisfaction rating than other areas. A number of respondents complained that the outcome measurement, reports and site visits took away time and resources from serving those in need. This is certainly true, and CAHWF staff tries hard to balance grantees’ scarce personnel resources with our need to be responsible funders. We have tried to make our forms accessible and easy to use, and have revised the paperwork, schedule and process several times in the past 4 years. This may be an issue that will never be completely solved, but we will keep trying.

Last year, a number of comments and suggestions indicated misconceptions or lack of knowledge about the Foundation and its processes. This year’s responses showed a significant improvement in that area – perhaps a result of both an additional year of CAHWF’s existence and staff efforts at education. On a related topic, numerous comments encouraged CAHWF to continue to provide public forums and trainings on health issues, which is a vote of confidence in our efforts to be a trusted source of information. We were very pleased to see a compliment on our “excellent…easy to navigate” website, which was totally redesigned and revised in 2005.

Questions were added this year related to integrity and treating all applicants equally and fairly. While we received high marks from the funded applicants, it was even more heartening to see that we received perfect scores on equality and fairness from the declined applicants.

Overall, there are no “red flags” in the survey responses. Although most ratings are close to last year’s and well above average, a majority of the ratings (38 out of 59 ratings, excluding the summated scores) are slightly less than in the 2005 survey. According to our data analyst, this is due to two interrelated factors:
1. The smaller number of responses (25) in 2006, which makes each response have a greater weight than each response in last year’s larger response pool (39 responses), and
2. Two respondents in the funded group consistently gave ratings that were below average or neutral. She also noted, “Other than that, people gave mostly above average or excellent ratings...”

The qualitative responses offer some good insights and the process as a whole helps to reinforce our efforts at being responsive and responsible grant makers. We plan to continue to administer the quality survey to applicants in the future, although a biannual survey will provide a larger respondent pool and, therefore, better validity.

**Background and Process**
In 2004, Dr. Richard Wiscott of Shippensburg University was asked to develop a questionnaire to evaluate the Foundation’s success in achieving our Mission, Vision, Values, Goals and Outcomes, and to assess how well we serve our grant applicants. In 2006, the survey was slightly revised to include additional Values added by the Board and sent to all Level I and II applicants from CY2005.

The survey was sent to all agencies that applied for Level I and II grants and received a decision in 2005, including both approved and declined applicants. Mini grant applicants were not surveyed. The questions were developed by breaking down the Foundation’s Mission, Vision and Values into their component parts and asking applicants to rate the Foundation’s achievements in each of these areas.

In January 2006, 33 surveys were sent out – 29 to agencies that were funded, and four to agencies that had been declined. If an agency had applied for more than one specific program, a survey was sent for each separate grant submission. In an effort to maintain confidentiality and impartiality, respondents mailed their completed questionnaires to a Dickinson College mailbox and the results were collated and analyzed by Jessica Grinspan, who had analyzed the survey for us last year. The data from this survey will be discussed by the Board and Grants Committee in an effort to improve and refine our grant making. We will also share the results with our grantees to let them know that their feedback is useful and to get additional input.

**Interpreting the results**

<table>
<thead>
<tr>
<th>Application decision</th>
<th>Total surveys sent</th>
<th># returned</th>
<th>% returned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Declined</td>
<td>4</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Funded</td>
<td>29</td>
<td>23</td>
<td>79%</td>
</tr>
<tr>
<td>Overall</td>
<td>33</td>
<td>25</td>
<td>76%</td>
</tr>
</tbody>
</table>

Respondents varied in size and area served, as well as the amount of their grant(s). While not useless, the ratings from the two Declined applicants are less robust than those of the 23 Funded applicants. Ms. Grinspan’s evaluation of the Funded ratings is that the mix of
respondents and responses provides a valid picture of how the Foundation is viewed by grantees who have had direct dealings with our policies and staff. The following summary is based on Ms. Grinspan’s excellent and thorough work.

The numbers in the right-hand column note the average of the ratings from each of the groups who were surveyed. For example, in item I.A, the average response of those who were funded was 4.13 (on a 1-5 scale) in support of the statement that “The Carlisle Health & Wellness Foundation is a leader that helps to ensure the continuous improvement of health in our community.” Among those who applied but were not funded, there was a slightly lower agreement with this statement (average 4.0). In the box for summated scores under each heading, the number in parentheses is last year’s summated score for that area.

Bulleted suggestions following each summary are summarized comments that were submitted and numbers in parentheses indicates that the same comment was made by that number of respondents. For example, if a comment is followed by (3), it means that three separate respondents made similar statements. In some areas notes in italics have been added to provide additional information or clarification.

<table>
<thead>
<tr>
<th>I.</th>
<th>Vision</th>
<th>1 = Strongly Disagree</th>
<th>2 = Disagree</th>
<th>3 = Neutral</th>
<th>4 = Agree</th>
<th>5 = Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>The Carlisle Health &amp; Wellness Foundation is a leader that helps to ensure the continuous improvement of health in our community.</td>
<td>Funded 4.13</td>
<td>Declined 4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>The Carlisle Health &amp; Wellness Foundation is a catalyst that works towards improving the health in our community.</td>
<td>Funded 4.30</td>
<td>Declined 4.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Summated score for Vision</td>
<td>Funded 4.22 (4.45)</td>
<td>Declined 4.25 (3.94)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Suggestions:
- Continue working to include the disenfranchised in decision making
- Vision is already clear, CAHWF is a leader!
- Continue to be visible and partner with the local coalitions and task forces that are addressing health-related issues
- Continue to support Sadler Center
- Follow up with/audit Sadler Center in regard to dental service delivery to patients,
especially poor ones
- Be visionary in leading the way to healthcare that is not discriminatory: physical, mental, emotional, dental, and vision care
- Health encompasses much more than patient scope of CAHWF—narrowing focus could provide a better sense of defined impact. To be a leader might mean being aggressive and broader in determining needs
- Look at all health issues, not a select group
- Take a more active role in bringing together the different organizations that work toward the community health—to encourage joint projects and collaboration and avoid duplication of effort. This is a continuing goal and challenge for CAHWF staff. We try to increase collaboration and system-focused programs.
- Increase access for the poor and those without insurance. Our enrollment efforts are a small step in this direction, as well as the significant funding for Sadler Health Center.
- Increase public awareness of CAHWF and its function in the community
- Continue to listen to the community
- Continue to hold focus groups

<table>
<thead>
<tr>
<th>II.</th>
<th>Mission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
</tr>
</tbody>
</table>
|     | 1 = Strongly Disagree  
|     | 2 = Disagree  
|     | 3 = Neutral  
|     | 4 = Agree  
|     | 5 = Strongly Agree |
| A   | The CAHWF addresses the health care needs of the community.            |
|     | Funded 3.91  
|     | Declined 3.00 |
| B   | The CAHWF addresses health care policies in the community.             |
|     | Funded 3.78  
|     | Declined 4.00 |
| C   | The CAHWF promotes responsible health practices in the community.      |
|     | Funded 4.00  
|     | Declined 3.50 |
| D   | The CAHWF helps to improve individuals’ access to health services in the community. |
|     | Funded 4.22  
|     | Declined 4.00 |
| E   | The CAHWF impacts the delivery of health services in the community.    |
|     | Funded 4.09  
|     | Declined 4.00 |
|     | Summated score for Mission                                            |
|     | Funded 4.00  205  
|     | Declined 3.70  205 (4.12)  
|     | Declined 3.90  205 |

Suggestions:
- Focus on obesity, cancer, heart and dental to make the greatest impact on the worst problems
• Resist the urge to spread recovery thinly over other problems that are not as devastating
• Resist the “political equity” trap
• Look at CDC’s information about violence as a public health issue
• Mission is already sound!
• Long-term mission to educate, identify and keep providing services that deal with fetal alcohol spectrum disorder because there are really no service providers in the area
• Refuse grant money to entities that discriminate or will not provide service (e.g. dental care for the poor that requires 4 visits over a period of one year for fillings and root canals)
• Approach providers with incentives to provide a certain number of hours of service for free to needy families.
• Clearly define what you are trying to impact
• More public debate and information sharing….forums such as “town hall meetings” or encouraging the media to enhance coverage of issues
• Broadly encompasses all healthcare needs already—is a leader
• Asking local service agencies and county offices what unmet needs they see
• Listen to the community—consider identifying access issues and addressing them
• Weekly column in the “living smart” section of the Sentinel
• Any ways for grantees to work together on related initiatives? Current examples: No Show collaboration (Behavioral Health Implementation Team) and Carlisle Regional Advocates for Nutrition and Activity (CRANA) activities.

### III. Values

Using the scale provided at the right, please circle the appropriate response to the following statements.

<table>
<thead>
<tr>
<th></th>
<th>1 = Not at All Evident</th>
<th>2 = Sometimes Evident</th>
<th>3 = Mostly Evident</th>
<th>4 = Always Evident</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Health education is an important value to the CAHWF.</td>
<td>funded 3.35&lt;br&gt;declined 3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>The CAHWF works to empower individuals.</td>
<td>funded 3.00&lt;br&gt;declined 3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>The CAHWF works to empower organizations.</td>
<td>funded 3.43&lt;br&gt;declined 3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>The CAHWF is committed to excellence.</td>
<td>funded 3.74&lt;br&gt;declined 3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>The CAHWF is committed to integrity.</td>
<td>funded 3.74&lt;br&gt;declined 3.50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>The CAHWF is committed to treating all applicants equally.</td>
<td>funded 3.64&lt;br&gt;declined 4.00</td>
<td></td>
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<tr>
<td>G</td>
<td>The CAHWF is committed to treating all applicants</td>
<td>funded 3.57</td>
<td></td>
<td></td>
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</tbody>
</table>
fairly.

Declined 4.00

The CAHWF is responsive to grantee needs.

Funded 3.50
Declined 3.00

Helping organizations achieve their goals is an important value to the CAHWF. (stewardship)

Funded 3.52
Declined 3.50

The CAHWF displays openness in all business transactions and communications.

Funded 3.61
Declined 3.50

Summated score for Values

Funded 3.50 (3.52)
Declined 3.55 (3.20)

Note that E, F, and G are new this year, due to revisions to CAHWF’s Values.

Suggestions:

• Promote education, empowerment, improvement through incentives that get people to take personal responsibility for their health
• Include the disenfranchised
• Continue to make diversity a focus on board and on committees
• Keep doing what you’re doing
• Expect grantees to provide education in the community as part of receiving grant funds
• Our organization has spent a lot of time arranging visits for CAHWF committee members, only to have people cancel at the last minute and few committee members actually attend. This is disheartening. Perhaps volunteers on committees could be better trained about the impact their visits have, as far as the preparation and time involved. We have emphasized this comment to the Board and Grants Committee.
• Look at two major areas with more emphasis: early identification and prevention of behavioral health problems in community/schools, and autism services
• Continue to provide educational opportunities to the community
• Newspaper column or lecture series
• Promote web page, include health information and encourage visitors to e-mail their concerns

IV. Goals

Using the scale provided at the right, please circle the appropriate response to the following statements.

1 = Strongly Disagree
2 = Disagree
3 = Neutral
4 = Agree
5 = Strongly Agree

The CAHWF convenes and plans with community stakeholders around specific issues.

Funded 4.19
Declined 5.00

The CAHWF provides funding that addresses identified needs.

