COMMUNITY PARTNERSHIPS FOR HEALTH EQUITY:
Macro-evaluation Final Report

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Community Science

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1. INTRODUCTION

The Colorado Trust's (The Trust) Community Partnerships for Health Equity (CPHE) strategy was a large-scale community-driven effort supporting community actions that would lead to healthier and more equitable communities across Colorado. A range of communities throughout Colorado were part of this strategy, from small rural towns with relatively homogenous populations to large urban neighborhoods and towns with racially, ethnically and linguistically diverse populations. The number of communities involved in the strategy gradually increased from eight to 27 from when it was launched in 2014 to when The Trust announced its conclusion in 2022.

The purposes of this final evaluation report for CPHE are to share the outcomes of the CPHE strategy based on evaluation data, summarize the patterns and trends that persisted throughout the strategy, and inform The Trust's future efforts to engage communities across the state to advance health equity. The report includes a high-level overview of CPHE and the context within which the evaluation was conducted (section 2), information sources for the findings reported here (section 3), key findings about the CPHE impact in communities (section 4), and factors that shaped and affected CPHE, inside The Trust and externally in communities (section 5). This report concludes with recommendations for future community change and health equity initiatives.

2. OVERVIEW OF CPHE

From its inception in 2014 to the end of the strategy in 2022, the implementation of CPHE evolved significantly. It is important to recognize this evolution to fully understand the patterns and trends observed throughout the macro-evaluation. In the first couple of years, as the strategy was being developed, the central idea was to focus on the social determinants of health and health inequity through "resident-driven grantmaking." This focus intended to shift how The Trust and philanthropy related to communities—to be in more direct relationship with residents rather than funding through nonprofits as intermediaries. A phased approach to CPHE was implemented, in which communities would go through development, planning and implementation phases for their health equity work. The Trust worked with the Colorado Nonprofit Development Center (CNDC) to administer grants to community teams because The Trust could not make grants directly to residents. The communities that used this phased approach are referred to in this report as "CNDC communities."

In 2017, The Trust made explicit that its goal and the north star for the CPHE strategy was building community power and effecting systems change to achieve health equity. In early 2020, The Trust continued to emphasize that health equity can only be achieved with shifting power so that the residents most affected by inequities can influence and lead the work.[1] To call explicit attention to the importance of building and shifting power, The Trust adopted an approach called the Community Partnerships Organizing Strategy (CPOS)[2] that used a Community Partnerships Organizing Cycle (CPOC), with rapid action cycles as its defining feature. The approach consists of four goals: develop leaders, take collective action, implement a community-appropriate organization, and build and support a community-organizing infrastructure in the state. The communities that used this approach are referred to in this report as "CPOC communities." To implement the CPOS approach, The Trust hired community

organizers and project administrators to support CPHE and communities. The Trust transitioned the initial roles of community partners to regional managers to recognize this shift.

In June 2022, The Trust's CEO and board decided to end CPHE by Dec. 31. The reasons included 1) the misalignment between The Trust's role as a grantmaker and a community organizer; 2) the barriers to community organizing and power building posed by legal limitations and The Trust's policies and practices as a philanthropic organization, which made it difficult to support the participating communities' aspirations; 3) the challenge in meeting the funding disbursement requirement for the Internal Revenue Service; and 4) the number of nonprofit organizations that were better positioned to organize communities.

Twenty-seven communities were part of the CPHE strategy between 2014 and 2022. The communities became part of the CPHE strategy at different times and were in varying stages of their work by the time the strategy concluded. Also, a few communities disengaged from the strategy during those eight years. Because of this variability, the information about each of the 27 communities also varied. Exhibit 1 lists the 27 communities, indicating which of the two approaches they used, communities from which The Trust withdrew its support or did not formally name the community as a CPHE community, and the state of community teams and activities or actions in the communities.

The Trust engaged Community Science to plan and evaluate CPHE from 2018 until the strategy's conclusion. The first step was to work with Trust staff and community team coordinators from the CNDC communities to develop a pathway of change that would guide the evaluation (see Exhibit 2). Community Science collected data in 2019 to test the pathway and made some minor adjustments, including changes when the CPOS approach was conceived. However, from that time onward, several events affected the evaluation's implementation:

1. The Trust's pivot from the phased approach to the CPOS approach in 2020 resulted in the simultaneous implementation of two approaches with different grantmaking processes, community team organization, and reporting requirements.