Funded 4.19
Declined 5.00
### C
The CAHWF grant process promotes best practices.
- Funded 4.19
- Declined 4.50

### D
The CAHWF evaluates grantees.
- Funded 4.57
- Declined 3.50

### E
The CAHWF evaluates itself and its processes.
- Funded 3.95
- Declined 4.50

### F
The CAHWF offers training and technical assistance to build the capacity of community organizations.
- Funded 4.35
- Declined 4.50

### G
Community assessment is a clear goal of the CAHWF.
- Funded 4.10
- Declined 4.50

### H
The CAHWF educates the community about needs and solutions.
- Funded 4.05
- Declined 4.00

### I
The CAHWF works to develop its capacity to achieve its vision, mission and objectives.
- Funded 4.26
- Declined 4.00

### J
The CAHWF practices excellent fiscal stewardship.
- Funded 4.45
- Declined 3.50

### Summated score for Goals
- Funded 4.23
- Declined 4.30

#### Suggestions:
- Foundation already was helpful in assisting in every step of grant writing process
- Already excellent
- Provide additional feedback on the grant, positive or negative
- Note that not every recipient can list grant outcomes that fit the formula of the grant reporting requirements
- Do another community needs assessment. *Our second Health Status Assessment is planned for 2006-07.*
- Provide education seminars for families/adults in community
- Ongoing feedback from CAHWF regarding the successes or shortcomings of the program

### V. Satisfaction

Using the scale provided at the right, please circle your level of satisfaction with the following items.

<table>
<thead>
<tr>
<th>1 = Extremely Dissatisfied</th>
<th>2 = Dissatisfied</th>
<th>3 = Somewhat Dissatisfied</th>
<th>4 = Neutral</th>
<th>5 = Somewhat Satisfied</th>
<th>6 = Satisfied</th>
<th>7 = Extremely Satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>A The grant application process</td>
<td>Funded 5.41</td>
<td>Declined 6.50</td>
<td></td>
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<tr>
<td>B Information, guidelines and forms on website</td>
<td>Funded 6.13</td>
<td>Declined 6.50</td>
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<tr>
<td></td>
<td>Description</td>
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<td>-----------------------------------------------------------------------------</td>
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<tr>
<td>C</td>
<td>Common Funding Application (if you were required to complete)</td>
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<tr>
<td></td>
<td>Funded 5.77  Declined 5.00</td>
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<tr>
<td>D</td>
<td>Program logic model / outcome measurement tool</td>
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<td></td>
<td>Funded 5.26  Declined 6.50</td>
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<tr>
<td>E</td>
<td>Terms of your Grant Contract Agreement</td>
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<tr>
<td></td>
<td>Funded 6.13  Declined NA</td>
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<tr>
<td>F</td>
<td>On-going support through the funding period</td>
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<tr>
<td></td>
<td>Funded 6.26  Declined 6.00</td>
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<tr>
<td>G</td>
<td>CAHWF staff</td>
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<td></td>
<td>Funded 6.65  Declined 6.50</td>
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<tr>
<td>H</td>
<td>Site visits scope and quality</td>
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<td></td>
<td>Funded 6.21  Declined NA</td>
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<tr>
<td>I</td>
<td>Training materials provided</td>
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<td></td>
<td>Funded 5.88  Declined NA</td>
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<tr>
<td>J</td>
<td>Technical assistance provided</td>
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<td></td>
<td>Funded 6.05  Declined NA</td>
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<tr>
<td>K</td>
<td>Evaluation of proposed or final grant outcomes</td>
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<td></td>
<td>Funded 5.79  Declined 7.00</td>
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<tr>
<td>L</td>
<td>Interim Report process, if applicable</td>
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<td></td>
<td>Funded 6.04  Declined NA</td>
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<tr>
<td>M</td>
<td>The final report process, if applicable</td>
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<tr>
<td></td>
<td>Funded 5.42  Declined NA</td>
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</tr>
<tr>
<td>N</td>
<td>Overall satisfaction with CAHWF</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Funded 6.26  Declined 6.50</td>
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<tr>
<td></td>
<td>Summated score for Satisfaction</td>
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<tr>
<td></td>
<td>Funded 5.93  (5.98)  Declined 6.31 (5.14)</td>
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</tr>
</tbody>
</table>

Positive experiences in conjunction with the CAHWF grant process:
- Staff—professional/flexible/helpful/patient/pleasant (15)
- Common funding application
- Excellent web site—easy to navigate
- Help was available if needed (3)
- Fair decision making
- Issues very concise

Negative experiences in conjunction with the CAHWF grant process:
- Working with program logic model on outcomes—[too much] time required to complete the paperwork as a volunteer agency
- Difficulty retaining staff when unsure if new grant will be accepted
- Concern that CAHWF may not grasp obstacles in our service delivery
- Still requires a lot of time to prepare application, interim reports and final reports
(2)  
- Payments slow to arrive. *We typically provide an initial payment “up front” and subsequent payments are sent upon approval of grantees’ reports. We will review our process to assure prompt payment.*
- Zip code lists are not all-inclusive. *The PA Attorney General has set the Foundation’s service area, based on the area served by the former Carlisle Hospital.*

| VI. | Outcomes | 1 = Strongly Disagree  
2 = Disagree  
3 = Neutral  
4 = Agree  
5 = Strongly Agree |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Using the scale provided at the right, please circle the appropriate response to the following statements.</td>
<td></td>
</tr>
<tr>
<td>A</td>
<td>This CAHWF grant has allowed us to increase the number of clients we serve.</td>
<td>Funded 4.43</td>
</tr>
<tr>
<td>B</td>
<td>The CAHWF grant has allowed us to expand our service area.</td>
<td>Funded 3.27</td>
</tr>
<tr>
<td>C</td>
<td>The CAHWF grant has enabled us to offer more services to our clients.</td>
<td>Funded 4.55</td>
</tr>
</tbody>
</table>
| D | Our organization has not changed as a result of receiving this CAHWF grant. | Funded 1.91  
*In other words, most HAVE changed.* |
| E | This CAHWF grant has helped us to be a more effective organization. | Funded 4.09 |
| F | Training and or technical assistance received in conjunction with this CAHWF grant has improved the skills of our staff. | Funded 3.41 |
| G | We gained knowledge as a result of this CAHWF grant. | Funded 4.09 |
| H | This CAHWF grant has enabled us to make a positive impact on the community. | Funded 4.70 |

| Summated score for Outcomes | Funded 4.09 (3.74) |

Specific ways the CAHWF grant has improved your ability to serve clients:
- Offered program not otherwise available to youth
- Increased [monetary] amount of healthcare/nursing scholarships
- Extended hours of service
- Served higher number of children
- Working with more programs and providing them with training, mentoring, and equipment so they can provide better services to their clients
- Provided a substance abuse-related teen support group in Perry County—never been one before now
• Allowed us to have a presence in Carlisle—enabling us to reach residents there
• Allowed us to serve greater number of clients
• Clients who “fall between the cracks” now receive quality services
• More money to do outreach
• Better able to support our financially needy healthcare students
• Seeing whole new population of clients
• Offered much better nutritional quality of food
• Provided opportunities to reach doctors and medical personnel in the community
• Helped with brainstorming and prioritizing activities
• Expansion of services offered to clients
• Has allowed the continuation of existing services
• Purchase of clinical materials to assist clients and their recovery
• Providing healthcare screenings to low-income community members
• Provided unique opportunity to provide services in a different way to impact a larger community group

Specific ways the CAHWF grant has improved your organization:
• Increased focus on the physical and mental health connection
• Focused efforts through use of “outcomes”—funding has allowed us to implement the “best practice”; research component validated the program need (2)
• Fostered longevity of program
• Strengthened mission “to assist infants, children, youth and adults with disabilities and their families to achieve their goal of development, growth, independence and full citizenship”
• Able to provide a substance abuse-related teen support group
• Able to purchase additional services for parent support group and teen group
• Given us the ability to reach more people and carry out our mission
• Extended mission to rural poor and hidden needy families
• Able to help more people
• Broader scope of service from alternative funding source
• Improved nutritional quality of food in the box
• Enabled us to have staff to focus on a specific issue that has resulted in a positive effect on our consumers
• Enabled us to expand service in Perry County
• Promoted a positive image of our agency to the public
• Our staff has learned how to work with clients in a different setting
• Able to offer a new service
• Continuation of services to allow for co-occurring collaboration
• Clinical supplies to benefit clients
• Allowed us to expand our healthcare services, in particular to low-income community members
• Innovation in service offerings

Specific skills, knowledge, and abilities obtained as a result of the CAHWF grant:
• Learned more from an exercise physiologist and expanded enjoyable and safe activity for children
• Improved grant writing skills (3)
• Increased collaborative partnerships (2)
• Better understanding of the importance of outcomes planning (5)
• Allowed participation in continuing education programs
• Opportunity to offer more staff training to maintain quality of service
• Much better understanding of the population in the Greater Carlisle Area
• Evaluation skills in regard to services delivered to families and the community
• Better understanding of the adult population and their needs
• Increased awareness of Medicare system and rising costs of prescriptions and how this impacts senior citizens and low-income individuals in the community
• More comfortable with developing outcomes and relating them to goals and objectives
• Able to focus on no-show rates and obstacles for appointment compliance
• Developed systems to track statistics
• Innovation in service offerings

Ways the CAHWF grant has allowed organizations to impact the community as a whole:
• Children participating bring their new interests, capabilities and skills home to their families (biological and foster). They want to continue to be physically fit or improve their fitness
• Support nursing and healthcare students financially
• Reaching underserved communities at little or no cost to them
• Provide research-based information to parents, helping them to be well informed parents
• Increase service and programs to the community
• Touching more deserving children in a positive way, which enhances the community in the CAHWF area
• Provided funding to train and mentor teachers in 18 classrooms regarding comprehensive health practices for preschool children
• Offering more services (drug & alcohol related)
• Been able to provide true and accurate information to the community regarding addiction and recovery
• Provide services not otherwise available
• Serve an area that has been overlooked
• By training more future healthcare professionals, we will play an important role in ensuring that high-quality healthcare is available to our community for years to come
• Able to meet a whole new population of clients in a geographic area that we would have otherwise overlooked
• Able to assist people in the community through a confusing time with all of the changes in medication plans—helping people make the best (educated) choices for their healthcare
- Community members are learning more about nutrition and activity and that our site provides new services
- Continuation of services
- Able to use collective results to leverage support for initiative

<table>
<thead>
<tr>
<th>VII.</th>
<th>Grant Focus Areas</th>
<th>1 = Not at all Important</th>
<th>2 = Somewhat Important</th>
<th>3 = Important</th>
<th>4 = Very Important</th>
<th>5 = Extremely Important</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Improving oral health</td>
<td>Funded 3.68</td>
<td>Declined 4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Advancing mental health access and services</td>
<td>Funded 4.22</td>
<td>Declined 4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td>Advancing substance abuse access and services</td>
<td>Funded 3.86</td>
<td>Declined 4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>Managing chronic diseases</td>
<td>Funded 4.24</td>
<td>Declined 4.00</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E</td>
<td>Reaching at-risk populations such as elder, lower income, and the under- and uninsured</td>
<td>Funded 4.27</td>
<td>Declined 4.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Promoting individual and shared responsibility for health via prevention and education</td>
<td>Funded 4.27</td>
<td>Declined 4.50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Summated score for Focus Areas</td>
<td>Funded 4.09</td>
<td>Declined 4.17</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other health and wellness areas suggested as important for the CAHWF to focus on/targeted health problems that should be considered for future proposal requests: [Note that the new Healthy People Grants have the potential to provide funding for critical health care needs outside of the Foundation’s current priority focus areas.]

- Obesity (3); Early childhood obesity (2)  *We fund in this area.*
- Cancer  *We fund in this area.*
- Heart  *We fund in this area.*
- Dental care to serve the poor (3); provide dentures and crowns at Sadler - *This is in discussion.*
- Violence as a public health issue—perhaps some pilot around prevention (2)
- Preschool/early childhood behavioral health—focus on preventing problems that would require remediation in school (2).  *We fund in this area.*
- Training and retention of qualified direct care staff  *We provide scholarships for health-related studies.*
- Children with autism
- Fetal alcohol spectrum disorder—be able to have doctors diagnose and recognize it, then have treatment and educational options available for families
- Hepatitis C
- Un- and underinsured  *We fund in this area through several programs.*
• Substance abuse  *We fund in this area.*  
• Available pre-natal care.  *We are working on this through Sadler.*  
• Vision health (2)  *We have funded in this area.*  
• Nutrition—educate parents/adults in shopping “smart”—selecting healthy foods that taste good and are not expensive.  *We fund in this area.*  
• Hygiene—hair and skin, etc.  
• STDs  
• HIV  
• Diabetes (2)  *We fund in this area.*  
• Depression in the elderly.  *We fund in this area.*  
• Foot care  
• Psychiatric care for dual diagnosed patients (MR + MH).  *We fund in this area.*  
• Mental health, with a focus on depression.  *We fund in this area.*  
• Drug and alcohol teen clubhouse—workshops, gym, job coach, tutors, study rooms, etc.  
• Health insurance.  *We fund in this area.*  
• Link school health improvement (HI) to corporate HI to community HI

### VIII. Other Comments

A. Is there anything else you would like the staff at the CAHWF to know to help improve the quality of the services provided?

- Continue being supportive
- Very positive experience
- Staff turnover in an organization is a bad sign.
- Sometimes, the questions you don’t ask are the ones that are most revealing—each grantee should have the mission to serve the community in regard to their specialty. These grants are about health services—quality and accessibility and delivery.
- Very grateful for support and expertise
- You do great work!

### IX. To help us analyze this information, please answer the following demographic questions:

<table>
<thead>
<tr>
<th>IX.</th>
<th>To help us analyze this information, please answer the following demographic questions:</th>
<th>Funded (# responding)</th>
<th>Declined (# responding)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>What is the size of your organization in terms of annual budget? (check one)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Less than $50,000</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>6. $50,000 to $250,000</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>7. $250,001 to $1,000,000</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>9. Over $1,000,000</td>
<td>9</td>
<td>2</td>
</tr>
<tr>
<td>B</td>
<td>What geographic area(s) do you serve? (check all that apply)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22. Cumberland County</td>
<td>22</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>10. Franklin County</td>
<td>10</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>15. Perry County</td>
<td>15</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>8. Adams County</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td><strong>C</strong></td>
<td>What was the size of your grant from CAHWF? (check one)</td>
<td>1 Dauphin Co. 0</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>11 $2,001 - $25,000</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 $25,000 or more</td>
<td></td>
</tr>
<tr>
<td><strong>D</strong></td>
<td>What role does the person completing this survey have? (check all that apply)</td>
<td>7 Executive Director 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Board member 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>12 Grant Project Manager 1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 Other 1</td>
<td></td>
</tr>
<tr>
<td><strong>E</strong></td>
<td>How many grants has your organization received from the CAHWF since 2002?</td>
<td>4 2 respondents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>5 5 respondents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>6 4 respondents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 7 respondents</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>4 6 respondents</td>
<td></td>
</tr>
</tbody>
</table>
Appendix E: CAHWF Source Document Tables

E-1 Chronology
Table of CAHWF Initiatives
June 1, 2001-May 30, 2006

* The Implementation Start Dates represent the date of funding approval and not the start of program operations.

** The End Dates for programs that extended beyond May 30, 2006 are recorded as 05/06. Of those initiatives that remained active after 05/06 the following are currently functioning: Adams Hanover Counseling Services; Carlisle Regional Advocates for Nutrition and Activity; Wellness at Work; Tobacco Prevention Outreach; Healthy Rx Program; and the Behavioral Speakers Bureau.

<table>
<thead>
<tr>
<th>Initiative</th>
<th>CAHWF Capacity</th>
<th>Function</th>
<th>Start *</th>
<th>End**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sadler Health Center Task Force</td>
<td>Community Organizer</td>
<td>Planning</td>
<td>02/02</td>
<td>11/02</td>
</tr>
<tr>
<td>Health Status Assessment</td>
<td>Community Organizer</td>
<td>Assessment/Prioritization</td>
<td>01/02</td>
<td>05/02</td>
</tr>
<tr>
<td>Adams Hanover Counseling Services</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>09/03</td>
<td>05/06</td>
</tr>
<tr>
<td>Prevention and Education Task Force</td>
<td>Community Organizer</td>
<td>Planning</td>
<td>11/02</td>
<td>09/04</td>
</tr>
<tr>
<td>Carlisle Regional Advocates for Nutrition and Activity</td>
<td>Community Organizer</td>
<td>Planning/Implementation</td>
<td>04/05</td>
<td>05/06</td>
</tr>
<tr>
<td>Wellness at Work</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>02/05</td>
<td>05/06</td>
</tr>
<tr>
<td>Tobacco Prevention Outreach</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>03/06</td>
<td>05/06</td>
</tr>
<tr>
<td>Continuum of Care Task Force</td>
<td>Community Organizer</td>
<td>Planning</td>
<td>01/03</td>
<td>02/04</td>
</tr>
<tr>
<td>Prescription Coalition</td>
<td>Community Organizer</td>
<td>Planning/Implementation</td>
<td>03/04</td>
<td>06/05</td>
</tr>
<tr>
<td>Health Rx Program</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>10/04</td>
<td>05/06</td>
</tr>
<tr>
<td>Enrollment Task Force</td>
<td>Community Organizer</td>
<td>Planning/Implementation</td>
<td>03/04</td>
<td>05/06</td>
</tr>
<tr>
<td>Behavioral Health Task Force</td>
<td>Community Organizer</td>
<td>Planning</td>
<td>10/03</td>
<td>01/05</td>
</tr>
<tr>
<td>Behavioral Health Implementation Team</td>
<td>Community Organizer</td>
<td>Planning/Implementation</td>
<td>01/05</td>
<td>05/06</td>
</tr>
<tr>
<td>Behavioral Speakers Bureau</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>03/06</td>
<td>05/06</td>
</tr>
<tr>
<td>Substance Abuse Program</td>
<td>Community Resource</td>
<td>Implementation</td>
<td>03/06</td>
<td>05/06</td>
</tr>
</tbody>
</table>

Source: Carlisle Health and Wellness Foundation
Table E-2

Carlisle Regional Health Status Assessment
May, 2002

The following issues were noted in all three or two out of the three assessment components used by Community Health Development Specialists and Abacus Custom Research to complete the first regional health status assessment.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Secondary Data</th>
<th>Community Discussion Group</th>
<th>General Population Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost as barrier to access (insurance, doctor’s visits, and prescription medications)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mental health services (needed)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Obesity/Weight</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Health information and referral services (needed)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Services for children with emotional problems or delinquent behavior</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home health services (needed)</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Drug and alcohol abuse</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Teen pregnancy</td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Affordable housing</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
</tbody>
</table>

Source: Carlisle Regional Health Status Assessment Report (2002)
Sadler Health Center Task Force (SHC)

The Sadler Clinic was established in the early 1980's and evolved as part of the charitable mission of the Carlisle Hospital and Health Services (CHHS). CHHS sold its assets to Health Management Association in 2001, which agreed to maintain the health clinic for the uninsured in downtown Carlisle, for a period of two years before relinquishing responsibility back to the community. The Sadler Health Center Task Force was convened in February, 2002. The work group was comprised of ten members representing CAHWF board members and selected community members. The purpose of the task force was to determine the best way to continue Sadler Clinic operations at the end of the two year period. The task force studied the various configurations of programs for the un/underinsured population in the service area. The task force completed its review and recommended that a new non-profit corporation 501(c) 3 be formed to assume the operations of the Sadler Clinic. A community based Board of Trustees assumed responsibility for the Sadler Health Center, officially incorporated on October 25, 2002 and commenced operations in June 19, 2003. In February, 2004 the Center moved to a newly designed facility at 100 N. Hanover St. Designated as a Federally Qualified Health Center Look-Alike in 2005, the Sadler Health Center Corporation continues to provide primary health and dental services to the residents of Cumberland County, western Perry County and parts of Adams County and Franklin County, without regard to our patients’ ability to pay (fees based on a sliding-scale fee schedule may apply).

Carlisle Regional Health Status Assessment (HSA)

The Health Status Assessment resulted from meetings beginning in 2001 between the United Ways of Carlisle and Cumberland County, Cumberland County Partnership for a Healthy Community and CAHWF. As result of the meetings, a decision to pool resources and collaborate on a community wide health status assessment was reached. The completion of the research and the production of the report were completed by Community Health Development Specialists and Abacus Custom Research. The study was conducted from January through May, 2002. A community task force consisting of ten members representing CAHWF, Cumberland County, The United Way of Carlisle and Cumberland County, Carlisle Regional Medical Center, PA DOH, Cumberland – Perry Association for Retarded Citizens, and Domestic Violence Services for Cumberland and Perry Counties participated in the production of the study. These individuals reviewed the survey instrument, assisted in identifying individuals and groups to be included in the survey process, reviewed the research results and reviewed and commented on results and recommendations prior to the production of the final report. The HSA report was presented to the CAHWF Board of Trustees in May, 2002. The 2002 Health Status Assessment findings were presented to the public at a Community Health Summit in June, 2002.
Continuum of Care (COC)

The Continuum of Care study began in January, 2003. The study was funded by CAHWF. The completion of the quantitative and qualitative research and the production of the report were completed by Community Health Development Specialists. A community task force consisting of twenty-five members representing CAHWF, Sadler Health Center, private practice medical providers, mental health providers, the religious community, the educational community, business, state government, county government, and community members participated in the study. The objectives of the task force included defining and assessing the existing regional health system; identifying manageable, yet important, system improvement strategies; and creating a working plan for identified system improvements. To accomplish these objectives the task force was divided into two sub groups – access and service delivery, and finance and policy. The process included meetings, reading of assigned articles and studies, convening of external experts, and facilitated discussion. The COC task force activity was completed in November, 2003. The COC report “Building a Better Continuum of Care” was completed in February 2004. The COC findings were presented to the public at a Community Health Summit in October, 2004. The COC study focused on health systems versus the status of individual health. Seven areas were identified for action: Prescriptions, Enrollment, Public Policy, Access, Prevention, Workforce and System Coordination.

Prevention and Education Task Force (P&E)

The Prevention and Education Task Force was convened in November, 2002. The task force was comprised of fourteen members representing CAHWF, Carlisle Regional Medical Center, the religious community, the educational community, private medical providers, mental health providers, county government representatives and community representatives. The task force was formed to understand how to intervene at an early stage to reduce the incidence of disease that results largely from behavioral factors. Through their studies, the partnership members realized a consistent theme among the various chronic illnesses, namely that individual behavior is the primary contributor to chronic disease. And, the most four important behavioral factors negatively affecting health are cigarette smoking and use of other tobacco products; poor diet; lack of exercise; and substance abuse. The findings and recommendations of the P&E task force “A Framework for Health Promotion” were presented to the CAHWF Board of Trustees in September, 2004.
**Behavioral Health Task Force (BHTF)**

The Behavioral Health Task Force was convened in October, 2003. The task force was comprised of thirty (30) members representing government officials, consumers of mental health services, persons recovering from mental illness or substance abuse, family representatives, behavioral health and medical treatment providers, criminal justice and legal professionals, education personnel, members of the religious community as well as CAHWF staff. Both mental illness and substance abuse were studied in depth as well as the large percentage of people with both, or co-occurring disorders. “Opportunities and Challenges,” the in-depth report produced by the Behavioral Health Task Force was presented to the CAHWF Board of Trustees in January, 2005. The Behavioral Health Task Force findings were presented to the public at a Community Health Summit in January, 2005.