2. The pivot alongside major shifts and turnover in The Trust's leadership and staffing delayed decision-making about staff expectations for documenting, storing and managing information and using the insights generated by the evaluation to support their work in communities.

3. The COVID-19 pandemic—which eliminated any potential for in-person site visits and relationship building between the evaluation team and new community teams that were part of the CPOS approach—put a pause on CPHE work in all communities, as participants shifted their focus and energy to meeting basic needs in the community.

4. The unanticipated, premature termination of CPHE prohibited the final round of data collection in fall 2023. The Trust's evaluation staff and regional managers and Community Science agreed that the community teams and the staff working on the front lines (i.e., community organizers, project administrators) would not be inclined to participate in the final round of data collection and were occupied trying to close out their grants. The evaluation team offered, and was able, to assist several CNDC communities in completing their final reports for The Trust.
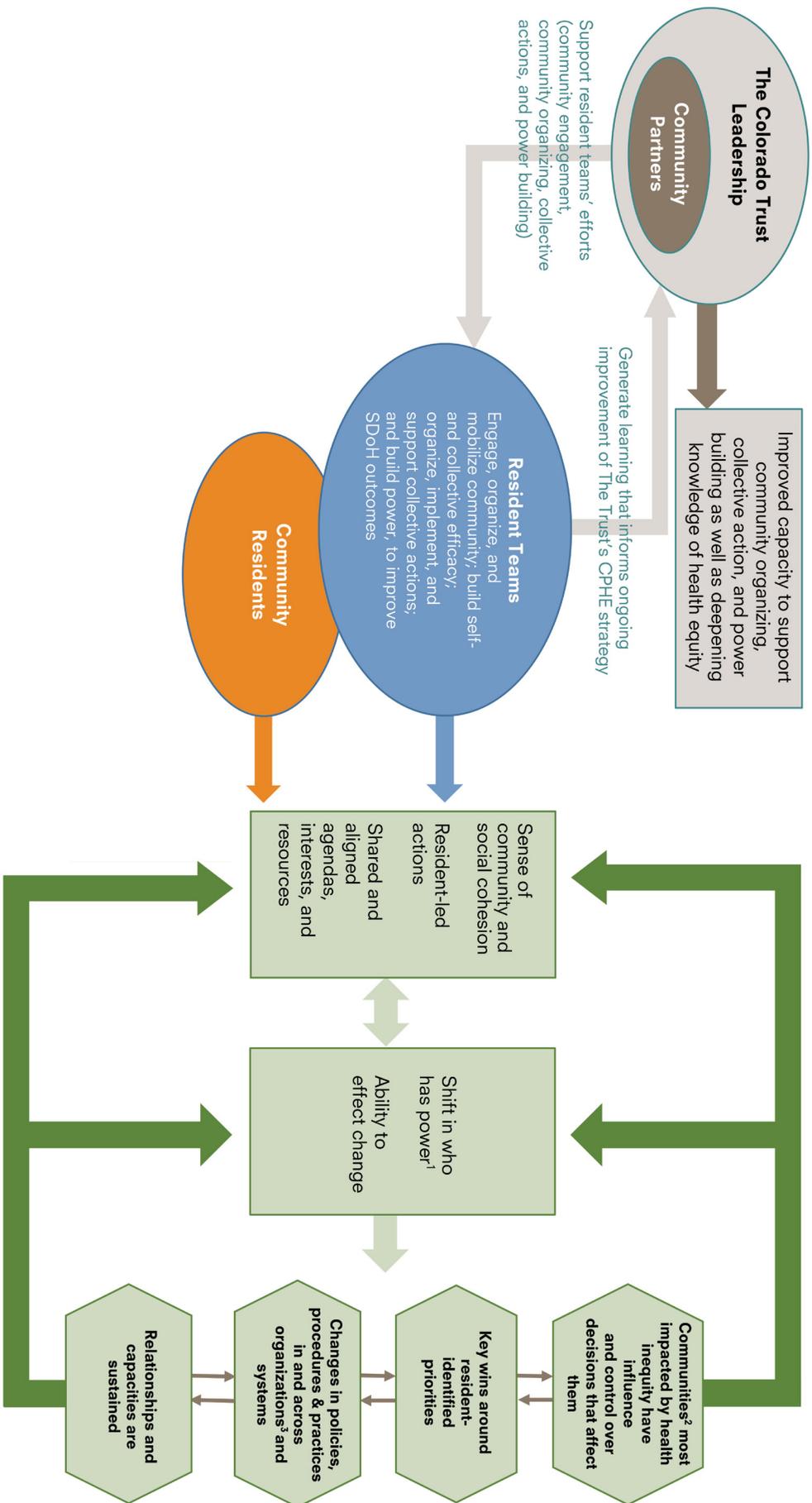
EXHIBIT 1: Communities That Participated in the CPHE Strategy