Source: Carlisle Area Health and Wellness Foundation
<table>
<thead>
<tr>
<th>LEVEL</th>
<th>DEFINITION</th>
<th>REGIONAL STRATEGY</th>
</tr>
</thead>
</table>
| **One**     | **Strengthening Individual Knowledge and Skills** | **Enhancing individual capacity**                                                                                                                                                                                                                                                                                                                                                                               
|             |                                                | Encourage more community organizations and institutions to share current health knowledge with constituents by creating opportunities for transfer for knowledge and fostering the change of norms and values.                                                                                                                                                                                                                          |
| **Two**     | **Promoting Community Education**              | **Reaching groups with information and resources**                                                                                                                                                                                                                                                                                                                                                                  
|             |                                                | Enhance positive media messages about health choices. Convene community-wide campaigns on health lifestyle choice, including the dissemination of information to a wide variety of organizations. Encourage all people to be active especially children, by supporting walking, biking, playing sports and exercising in local communities.                                                                                                                     |
| **Three**   | **Educating Providers**                        | **Informing providers who influence others**                                                                                                                                                                                                                                                                                                                                                                      
|             |                                                | Encourage physicians and other health practitioners to regularly communicate and briefly counsel patients regarding eating habits, activity and use of tobacco. Develop capacities and referral systems to help patients access further nutrition, physical activity, tobacco cessation and substance abuse resources.                                                                                                                                   |
| **Four**    | **Fostering Coalitions and Networks**          | **Convening groups and individuals for greater impact**                                                                                                                                                                                                                                                                                                                                                         
|             |                                                | Establish a broad-based coalition to support and advocate health promotion. Work with and strengthen communication between existing groups with health-related missions.                                                                                                                                                                                                                                           |
| **Five**    | **Changing Organizational Practices**          | **Adopting regulations and shaping norms**                                                                                                                                                                                                                                                                                                                                                                      
|             |                                                | Encourage and aide local institutions and organizations to adopt and promote healthier lifestyles and for their constituents, especially at schools and worksites.                                                                                                                                                                                                                                             |
| **Six**     | **Influencing Policy and Legislation**         | **Developing strategies to change laws and policies**                                                                                                                                                                                                                                                                                                                                                       
|             |                                                | Enhance the region’s ability to influence health-related legislation and regulation through appropriately active nonprofits and knowledgeable citizenry                                                                                                                                                                                                                                                       |

Table E-4 Prevention and Education Task Force Strategic Recommendations
### Capacity and Workforce

#### Recruitment and Retention

**Health Problem**
Concern over the current and anticipated numbers and types of health care providers in the Carlisle regional health system; specifically the limited number of surgeons, pediatricians, obstetricians, dentists, mental health providers, and registered nurses; limited number of providers who accept Medicaid

**Recommendation**
Plan, develop and implement a coordinated recruitment and retention strategy

#### Coordination of Activities

**Health Problem**
A health system is not as coordinated as it could, should or ought to be; it is currently fragmented/frayed/uncoordinated

**Recommendation**
Establishing a better/different connection among and between the provider community (primary care, dental health, mental health, specialty care and supportive services)

### Barriers to Access Points and Services

#### Creating Enhance Access

**Health Problem**
Limited affordable, accessible, adequate and continuous access to primary and preventative health services for the low income and uninsured population

**Recommendation**
Enhancement and/or establishment of existing access points in and for the Carlisle region.

#### Medicaid and CHIP Enrollment

**Health Problem**
Individuals that are eligible to participate in and be covered by Medicaid and CHIP may not be enrolled; those that are enrolled may not be fully aware of what/how they can access services

**Recommendation**
Coordinated Medicaid/CHIP education and enrollment strategy

#### Prescription Medication Assistance

**Health Problem**
High cost of prescription medications; limited or no insurance coverage for prescriptions

**Recommendation**
Enhance and develop an accessible, affordable and appropriate prescription assistance strategy
Health Resources, Education and Promotion Activities

Health Problem
Limited understanding and appreciation for the existing health, human and social service available in the Carlisle Region, with a particular focus on individuals (and the community) making healthier decisions and adopting a healthier lifestyle

Recommendation
Enhance and develop health education and promotion activities

Health Budget and Policy

Legislative and Resource Advocacy Strategy

Health Problem
Perception that legislation and policies are introduced deliberated and enacted without direct and balanced community health system input; similarly, resources may not be allocated properly if resource holder are working with limited or misinformation

Recommendation
Plan, develop and implement a coordinated legislative and resource advocacy strategy

Source: Continuum of Care Task Force Report “Building a Better Continuum of Care”
| **Table E-6**  
**Behavioral Health Task Force Recommendations** |
<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prevention and Wellness Recommendations</strong></td>
</tr>
<tr>
<td>1. Initiate public education campaigns to address stigma and wellness concepts.</td>
</tr>
<tr>
<td>2. Provide public and/or private insurance coverage – including behavioral health coverage – for all in need and assure that eligible persons are aware of it and have access to it.</td>
</tr>
<tr>
<td>3. Provide an opportunity to all families of infants and young children to receive screening and education regarding risk and resiliency factors related to behavioral health, as well as appropriate referrals and treatment.</td>
</tr>
<tr>
<td>4. Strengthen and expand school and community-based child and adolescent prevention/wellness/resiliency programs.</td>
</tr>
<tr>
<td><strong>Clinical Service Recommendations</strong></td>
</tr>
<tr>
<td>1. Improve education of healthcare and social service students and professionals regarding diagnosis and treatment of mental illness, substance abuse and dual diagnosis.</td>
</tr>
<tr>
<td>2. Increase collaboration and coordination among stakeholders, including service providers, persons in recovery, consumers, advocates, families, government officials, policy makers and funders.</td>
</tr>
<tr>
<td>3. Increase the consistent availability of qualified psychiatrists, and other allied professionals in our area.</td>
</tr>
<tr>
<td>4. Educate employers about insurance coverage for behavioral health.</td>
</tr>
<tr>
<td>5. Expand the outreach efforts of Crisis Services.</td>
</tr>
<tr>
<td>6. Develop an independent ombudsman program for persons with behavioral health problems.</td>
</tr>
<tr>
<td><strong>Supportive Service Recommendations</strong></td>
</tr>
<tr>
<td>1. Promote public policies that assure access to varied and creative housing opportunities to address the variety of people and their behavioral needs.</td>
</tr>
<tr>
<td>2. Develop and expand community supports, including assistance in connecting to community activities and organizations, transportation, psychological and social rehabilitation, case management and employment training/assistance.</td>
</tr>
<tr>
<td>3. Promote financial assistance for medication costs of individuals who are without coverage or between coverage.</td>
</tr>
<tr>
<td>4. Support the recommendations of the Cumberland County Criminal Justice Policy Team’s Mental illness Subcommittee report on local forensic issues and needs.</td>
</tr>
</tbody>
</table>

Source: Behavioral Health Task Force Report “Opportunities and Challenges”
Table E-7 CAHWF Planning Network “Working Groups”

**Enrollment Task Force (ENR)**

The Enrollment Task Force was convened in March, 2004. The task force consists of CAHWF members, county government representatives and school district representatives. The task force used several strategies to increase awareness of and participation in CHIP, the state program for children’s health. Four school districts in Cumberland and Perry Counties participate annually in this effort. CAHWF awarded a $3,000 grant in May 2005 to a non-profit community organization, Join Hands, to sustain this initiative in western Perry County.

**Behavioral Health Implementation Team (BHIT)**

The Behavioral Health Implementation Team was organized in January, 2005. The team is comprised of former members of the Behavioral Health Task Force. The objective of the team is to implement actions recommended by the Behavioral Health Task Force. The team is organized into three committees for the purpose of implementing these changes. These committees are prevention, clinical, and supportive. CAHWF administratively supported the three subcommittees and actively participated with these subgroups. Each group centered their activities on a particular task force recommendation. The clinical subcommittee explored ways to decrease “no shows” at provider agencies to improve provider efficiency and accessibility. As a result of the clinical subcommittee’s efforts, CAHWF approved a foundation initiative grant for $4,500 in June 2006 to fund a pilot project at a behavioral health office site, the NHS/Stevens Center. In 2006, an interactive telephone system capable of automatically reminding patients of appointments was installed to reduce “no shows”. In an effort to address stigma and introduce wellness concepts, the prevention subcommittee identified several behavioral health advocacy groups and assisted these groups in the development of a behavioral health speaker bureau, “In My Own Words”. CAWHF awarded a foundation initiative grant for $10,000 in March, 2006 to fund this project.

**Prescription Coalition (PC)**

The Prescription Coalition was convened in March, 2004. The work group was comprised of six members representing CAHWF, the county government, Sadler Health Center and volunteer pharmacists. The Prescription Coalition reviewed prescription assistance programs in twenty other similarly sized communities. After a review of “best practices” literature, telephone interviews and on-site visits, the coalition prepared a report and presented its recommendations to the Board of Trustees at the October, 2004 board meeting. The prescription Coalition’s work resulted in the approval of a proactive grant to the Sadler Health Center Corporation for the start up of the Healthy Community Rx Program.

Source: Carlisle Area Health and Wellness Foundation
The Carlisle Regional Advocates for Nutrition and Activity (CRANA)

CAHWF facilitated the formation and development of the Carlisle Regional Advocates for Nutrition and Activity. (CRANA) first convened in April, 2005. The coalition is a broad-based collaboration formed to improve the nutrition and activity levels of people in the Carlisle region at the community, school/youth and workplace levels through behavior-based education, programs and activities. CRANA members include American Cancer Society, American Heart Association, Big Spring School District, Borough of Carlisle, Carlisle Area Health and Wellness Foundation, Carlisle Area School District, Carlisle Borough, Parks and Recreation, Carlisle Family YMCA, Carlisle Regional Medical Center, Central PA Magazine, Cumberland County HR, Cumberland County Planning Commission, Cumberland Valley School District, Cumberland/Perry Tapestry of Health, Family Health Council of Central PA, Highmark Blue Shield, Highmark Caring Foundation, PA Department of Health, Pennsylvania Advocates for Nutrition and Activity, Sadler Health Center Corporation, Shippensburg Parks and Recreation, South Middleton School District, South Middleton Township, Strong Consulting Company and the YWCA of Carlisle. Activities are coordinated and sponsored by the Carlisle Area Health & Wellness Foundation (CAHWF). Three subcommittees have been formed around the three levels of activity stated above – community, school/youth and workplace.

Source: Carlisle Area Health and Wellness Foundation
<table>
<thead>
<tr>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Disease</td>
<td>$2,019,284</td>
<td>$864,994</td>
<td>$1,343,06</td>
<td>$1,193,244</td>
<td>$5,420,582</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>433,771</td>
<td>946,525</td>
<td>507,879</td>
<td>754,612</td>
<td>2,642,787</td>
</tr>
<tr>
<td>Oral Health</td>
<td>1,030,550</td>
<td>337,500</td>
<td>344,000</td>
<td>248,848</td>
<td>1,960,900</td>
</tr>
<tr>
<td>General Mission</td>
<td>223,456</td>
<td>151,759</td>
<td>100,000</td>
<td>110,000</td>
<td>585,215</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$3,707,063</strong></td>
<td><strong>$2,300,778</strong></td>
<td><strong>$2,294,939</strong></td>
<td><strong>$2,306,704</strong></td>
<td><strong>$10,609,484</strong></td>
</tr>
</tbody>
</table>

**FY 2002-2003**
$2,626,379 of the $3,707,063 or (71%) of approved grants were awarded to the Sadler Health Corporation to meet capital and 2003-2004 operating requirements. The Sadler Health Corporation grants were allocated as follows: chronic illness $1,545,827; oral health $1,030,552; general mission $50,000.

**FY 2003-2004**
$800,000 of the $2,300,778 or (35%) of approved grants were awarded to the Sadler Health Corporation to meet 2004-2005 operating requirements. The Sadler Health Corporation grants were allocated as follows: chronic illness $412,400; oral health $337,500.

$946,994 of the $2,300,778 or (41%) of approved grants were awarded to behavioral health services. $572,054 or (60%) of the total approved behavioral health grants were awarded to two service providers. Adams Hanover Counseling Services received a $350,000 three year grant to start up and manage a community psychiatric practice in the Carlisle area. Northwestern Services/Stevens Center received $222,054 two year grant to support the addition of an outpatient clinical treatment team.
FY 2004-2005
$1,000,000 of the $2,294,939 or (44%) of approved grants were awarded to the Sadler Health Corporation to meet 2005-2006 operating requirements. The Sadler Health Corporation grants were allocated as follows: chronic illness $656,000; oral health $344,000. $200,000 of the $656,000 allocated to the chronic illness category was a three year grant earmarked for the prescription initiative, Health Rx.

FY 2005-2006
$1,024,880 of the $2,306,704 or (44%) of approved grants were awarded to the Sadler Health Corporation to meet capital and 2006-2007 operating requirements. The Sadler Health Corporation grants were allocated as follows: chronic illness $776,080; oral health $248,800. $24,880 of the $776,080 allocated to the chronic illness category was for the start up of a smoking education and cessation program at Sadler Health Center.

Within the behavioral health category, Northwestern Services/Stevens Center received a $222,054 two year grant renewal to support the addition of an outpatient clinical treatment team.

Other
Prevention and education services as well as services focused on vulnerable populations are not separately shown but are incorporated in the four categories.

The general mission category is predominantly comprised of grant awards for academic scholarships.

Source: Carlisle Health and Wellness Foundation
### Table E-10 CAHWF Partnerships

<table>
<thead>
<tr>
<th><strong>Healthy Community Rx: Prescription Initiative Sadler Health Center (HRX)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The 2002 Health Status Assessment (HSA) initially identified the community health concern over access barriers to prescription medication. The Continuum of Care (COC) study reconfirmed the problem. In most cases, the treatment of chronic, life-threatening conditions and serious behavioral health problems require medication to improve patients’ chances of overcoming these debilitating illnesses. CAHWF in collaboration with the Sadler Health Center initiated a pharmaceutical program start up in late 2004 that became operational in November, 2005. CAHWF funded the initial project and continues to fund the service. Sadler manages the program ensuring that prescriptions for life threatening or behavioral needs of uninsured and under insure persons at or below the 200% of the Federal poverty Guidelines are received. The program was initially opened to Sadler patients but currently serves all community members.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Adams-Hanover Counseling Services (AHCS)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHWF began collaboration with Adams-Hanover Counseling Services in September, 2003 for the purpose of increasing psychiatric resources in the CAHWF service area. The collaboration successfully recruited a community psychiatrist and opened a new Carlisle practice in October, 2005. CAHWF provided the funding for the recruitment; practice start up costs; and, operating losses resulting from practice operations (funding was approved for a three years of operations). Adams-Hanover Counseling Services provided administrative and management practice support. This full-time practice remains in operation as an independent practice (September, 2007) and focuses on medical evaluation, management and stabilization for a mix of public and private patients.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Carlisle Mobilization Recovery Effort – Behavioral Speakers Bureau (BSB)</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Through the work of the Behavioral Health Implementation Team, CAHWF partnered with the RASE project, the Carlisle Recovery Mobilization Effort and NAMI (a national grass roots mental health advocacy organization) to fund and develop a speakers bureau. In March 2006 CAHWF awarded a grant to Substance Abuse Services, Inc. for this purpose. An independent, non-profit 501(c3) incorporated in 2000, Substance Abuse Services, Inc (SASI), created the RASE Project in 2001. RASE stands for Recovery, Advocacy, Service, and Empowerment. The RASE Project was designed to provide a voice for the anonymous recovering population. The mission of RASE is to assist all those individuals affected by substance use issues, problems, and concerns by fostering progress, enriching lives, and ultimately enhancing the recovery process. The Carlisle Mobilization Recovery Effort (CRME) was established in 2005 as the first satellite office of the RASE project. Its carries out RASE’s mission in CAHWF’s service area. CRME manages the speaker’s bureau and relies on it as one approach to reduce stigma and discrimination against people who have experienced behavioral health problems.</td>
</tr>
</tbody>
</table>
Hope Station – Substance Abuse Program (SAP)

CAHWF actively collaborated with the Cumberland-Perry Substance Abuse Prevention Coalition (SAPC) in 2005 to develop a project targeted at creating greater awareness and providing education on substance abuse issues. The final project funded by CAHWF in March 2006, employing the Hope Station Opportunity Area Neighborhood Council as the fiscal agent for the grant, supported three distinct prevention campaigns. First, funds were provided for the development and distribution of a family activity guide designed to promote positive family interaction and healthy alternatives to substance abuse. Second, funds were designated to pay for radio air time to run a series of paid radio advertisements focused on the critical role of parents in the prevention of substance abuse by their children. Third, six installments of a comic strip, The Family Business, were purchased. This comic strip featured prevention messages for parents and families. It was featured in regional publications, community newsletters, and church bulletins.

Wellness at Work/Pilot Project (WW)

The Carlisle Area Health & Wellness Foundation (CAHWF), in partnership with the Greater Carlisle Area Chamber of Commerce and seven area employers began discussions on a pilot workplace wellness project in February, 2005 and began the project in June 2005. Participating employers include the public, private and nonprofit sectors and range in size from 100 to 1200 employees, with a total of about 2600 employees in the pilot project. At the project’s inception, CAHWF actively partnered with the Greater Carlisle Chamber of Commerce and seven area employers in the selection of a consultant, The Susan P. Byrnes Health Education Center, to lead the endeavor. Wellness at Work programs were started at each of the participating employer’s work sites. CAHWF provided administrative support for the project and participated in all of the group meetings during the period under review. Although each of the participants contributed to program costs, CAHWF was the primary funding source awarding grants of $56,612 on June 14, 2005 and $78,565 on June 20, 2006. The short term objective of the project is to improve the health of participating member’s employees. The long term objective of the project is to demonstrate the benefit of wellness at work programs for the purpose of changing societal norms, employee behavior and institutional policy and procedures that ideally will lead to the improvement of overall community health status.

Sadler Health Center – Tobacco Prevention Outreach (TPO) CAHWF actively collaborated with the Cumberland-Perry Tobacco Prevention Coalition in 2005 to develop a project aimed at increasing awareness of the effects of tobacco. The final project funded by CAHWF on March 29 2006 with a $24,880 proactive grant to the Sadler Health Center was designed to achieve three objectives. First, funds were included to provide a part-time clerical assistance to the Tobacco Treatment Specialist (TTS) at Sadler Health Center. This staffing increase was aimed at providing the TTS with additional time to devote to provide increased cessation services especially in Perry County. Second, it was expected with the additional staffing the TTS would also be able to increase outreach efforts with physician and dentist offices in the community. Finally, a portion of the funds was dedicated to pay for radio advertising to promote the Sadler’s cessation program.
Table E-11  The Value of Networking

**Increased Individual Organization Management Knowledge and Resources**  
Community Representative in Response to Participation on Behavioral Health Task Force

“No there were a lot of new people. I mean there were some I had worked with, but there were a number I had never met before. They (CAHWF) brought in a lot of health professionals and people from that area which I really don’t ever touch on too much. It was beneficial to me because I got to expand my horizons.”

Service Provider in Response to Participation on Enrollment Task Force  
*comment on ability to solve insurance related problems for staff members*

“So, yes, that definitely affects the performance of my job because I know the people now, I know some of the people at the HMO. I can pick up the phone and call the guy that runs the hospital. I couldn’t have done that otherwise. So, yea, professionally that certainly helps your organization.”

**Increased Community Trust**  
Service Provider in Response to Participation on Behavioral Health Task Force

“I think that it (CAHWF) brought together the right people. On that group we were able to think about things from others’ viewpoints. (For example) it is difficult to be a consumer trying to see the legal side of things, or, being a legal person, and trying to understand a family members’ side of things. You know, so I think that it (task force meetings) did a real good job of bringing all that out… And, in conversation, you’re able to kind of share those things. Which in turn starts to break down stigma, I think, misunderstanding, I think all kinds of things.”

**Increased Inter-Organizational Communication and Cooperation**  
Service Provider in Response to Participation in Wellness at Work Project

“I’m part of the wellness at work and I think it’s just amazing how the community has come together and we realize there is a lot of issues related to health and if we don’t work together and bring the organizations within the Greater Carlisle community together we’re going to fail. So there’s a lot of effort that’s taking place. I know we want to take this to the next level ( beyond the existing project members) with your organizations (other members of focus group) and work collaboratively so instead of working in isolation we might be sharing resources and doing things and sharing best practices and lessons learned on our wellness programs.”
Strengthening of Ties Between Organizations
CAHWF Board Member in Response to Participation on Sadler Health Task Force
(appointment of Sadler Health Center Board member to CAHWF committee)

“I think it’s (Sadler Task Force) effective because I do think that there are folks and there have been, Dr. F. is on the public policy committee of the Foundation and so there has been cross-pollination between the two groups…”

Sources: Key Stakeholder Interviews and Focus Groups conducted by Researcher
Table E-12

**PREVENTION AND EDUCATION TASK FORCE TIMELINE**

<table>
<thead>
<tr>
<th>Month</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2002</td>
<td>Invitation to potential Task force members.</td>
</tr>
<tr>
<td>December 2002</td>
<td>Chose topics to study: Cancer, Cardiovascular Disease, Diabetes, Asthma, Substance Abuse</td>
</tr>
<tr>
<td>January 2003</td>
<td>Prevention Overview by Dr. Sam Monismith (Penn State)</td>
</tr>
<tr>
<td>February 2003</td>
<td>Study of Asthma. Expert speakers were Dr. Leon Sweer of Carlisle Regional Medical Center and</td>
</tr>
<tr>
<td>March 2003</td>
<td>John Hughes, Program Director of Respiratory Therapy at Millersville University</td>
</tr>
<tr>
<td>April 2003</td>
<td>Process asthma information for interim report. Visit the Hanover Wellness Connection in Hanover PA.</td>
</tr>
<tr>
<td>June 2003</td>
<td>Andrew J. Behnke, M.D. (Cumberland Valley Endocrinology Center, LLC)</td>
</tr>
<tr>
<td>July 2003</td>
<td>Process diabetes information for interim report.</td>
</tr>
<tr>
<td>August 2003</td>
<td>Study of Cardiovascular Disease. Dr. Lynn Smaha, (Past President of national office of the American Heart Association)</td>
</tr>
<tr>
<td>September 2003</td>
<td>Joyce Levin R.N., PA Department of Health</td>
</tr>
<tr>
<td>October 2003</td>
<td>Process cardiovascular information for interim report.</td>
</tr>
<tr>
<td>November 2003</td>
<td>Study of Substance Abuse. Special speakers were from Perry Human Services and Cumberland-Perry Drug &amp; Alcohol Commission.</td>
</tr>
<tr>
<td>December 2003</td>
<td>Process drug and alcohol information for interim report.</td>
</tr>
<tr>
<td>March 2004</td>
<td>Wallace A. Longton, M.D., specialist in Radiation Oncology</td>
</tr>
<tr>
<td>April 2004</td>
<td>Process cancer information for interim report.</td>
</tr>
<tr>
<td>June 2004</td>
<td>Community Focus Group</td>
</tr>
<tr>
<td>July 2004</td>
<td>Review First Draft of Final Report</td>
</tr>
<tr>
<td>September 2004</td>
<td>Release Final Report</td>
</tr>
</tbody>
</table>

**Source:** Prevention and Education Task Force Report: “A Framework for Health Promotion”
<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>October 15, 2003</td>
<td>Organizational Meeting</td>
</tr>
<tr>
<td>November 19, 2003</td>
<td>Prevention/Wellness Panel on Substance Abuse (AODD)</td>
</tr>
<tr>
<td>December 17, 2003</td>
<td>Prevention/Wellness Panel on Mental Illness (MI)</td>
</tr>
<tr>
<td>January 21, 2004</td>
<td>Prevention/Wellness Recommendations – Group Process</td>
</tr>
<tr>
<td>February 18</td>
<td>Overview of the Local MH/D&amp;A Service Continuum</td>
</tr>
<tr>
<td>March 17</td>
<td>Clinical Services Panel on AODD</td>
</tr>
<tr>
<td>April 21</td>
<td>Clinical Services Panel on MI</td>
</tr>
<tr>
<td>May 19</td>
<td>Clinical Services Recommendations - Group Process</td>
</tr>
<tr>
<td>June 16</td>
<td>Supportive Services Panel for AODD</td>
</tr>
<tr>
<td>July 21</td>
<td>Supportive Services Panel for MI</td>
</tr>
<tr>
<td>August 18</td>
<td>Supportive Services Recommendations</td>
</tr>
<tr>
<td>September 15</td>
<td>Crisis and Forensic Services</td>
</tr>
<tr>
<td>October 20</td>
<td>Draft Report Review – Task Force</td>
</tr>
<tr>
<td>November-December</td>
<td>Final Report Review - Steering Committee</td>
</tr>
<tr>
<td>December 14</td>
<td>Presentation to Foundation Board</td>
</tr>
<tr>
<td>January 12, 2005</td>
<td>Release of Final Report</td>
</tr>
</tbody>
</table>

**Source:** Behavioral Health Task Force Report: “Opportunities and Challenges”
Behavioral Health Task Force Funded Recommendations
“Opportunities and Challenges” Final Report
January, 2005

Prevention and Wellness Recommendations
Initiate public education campaigns to address stigma and wellness concepts.