CPHE Community	Approach Used	Status of Formally Established Team and Relationships	State of Activities and Actions	Culmination Grant	Population Served or Represented	Priority Isues
Alamosa	CPOS approach	Established	Conducted	Awarded	Young adults 18-30 years old	Housing and Youth Development
Antonito	Phased approach	Established	Conducted	Awarded	Hispanic/Latino residents 12-35 years old	Sense of Community and Economic Development
Avondale	Phased approach	Established	Conducted	Awarded	Youth, elders, and monolingual Spanish speakers	Sense of Community and Food Security
Center	CPOS approach The Trust decided not to approve in February 2022 because of pending decisions about the strategy's future.	Not established	None	Awarded	Migrant workers	Housing for migrant workers
Clifton	CPOS approach	Established	Conducted	Awarded	Residents	Food Security, Community Engagement, and Other Basic Needs
Craig	CPOS approach The Trust withdrew its support at the end of 2021 and awarded the team an exit grant.	Established	Conducted	Ineligible	Youth and young adults	Substance Use Disorder and Mental Health
Dog Patch (Pueblo)	CPOS approach	Established	Conducted	Awarded	Neighborhood residents	Sense of Safety and Community
Dove Creek	Phased approach	Established	Conducted	Awarded	Young families and residents 0-45 years old	Sense of Community and Economic Development
Durango and Southwest Colorado	CPOS approach	Not established	Conducted	Awarded	Indigenous community	Concerns and Experiences of Indigenous Women and Families

CPHE Community	Approach Used	Status of Formally Established Team and Relationships	State of Activities and Actions	Culmination Grant	Population Served or Represented	Priority Issues
El Jebel	CPOS approach	Not established	None	Ineligible	Not identified	Not Identified
Fort Collins	CPOS approach	Not established	Conducted	Awarded	Not identified	Community Engagement and Language Justice
Fort Lupton	CPOS approach	Not established	None	Awarded	Not identified	Not Identified
Fort Morgan	Phased approach	Established	Conducted	Awarded	Immigrants and residents who speak languages other than English	Language Justice, Affordable Housing, and Recreational Opportunities
Fountain	CPOS approach	Established	Conducted	Awarded	Downtown residents	Youth Engagement, Food Security and Economic Development
Grand Valley (Parachute and Battlement Mesa)	Phased approach	Established	Conducted	Withdrew application	Low-income residents, monolingual Spanish speakers, and undocumented residents	Language Justice, Economic Development, Sense of Community, and Food Security
Greeley	CPOS approach	Established	Conducted	Awarded	Not identified	Food Security
Hillside (Colorado Springs)	CPOS approach	Established	Conducted	Awarded	Neighborhood residents	Sense of Safety and Leadership Development
Lago Vista (Loveland)	Phased approach	Established	Conducted	Awarded	Black and Hispanic/Latinx residents, Spanish-speaking residents, and youth	Sense of Safety and Youth Development
Las Animas	CPOS approach The Trust decided not to approve in February 2022 because of pending decisions about the strategy's future.	Not established	Conducted	Awarded	Not identified	Not Identified

CPHE Community	Approach Used	Status of Formally Established Team and Relationships	State of Activities and Actions	Culmination Grant	Population Served or Represented	Priority Isues
Manzanola	Phased approach The Trust withdrew its support and awarded the team an exit grant.	Established	Conducted	Ineligible	Youth and families	Economic Development
Montbello (Denver)	CPOS approach	Established	Conducted	Awarded	Neighborhood youth	Literacy and Youth Development
Northwest Aurora	CPOS approach	Established	Conducted	Awarded	Not identified	Housing and Homelessness
Olathe	Phased approach The Trust withdrew its support in 2021 and gave a separate grant to continue a language justice effort.	Established	Conducted	Awarded	Monolingual Spanish speakers, people living in poverty, and middle and high school youth	Economic Development and Language Justice
Saguache	Phased approach	Established	Conducted	Awarded	Seniors, youth, and immigrants	Poverty, Youth Development, and Community Engagement
San Luis	Phased approach	Established	Conducted	Awarded	Young Hispanic adults	Sense of Community and Economic Development
Sheridan	Phased approach	Established	Conducted	Awarded	Low-income residents, youth, and monolingual Spanish speakers	Sense of Community and Engaging Impacted People in Public Process and Education
Yuma	Phased approach	Established	Conducted	Awarded	Youth, residents who speak a language other than English, and low-income communities	Housing, Youth Development, and Recreation