<table>
<thead>
<tr>
<th>Grant Awards</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Substance Abuse Services, Inc.</td>
<td></td>
</tr>
<tr>
<td><strong>Carlisle Recovery Mobilization Effort</strong></td>
<td></td>
</tr>
<tr>
<td>$64,000.00 Approval Date 06/14/05</td>
<td></td>
</tr>
<tr>
<td>$71,332.00 Renewal Date 06/20/06</td>
<td></td>
</tr>
<tr>
<td>This pilot program utilizes Carlisle-area persons in recovery to create an advocacy group that will educate the public and policy makers about successful treatment of and recovery from substance abuse and alcohol addiction.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse Services, Inc.</th>
<th>Behavioral Health Speakers Bureau</th>
</tr>
</thead>
<tbody>
<tr>
<td>$10,000.00 Approval Date 03/29/06</td>
<td></td>
</tr>
<tr>
<td>A speakers’ bureau composed of persons and family members in recovery will share their own experiences in hopes of lessening stigma by increasing the understanding of addiction and mental illness and its impact on family, business and community life.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Substance Abuse Services, Inc.</th>
<th>Spring Recovery Jam 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,485.00 Approval Date 03/24/06</td>
<td></td>
</tr>
<tr>
<td>Publicity and implementation costs were granted for a one-day recovery event.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hope Station</th>
<th>Substance Abuse Prevention Coalition Media Education Promotion</th>
</tr>
</thead>
<tbody>
<tr>
<td>$24,800.00 Approval Date 06/19/06</td>
<td></td>
</tr>
<tr>
<td>This multifaceted prevention initiative uses family-based materials, a comic strip and public service announcements to address educate and increase public awareness of current local alcohol, tobacco and other drug (ATOD) issues.</td>
<td></td>
</tr>
</tbody>
</table>

Provide public and/or private insurance coverage – including behavioral health coverage – for all in need and assure that eligible persons are aware of it and have access to it.
Provide an opportunity to all families of infants and young children to receive screening and education regarding risk and resiliency factors related to behavioral health, as well as appropriate referrals and treatment.

Grant Awards
United Cerebral Palsy of Central PA, Inc.

**Early Intervention**
$87,000.00 Approval Date 10/11/05
An early intervention service to children with disabilities provides therapy when it can have a great impact.
United Way of Carlisle and Cumberland County

**Success by Six Preschool Health Curriculum**
$20,100.00 Approval Date 06/29/05
A comprehensive health education curriculum will be implemented along with providing supportive materials in area preschools.

Strengthen and expand school and community-based child and adolescent prevention/wellness/resiliency programs.

Grant Awards
Diakon Lutheran Social Ministries

**Perry Families Initiative**
$131,546.00 Approval Date 04/08/03
$141,217.00 Renewal Date 06/14/05
$137,714.00 Renewal Date 06/20/06
Intensive counseling supports Perry County children who are at risk of out-of-home placement and their families. Renewal.

Perry Human Services

**Teen and Family Support Services**
$17,030.00 Approval Date 06/29/05
Services are starting for at risk youth and their families to include a new teen support group and an enhanced parent/family support group.

United Way of Adams County

**Project Venture**
$95,627.00 Approval Date 02/14/06
A collaborative two year program with Upper Adams School District will focus on building resiliency and leadership skills to reduce alcohol and other drug use among middle school students.
Clinical Service Recommendations

Improve education of healthcare and social service students and professionals regarding diagnosis and treatment of mental illness, substance abuse and dual diagnosis.

Increase collaboration and coordination among stakeholders, including service providers, persons in recovery, consumers, advocates, families, government officials, policy makers and funders.

Increase the consistent availability of qualified psychiatrists, and other allied professionals in our area.

Grant Awards
Adams-Hanover Counseling
Shelter Services
$ 49,999.00 Approval Date 12/10/02
$ 48,084.00 Renewal Date 12/09/03
$118,825.00 Renewal Date 02/08/05
On-site mental health and substance abuse counseling at James Wilson Safe Harbor, Sadler Health Center and the Domestic Violence Services for Cumberland and Perry Counties. Renewal for two years

NHS/The Stevens Center
Drug and Alcohol
$55,400.00 Approval Date 10/11/05
Outpatient substance abuse treatment is provided to clients, many of whom also have mental illness.

NHS/The Stevens Center
Comprehensive Clinical Team
$222,054.00 Approval Date 04/13/04
$222,054.00 Renewal Date 02/14/06
A team made up of a psychiatrist, physician assistant and psychiatric nurse increases access to services and reduces waiting times for residents of Cumberland and Perry counties.
Renewal

Educate employers about insurance coverage for behavioral health.

Expand the outreach efforts of Crisis Services.

Develop an independent ombudsman program for persons with behavioral health problems.
Supportive Service Recommendations

Promote public policies that assure access to varied and creative housing opportunities to address the variety of people and their behavioral needs.

Develop and expand community supports, including assistance in connecting to community activities and organizations, transportation, psychological and social rehabilitation, case management and employment training/assistance.

Promote financial assistance for medication costs of individuals who are without coverage or between coverage.

Grant Award
Todd Baird Lindsey Foundation

Medication Assistance
$ 9,999.00 Approval Date 01/28/04
$12,000.00 Renewal Date 01/26/05
$16,000.00 Renewal Date 01/25/06
Medication assistance program

Health Share Community Partnership

Prescription and Durable Medical Equipment
$ 9,999.00 Approval Date 10/22/03
$15,000.00 Renewal Date 05/25/05
Prescription drugs and durable medical equipment are provided for low-income persons in the CAHWF area.

Sadler Health Center Corporation

Prescription Initiative
$200,000.00 Approval Date 10/12/04
Uninsured and underinsured persons at or below 200% of federal poverty guidelines will be assisted to obtain prescriptions to treat chronic, life-threatening diseases such as diabetes, asthma, COPD and hypertension as well as behavioral health needs.

Samaritan Fellowship, Inc.

Prescriptions Plus
$8,000.00 Approval Date 04/28/04
Prescription drugs and durable medical equipment is provided for low-income persons in the Carlisle area.

Cumberland-Perry Association for Retarded Citizens (CPARC)

Prescriptions Advocate for Medicare Part D / Cumberland County
$25,000.00 Approval Date 08/24/05
Through CPARC, a temporary coordinator will work in Cumberland County for six months to assist in the provider and volunteer training, promotion and enrollment of individuals into the new government prescription program.
Cumberland-Perry Association for Retarded Citizens (CPARC)

**Prescription Advocate for Medicare Part D / Perry County**

$10,340.00  Approval Date 08/24/05

Through CPARC, a temporary coordinator will work in Perry County for six months to assist in the provider and volunteer training, promotion and enrollment of individuals into the new government prescription program.

Cumberland-Perry Association for Retarded Citizens (CPARC)

**Extension of Medicare D Prescription Enrollment Advocates for Cumberland and Perry Counties**

$7,128.00 Approval Date 02/14/06

An extension of services for two temporary coordinators to focus on the new Medicare D Prescription program was granted. Renewal

**Support the recommendations of the Cumberland County Criminal Justice Policy Team’s Mental illness Subcommittee report on local forensic issues and needs.**

Source: Carlisle Area Health and Wellness Foundation
Table E-15
Continuum of Care Task Force Funded Recommendations
“Building a Better Continuum of Care” Final Report
February, 2004

Capacity and Workforce

Recruitment and Retention

Health Problem
Concern over the current and anticipated numbers and types of health care providers in the Carlisle regional health system; specifically the limited number of surgeons, pediatricians, obstetricians, dentists, mental health providers, and registered nurses; limited number of providers who accept Medicaid

Recommendation
Plan, develop and implement a coordinated recruitment and retention strategy

Grant Awards
Carlisle Area Healthcare Auxiliary
Health Professional Scholarships
$25,000.00 Approval Date 06/27/03
$25,000.00 Renewal Date 01/13/04
$25,000.00 Renewal Date 01/11/05

Funding for scholarships for local students who are pursuing post-high school degrees in healthcare-related fields. Students will be encouraged to return to CAHWF’s service area to work after graduation.

HACC Foundation
Scholarships
$75,000.00 Approval Date 01/13/04
$75,000.00 Renewal Date 01/11/05
$75,000.00 Renewal Date 02/14/06

Funding for scholarships for local students who are pursuing post-high school degrees in healthcare-related fields. Students will be encouraged to return to CAHWF’s service area to work after graduation.

Carlisle Area Healthcare Auxiliary
Luella Davis Scholarship
$10,000.00 Approval Date 04/26/06
A one-time gift was added to the Carlisle Area Healthcare Auxiliary scholarship fund in honor of the contributions to local healthcare made by Luella Davis, RN and the H. Robert Davis, MD family.
Coordination of Activities

**Health Problem**
A health system is not as coordinated as it could, should or ought to be; it is currently fragmented/frayed/uncoordinated

**Recommendation**
Establishing a better/different connection among and between the provider community (primary care, dental health, mental health, specialty care and supportive services)

**Barriers to Access Points and Services**

**Creating Enhance Access**

**Health Problem**
Limited affordable, accessible, adequate and continuous access to primary and preventative health services for the low income and uninsured population

**Recommendation**
Enhancement and/or establishment of existing access points in and for the Carlisle region.

---

**Grant Awards**
Sadler Health Center Corporation

**New Clinic**
$2,250,000.00 Approval 2002-2003
This funding has allowed the organization to hire an Interim Director to coordinate the transition of the existing Sadler Clinic to the Sadler Health Center and to cover the costs associated with the transition. The clinic provides comprehensive health care services in downtown Carlisle. Initial Funding: $150,000. Building: $1,000,000; 2003-2004 operations $1,400,000

Sadler Health Center Corporation

**2004-05 Operations**
$750,000.00 Approval 2003-2004
Major funding for the health center that provides medical, dental and mental health services in the CAHWF region.

Sadler Health Center Corporation

**2005-06 Operations**
$800,000.00 Approval 2004-2005
Financial support provided for health center operations in 2005-06, including additional funds for a capital reserve fund. Renewal.

Sadler Health Center Corporation

**2006-07 Operations**
$800,000.00 Approval 2005-2006
Core support for the community health center that serves thousands of area residents. Sadler provides medical and dental care, tobacco cessation programs, immunizations, HIV/STD testing and treatment, prevention/education services and a prescription assistance program. Renewal $248,000 (dental); $552,000 (medical)
Sadler Health Center Corporation  
**Renovation**  
$200,000.00 Approval 2005-2006  
Funds reserved for a major renovation and upgrade of the Sadler Health Center’s physical space and telephone system, planned for 2006-07.

---

**Medicaid and CHIP Enrollment**  
**Health Problem**  
Individuals that are eligible to participate in and be covered by Medicaid and CHIP may not be enrolled; those that are enrolled may not be fully aware of what/how they can access services  
**Recommendation**  
Coordinated Medicaid/CHIP education and enrollment strategy

<table>
<thead>
<tr>
<th>Grant Award</th>
<th>Join Hands</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>COMPASS Pilot for Perry County</strong></td>
<td></td>
</tr>
<tr>
<td>$3,000.00 Approval Date 05/25/05</td>
<td></td>
</tr>
<tr>
<td>Support and assistance is offered to help parents sign up for the Children's Health Insurance Program and other related programs.</td>
<td></td>
</tr>
</tbody>
</table>

---

**Prescription Medication Assistance**  
**Health Problem**  
High cost of prescription medications; limited or no insurance coverage for prescriptions  
**Recommendation**  
Enhance and develop accessible, affordable and appropriate prescription assistance Strategy

<table>
<thead>
<tr>
<th>Grant Award</th>
<th>Todd Baird Lindsey Foundation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medication Assistance</strong></td>
<td></td>
</tr>
<tr>
<td>$ 9,999.00 Approval Date 01/28/04</td>
<td></td>
</tr>
<tr>
<td>$12,000.00 Renewal Date 01/26/05</td>
<td></td>
</tr>
<tr>
<td>$16,000.00 Renewal Date 01/25/06</td>
<td></td>
</tr>
<tr>
<td>Medication assistance program</td>
<td></td>
</tr>
</tbody>
</table>

Health Share Community Partnership  
**Prescription and Durable Medical Equipment**  
$ 9,999.00 Approval Date 10/22/03  
$15,000.00 Renewal Date 05/25/05  
Prescription drugs and durable medical equipment are provided for low-income persons in the CAHWF area.
Sadler Health Center Corporation  
**Prescription Initiative**  
$200,000.00 Approval Date 10/12/04  
Uninsured and underinsured persons at or below 200% of federal poverty guidelines will be assisted to obtain prescriptions to treat chronic, life-threatening diseases such as diabetes, asthma, COPD and hypertension as well as behavioral health needs.

Samaritan Fellowship, Inc.  
**Prescriptions Plus**  
$8,000.00 Approval Date 04/28/04  
Prescription drugs and durable medical equipment is provided for low-income persons in the Carlisle area.

Cumberland-Perry Association for Retarded Citizens (CPARC)  
**Prescriptions Advocate for Medicare Part D / Cumberland County**  
$25,000.00 Approval Date 08/24/05  
Through CPARC, a temporary coordinator will work in Cumberland County for six months to assist in the provider and volunteer training, promotion and enrollment of individuals into the new government prescription program.

Cumberland-Perry Association for Retarded Citizens (CPARC)  
**Prescription Advocate for Medicare Part D / Perry County**  
$10,340.00 Approval Date 08/24/05  
Through CPARC, a temporary coordinator will work in Perry County for six months to assist in the provider and volunteer training, promotion and enrollment of individuals into the new government prescription program.

Cumberland-Perry Association for Retarded Citizens (CPARC)  
**Extension of Medicare D Prescription Enrollment Advocates for Cumberland and Perry Counties**  
$7,128.00 Approval Date 02/14/06  
An extension of services for two temporary coordinators to focus on the new Medicare D Prescription program was granted. Renewal

Join Hands  
**Emergency Access for Prescription Medication**  
$10,000.00 Approval Date 04/16/03  
$25,000.00 Renewal Date 07/28/04  
$25,000.00 Renewal Date 01/25/06  
Prescribed medication and limited medical equipment is procured for people who are under/uninsured. Renewal
Health Resources, Education and Promotion Activities
Health Problem
Limited understanding and appreciation for the existing health, human and social service available in the Carlisle Region, with a particular focus on individuals (and the community) making healthier decisions and adopting a healthier lifestyle
Recommendation
Enhance and develop health education and promotion activities
Response
Refer to Prevention and Education Responses

Health Budget and Policy

Legislative and Resource Advocacy Strategy
Health Problem
Perception that legislation and policies are introduced deliberated and enacted without direct and balanced community health system input; similarly, resources may not be allocated properly if resource holder are working with limited or misinformation
Recommendation
Plan, develop and implement a coordinated legislative and resource advocacy strategy

Source: Carlisle Area Health and Wellness Foundation
Table E-16  
Prevention and Education Task Force Funded Recommendations  
“A Framework for Health Promotion” Final Report  
September, 2004

<table>
<thead>
<tr>
<th>Level One</th>
<th>Strengthening Individual Knowledge and Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Definition</td>
<td>Enhancing individual capacity</td>
</tr>
<tr>
<td>Regional Strategy</td>
<td>Encourage more community organizations and institutions to share current health knowledge with constituents by creating opportunities for transfer for knowledge and fostering the change of norms and values.</td>
</tr>
</tbody>
</table>

### CAHWF GRANTS

Carlisle Area Religious Council (Project S.H.A.R.E)  
**Infant Formula and Adult Nutrition**  
$57,959.00  Approval Date  12/10/02  
$55,900.00  Renewal Date  12/09/03  
$146,000.00  Renewal Date  02/08/05  
Infant formula, fresh fruits, vegetables and other nutritious foods are provided for persons in the Carlisle area.  
Renewal for two years

Family Health Council of Central PA, Inc.  
Cumberland Perry Tapestry of Health  
**Cooking and Nutrition**  
$17,200.00  Approval  Date 06/29/05  
Funds provide cooking classes to lower-income and at-risk population to improve family nutrition.

Carlisle Area Religious Council (Project S.H.A.R.E.)  
**Regional Share**  
$15,700.00  Approval Date 04/13/04  
$2,000.00  Renewal Date 11/08/05  
The delivery of fresh produce and perishable goods to other food banks is enhanced through coordination and transportation.
**Level Two**  
**Promoting Community Education**  
**Definition**  
Reaching groups with information and resources  
**Regional Strategy**  
Enhance positive media messages about health choices.  
Convene community-wide campaigns on health lifestyle choice, including the dissemination of information to a wide variety of organizations.  
Encourage all people to be active especially children, by supporting walking, biking, playing sports and exercising in local communities.

**CAHWF GRANTS**

**Bosler Free Library**  
**Consumer Health Library**  
$126,500.00 Approval Date 04/08/03  
Develop and maintain a health resources collection and provide health screenings/education at library sites. This grant uses several libraries in the CAHWF area.

**Diakon Lutheran Social Ministries**  
**Big Spring Senior Center**  
$2,000.00 Approval Date 04/16/03  
The Big Spring Senior Center will initiate Experts on Health project. This is an educational project that brings qualified professionals

**Cumberland Valley Diabetes Education and Awareness Fund**  
**Diabetes Awareness Day**  
$2,000.00 Approval Date 02/01/05  
A local Diabetes Awareness Day featured national speakers and education for the public and providers.

**Hoffman Homes, Inc.**  
**Youth Fitness Center**  
$9,500.00 Approval Date 01/26/05  
Equipment was purchased for a new Fitness Center and teen obesity program.

**Mooreland Elementary School**  
**Walking Program**  
$1,950.00 Approval Date 05/23/05  
Pedometers were purchased for some Carlisle Area School District students to encourage activity.
United Way of Carlisle and Cumberland County/Success by Six

**Preschool Health Curriculum**
$28,468.00 Approval Date 12/10/02
$11,300.00 Renewal Date 03/09/04
$20,100.00 Renewal Date 06/29/05
A comprehensive health education curriculum will be implemented along with providing supportive materials in area preschools.

Bethel Christian Academy

**Health and Wellness Initiatives**
$1,225.00 Approval Date 11/08/05
Pedometers, incentives and other materials are provided for students to increase regular physical activity.

Big Spring School District

**Current Trends in Physical Fitness**
$2,000.00 Approval Date 12/21/05
"Frisbee Friday" was a celebratory event with physical activities, nutritious snacks and healthy beverages for this middle school.

Carlisle Area School District

**The Opera of Health**
$3,500.00 Approval Date 12/19/05
This school assemble presentation helps educate students about exercise and nutrition.
Bellaire Elementary School - $500 Crestview Elementary School - $500 Hamilton Elementary School - $500 LeTort Elementary School - $500 Mooreland Elementary School - $500 Mt. Holly Springs Elementary School - $500 North Dickinson Elementary School - $500

Carlisle Area School District

**North Dickinson Elementary School PTO Elementary Playground**
$1,500.00 Approval Date 03/08/06
New elementary playground equipment was part of upgrading the school’s outdoor playground area.

Carlisle Family YMCA

**Youth Fitness Center**
$24,100.00 Approval Date 06/28/06
Exercise opportunities will be increased for the community’s young people by equipping a Youth Fitness Center.

Historic Carlisle, Inc.

**Walking Tour of Carlisle's Wayside Markers**
$1,000.00 Approval Date 11/08/05
Brochures featuring a walking route for Carlisle's historical markers were printed and distributed.
Presbyterian Homes, Inc.

**Newville Community Wellness**
$25,000.00 Approval Date 08/22/05
Two projects are part of a broad-based community collaboration to improve overall health and wellness in the Newville area. One project funds nutrition education for elementary-age students and the other project provides after school physical activities in a multigenerational setting.

Special Olympics PA Area M

**Development of Bocce Court North Middleton**
$2,000.00 Approval Date 04/17/06
Support will help to construct a bocce court for those with disabilities and the public.

Upper Adams School District

**Bendersville Elementary Nutritional Investigators**
$1,630.00 Approval Date 06/16/06
Fifth and sixth grade students write an educational puppet show called Nutrition Investigators and perform it for K through 4th graders in the school district.

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**Level Three**

**Educating Providers**

**Definition**
Informing providers who influence others

**Regional Strategy**
Encourage physicians and other health practitioners to regularly communicate and briefly counsel patients regarding eating habits, activity and use of tobacco. Develop capacities and referral systems to help patients access further nutrition, physical activity, tobacco cessation and substance abuse resources.

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**CAHWF GRANTS**

Carlisle Family YMCA

**Fit for Life**
$20,873.00 Approval Date 03/25/03
$20,873.00 Renewal Date 08/25/04
$24,220.00 Renewal Date 06/29/05
$14,700.00 Renewal Date 06/28/06
A comprehensive program instructs obese youth and teens with their families in activity, good fitness practices and sensible nutrition in order to improve both health and self-esteem.

YWCA of Carlisle

**New Face of Fitness**
$19,202.00 Approval Date 05/25/05
$26,526.00 Renewal Date 06/28/06
This demonstration grant is designed to attract and retain women in an exercise program who traditionally do not feel comfortable or cannot keep up with mainstream
aerobics/fitness classes. Along with activity the women aged 20-55 will receive nutritional and other health information.

YWCA of Carlisle
**Partners in Wellness**
$15,000.00 Approval Date 09/29/04
$25,000.00 Renewal Date 05/25/05
$20,000.00 Renewal Date 06/28/06

Education and complementary therapeutic services (yoga, Reiki and massage) benefit persons diagnosed with cancer.

YWCA
**Encore Plus**
$28,468.00 Approval Date 09/17/02
$46,092.00 Renewal Date 12/09/03

This funding will expand breast and cervical cancer education, screening and follow up support to low-income women in Cumberland and Perry counties.

Sadler Health Center Corporation
**Tobacco Coalition Initiative**
$24,880.00 Approval Date 03/29/06

Awareness of the effects of tobacco use and the importance of cessation will be provided through outreach and advertising efforts, as well as classes.

**Level Five**
**Changing Organizational Practices**
**Definition**
Adopting regulations and shaping norms

**Regional Strategy**
Encourage and aide local institutions and organizations to adopt and promote healthier lifestyles and for their constituents, especially at schools and worksites.

**CAHWF GRANTS**

Newville Day Care
**Staff Support**
$9,456.00 Approval Date 10/22/03

This grant will provide funding for additional staff time to enhance the health and safety curriculum and increase physical education equipment.

Susan P. Byrnes Health Education Center
**Wellness at Work**
$56,612.00 Approval Date 06/14/05
$78,565.00 Renewal Date 06/20/06

This one-year pilot program will enhance employee wellness at seven locations with an emphasis on needs assessment, onsite wellness teams, customized plan development, trainings and evaluation.
Big Spring School District
Current Trends in Physical Fitness
$2,000.00 Approval Date 12/21/05
Physical education equipment is included in a unique high school class teaching students to develop life-long fitness habits.

Boys and Girls Club of Central PA
Triple Play: A Game Plan for the Mind, Body and Soul
$22,000.00 Approval Date 03/29/06
The health and physical activity curriculum, Triple Play, becomes a core part of an after-school and summer program.

South Middleton School District
Yellow Breeches Middle School Introduction to Lifetime Fitness
$2,000.00 Approval Date 03/23/06
Increased lifetime fitness activities were introduced into physical education classes.

Source: Carlisle Area Health and Wellness Foundation
Sadler Health Center Corporation
The Sadler Health Center officially incorporated on October 25, 2002 and commenced operations in June 19, 2003. In February, 2004 the Center moved to a new facility at 100 N. Hanover St. Designated as a Federally Qualified Health Center Look-Alike in 2005, the Sadler Health Center Corporation provides primary health and dental services to the residents of Cumberland County, western Perry County and parts of Adams County and Franklin County, without regard to our patients' ability to pay (fees based on a sliding-scale fee schedule may apply). Since its incorporation, Sadler Health Center has consistently increased the volume of medical and dental services provided to community members. Provided below is a summary of encounters provided by center staff since its incorporation.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Encounters</td>
<td>10018</td>
<td>9209</td>
<td>6500</td>
<td>3911</td>
</tr>
<tr>
<td>Dental Encounters</td>
<td>6061</td>
<td>5025</td>
<td>4233</td>
<td>2677</td>
</tr>
<tr>
<td>Total Patient Encounters</td>
<td>16079</td>
<td>14234</td>
<td>10733</td>
<td>6588</td>
</tr>
</tbody>
</table>

Provided below is a table showing medical patient and dental patient insurance sources as percentages of overall patient resources. Based on this data, Sadler Health Center fulfills its mission to provide services to those with limited resources.

<table>
<thead>
<tr>
<th>Insurance Coverage</th>
<th>Medical FY 2007-06</th>
<th>Medical FY 2006-05</th>
<th>Dental FY 2005-06</th>
<th>Dental FY 2004-05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>9%</td>
<td>11%</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>59%</td>
<td>62%</td>
<td>68%</td>
<td>70%</td>
</tr>
<tr>
<td>Uninsured</td>
<td>28%</td>
<td>27%</td>
<td>25%</td>
<td>30%</td>
</tr>
<tr>
<td>Other</td>
<td>4%</td>
<td>0%</td>
<td>4%</td>
<td>0%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Healthy Rx Program
The Healthy Rx program at the Sadler Health Center offers patients prescription assistance, referrals to participating physicians who offer discounted fees; durable medical equipment acquisition; on-line COMPASS applications, and Medicare D counseling. The program started operations in September 2005. Definitions and data on program services are provided below for the periods September 1, 2005 – June 30, 2006 and July1, 2006 – June 30, 2007.

Definitions:
# PAP – number of prescriptions filled through pharmaceutical assistance programs offered by pharmaceutical companies
$ PAP - retail value of medications if purchased by patient at a pharmacy
#340B – number of clients (Sadler patients only) accessing the federal government’s 340B discount drug program. The “340B Program” requires drug manufacturers to provide outpatient drugs to certain covered entities including Sadler Health Center as a FQHC Look A-Like at a reduced price. The 340B price defined in the statute is a ceiling price Entities can negotiate below ceiling prices with manufacturers.

$340B Patient Cost – cost to clients who have used the 340B program

<table>
<thead>
<tr>
<th>Description</th>
<th>July 1, 2006 June 30, 2007</th>
<th>September 1, 2005 June 30, 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Seen</td>
<td>2057*</td>
<td>807</td>
</tr>
<tr>
<td># PAP</td>
<td>2818</td>
<td>838</td>
</tr>
<tr>
<td>$ PAP</td>
<td>$1,072,288</td>
<td>$264,484</td>
</tr>
<tr>
<td>#340B</td>
<td>2009</td>
<td>247</td>
</tr>
<tr>
<td>$340B Patient Cost</td>
<td>$22,503</td>
<td>$2,754</td>
</tr>
</tbody>
</table>

* In the first nine month of the year beginning July 1, 2006 and ending June 30, 2007 1358 patients were seen.

Source: CAHWF Interim and Final Grant Evaluation Reports
Northwestern Human Services – The Stevens Center
Comprehensive Clinical Team

The comprehensive clinical team grant request was submitted in January 2004. Due to the challenge of recruiting a psychiatrist, the actual implementation date of the program was March 14, 2005. The goals of the comprehensive clinical team included reducing or controlling client’s psychiatric symptoms; increasing collaboration with other providers; and, reducing and maintaining access time for both new and existing clients.

The team goals were being met based on final reports submitted by the Director of Outpatient Services for the period March 14, 2005 – February 28, 2006 and the period March 1, 2006 – February 28, 2007. Each report stated that major areas of improvement resulting from the implementation of the team included: increase in access time for psychiatric services; clients reporting a reduction or control of their psychiatric symptoms; and an increase in collaboration of client care with other providers.

Service data for the two year period is provided below. This data represents total team services (psychiatrist, physician assistant, nurse).

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Assessment</td>
<td>67</td>
<td>72</td>
</tr>
<tr>
<td>Psychiatric Evaluation</td>
<td>321</td>
<td>292</td>
</tr>
<tr>
<td>Medication Visit</td>
<td>3567</td>
<td>3682</td>
</tr>
<tr>
<td>Clozaril Services</td>
<td>325</td>
<td>273</td>
</tr>
<tr>
<td>Initial Therapy Sessions</td>
<td>49</td>
<td>7</td>
</tr>
<tr>
<td>Administration/Evaluation of Medication</td>
<td>1070</td>
<td>866</td>
</tr>
<tr>
<td>Medical Group</td>
<td>196</td>
<td>67</td>
</tr>
<tr>
<td><strong>Total Services</strong></td>
<td><strong>5595</strong></td>
<td><strong>5259</strong></td>
</tr>
<tr>
<td>Cancelled/Missed Appointments</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Cancelled Appointments</td>
<td>589</td>
<td>558</td>
</tr>
<tr>
<td># of Missed Appointments</td>
<td>690</td>
<td>775</td>
</tr>
</tbody>
</table>

Adams-Hanover Counseling Services, Inc.
Carlisle Psychiatric Services

The Carlisle Psychiatric Services opened to deliver services on October, 1, 2005. The practice goals included assuring easy and prompt access to psychiatric care; avoiding disruption in treatment /minimizing noncompliance with medications; helping individuals and families develop connections between primary care practitioners and behavioral health specialists; avoiding more intensive and costly treatment as a result of gaps or lapses in outpatient psychiatric care; and, promoting people’s highest level of functioning.
The practice goals were being met based on an interim report submitted by the Adams-Hanover Counseling Services Executive Director for the period October 1, 2005 – January 31, 2006,

In the four month period covered by the report, Carlisle Psychiatric Services served 100 patients in an office based outpatient setting and provided 36 consultative services in an inpatient setting – the Carlisle Regional Medical Center.

Source: CAHWF Interim and Final Grant Evaluation Reports
### Table E-19  Prevention and Education Services

#### Wellness at Work Initiative

The goals of the initiative were to assist employees to reduce health risks, enhance quality of life and increase individual productivity. The data provided below summarizes the activity and outcomes for the first year of the grant award (July 1, 2005 – June 30, 2006).

1. The participation rate at wellness programs offered by six organizations documenting attendance was 71% (2,236 employees of 3,130 total employees).
2. Based on pre/post testing results from wellness program participants there was a 30% increase in knowledge and attitude and a 15% increase in intent to change behavior among participants.
3. 244 employees participated in weight/activity contests.
   - **Holiday Weight Maintenance Programs**
     - 91% of participants stayed within three pounds a three pound limit
     - 2,683 miles walked for an average of 3.7 miles per day
   - **Walking and Activity Programs**
     - 26,972 miles of activity
     - 3.8 miles/day/participant
     - Average exercise frequency progressed from 2-3 times per week to 4-5 times per week

#### Tobacco Coalition Initiative (Sadler Health Center)

The goals of the initiative were as follows: to increase awareness of the effects of tobacco use and the importance of professional intervention through outreach and advertising; and, to meet the growing demand for cessation services. With the CAHWF grant award the Tobacco Cessation staff at Sadler Health Center accomplished the following:

1. Provided three “Lunch and Learn” programs to local physician offices in an outreach effort to network with other health care professionals.
2. 351 adults attended and completed cessation classes from the inception of the grant award in April, 2006 through June, 2007. Based on program records, the one month quit rate was 90%-100% and the six month quit rate was 51%.

Source: CAHWF Interim and Final Grant Evaluation Reports
Appendix F: Inter-Organizational Network and Community Health Partnership Models

Within limitations given the type of organizations being described – (intergovernmental networks vs. community partnerships) Robert Agranoff’s (2003) models and the community health partnership models offered by Romana Hasnain –Wynia et al. (2001) may be cross-walked. The table below integrates the two sets of models based on a combination of activities (exchange, capacity, strategy, decision) completed by each network model. The difference between network models is therefore based on the number of activities completed by each network model. Legitimate network activities run the gamut from information exchange to joint action.

<table>
<thead>
<tr>
<th>Community Health Partnership Models</th>
<th>Inter-Organizational Networks</th>
<th>Exchange</th>
<th>Capacity</th>
<th>Strategy</th>
<th>Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>facilitating information</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>developmental</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>decentralized action outreach</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
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Community Health Partnership Models

**Facilitating Community Health Partnership** – The partnership convenes members to allow ideas for collaborative activities to be generated by members. The partnership provides support for members of the partnership to act on these recommended collaborative activities.

**Decentralized Action Community Health Partnerships** – Partnership members identify local needs, define goals, and recommend initiatives. These initiatives are implemented by either member organizations and/or organizations that are not part of the partnership. The planning function and implementation of initiatives are separate activities.

**Centralized Action Community Health Partnerships** – Partnership members identify, prioritize, implement and manage initiatives.

Inter-Organizational Networks

**Information Network** – Network members exchange information, examines common issues and problems, explore possible solutions to common problems. All actions are voluntary and taken within the membership organization.

**Developmental Network** - Network members exchange information, participate in education activities, examines common issues and problems, explore possible solutions to common problems, and are encourage to adopt these recommended solutions. Dyadic and/or multiple organization collaboration often results from these networking activities.
Outreach Networks - Network members exchange information, participate in education activities, examines common issues and problems, explore possible solutions to common problems, and create and advocate for concerted strategic action. These strategic actions may be adopted and carried out by network organizations and/or organizations that are not members of the network.

Action Networks - Network members exchange information, participate in education activities, examine common issues and problems, explore possible solutions to common problems, and jointly implement collaborative strategies.

Network Activities

Exchange – the identification of common problems/ issues and the transfer of information among network members of individual network member organization’s policies and programs, technologies and strategies

Capacity - the provision of education combined with partner information and technical exchange that enhances member information capacity to implement solutions

Strategy - the development of joint strategies designed to respond to issues/ problems identified by the network

Decision - the initiation of joint action to resolve identified issues / problems
REFERENCES


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Primary responsibility for teaching financial accounting course (IB&M 210), introductory business course (IB&M 100), finance course (IB&M300Q), and senior seminar (IB&M400). In addition developed and teach a health policy and management course (IB&M300R), entrepreneurship and small business management course (IB&M 300Z) and nonprofit management course (IB&M 300AO).

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PUBLICATIONS

“Fusing culture and strategy – prescription for success at Doctors Community Hospital” co-authored with Dr. Michael Fratantuono in Business Case Journal, 14(1), 58-83.

EDUCATIONAL PROJECTS
- Collaborated with Professor Michael Poulton on the development of a business plan exercise for students enrolled in the Fundamentals of Business course (IB&M 100). This business plan exercise currently is available on the McGraw –Hill web site that supports Business: An Integrative Approach by Fred Fry, Charles Stoner, and Richard Hattwick

- With the assistance of Dmiter Banov (05”) and Reginald Addae (08”) completed a series of Excel tutorials to support the current course text, Financial Accounting (8th ed.) by Belverd Needles and Marian Powers. The four tutorials provide instruction on the accounting cycle beginning with recording accounting transactions through financial statement preparation and presentation.