EXHIBIT 2: Pathway of Change Created in 2018

The Colorado Trust Leadership

Community Partners

Support resident teams' efforts (community engagement, community organizing, collective actions, and power building)

Generate learning that informs ongoing improvement of The Trust's CPHE strategy

Improved capacity to support community organizing, collective action, and power building as well as deepening knowledge of health equity

Resident Teams

Engage, organize, and mobilize community; build self- and collective efficacy; organize, implement, and support collective actions; and build power, to improve SDoH outcomes

Community Residents

Sense of community and social cohesion

Resident-led actions

Shared and aligned agendas, interests, and resources

Shift in who has power[1]

Ability to effect change

Relationships and capacities are sustained

Changes in policies, procedures & practices in and across organizations[3] and systems

Key wins around resident-identified priorities

Communities[2] most impacted by health inequity have influence and control over decisions that affect them

Historical context of community, social norms, location and geography of community, economic and political climate

[1]*Power to drive policies and make decisions (not individual power)*
[2]*Group of people who share a history, an identity, or have relationships with one another, and not necessarily all the people within the geographic boundaries of a place*
[3]*Broadly defined and can include public, private, and nonprofit institutions*

The events on page 9 had several impacts on the evaluation:

- The evaluation questions were adapted annually in response to new insights (e.g., a question was answered, and the evaluation team did not need to ask it again) and there were challenges to getting consistent data (e.g., different data collection methods over time). Questions were also changed to realign with the strategy's evolution (e.g., the addition of the CPOS approach).

- There was great variability in the amount and quality of data about each CPHE community.

- Any difference CPHE made in communities in 2022 was challenging to assess because site visits were not conducted after The Trust announced the strategy's conclusion. The evaluation had to depend on CNDC communities' self-reports and existing documentation The Trust had about the CPOC communities, which was limited.

- Issues regarding The Trust's pivot and lack of clarity about processes and intended outcomes dominated the data collected from community teams that participated in telephone interviews and focus groups. Therefore, it was often difficult to dig deeply into community outcomes.

3. INFORMATION SOURCES FOR THIS REPORT

The findings in this report are based on the following sources of information:

- Final reports submitted by Dec. 31, 2022, by community teams that were part of the phased approach.

- Documentation of 36 approved actions submitted by community teams that were part of the CPOS approach.

- Seven quarterly learning discussions with The Trust's staff, including regional managers, community organizers, project administrators and operations staff.

- Telephone interviews conducted by Community Science with 11 CPHE communities in 2020 (49 people) and in 2021 (48 people), of which six were CNDC communities, and five were CPOC communities (three communities were included in both years to allow the evaluation team to assess whether and what type of changes might have occurred over two years[3]).

- Large group discussions about responses to the COVID-19 pandemic, facilitated by Community Science in May and June 2020, with 18 CPHE communities participating.[4]

- A summary of frequently asked questions and answers about the shift to the CPOS approach and a listening session with grantees of The Trust's Building and Bridging Power initiative, which aims to build a statewide community organizing infrastructure by connecting grassroots organizations with policy organizations.

We analyzed the data looking specifically for patterns about the following:

- Types of accomplishments, outcomes and challenges

- Relationship among accomplishments, challenges, support from The Trust's staff and other conditions

- Alignment with the CPHE Pathway of Change.

We focused on patterns—demonstrated by at least three communities—common to CNDC and CPOC communities. We noted any distinct differences between the two types of communities that contributed to important lessons for The Trust.

4. THE IMPACT OF CPHE COMMUNITIES

4.1 Laying the Groundwork

The engagement of residents was a consistent accomplishment across CNDC and CPOC communities; the extent and depth of engagement varied widely. Across all the communities, residents came together—voluntarily and with compensation from The Trust for their participation. They were engaged, convened and supported by The Trust's regional teams (i.e., community partners initially and then senior organizers, organizers and project administrators). Interviews, final reports from the CNDC communities, and the after-action review report from evaluation partner Change Matrix confirmed that residents across communities came together to strengthen their communities. One common attribute stood out: they were very committed to improving their neighborhoods, towns, cities or rural areas so that all residents could have a better quality of life.

The number of residents who came together on a team varied widely across the communities, ranging from as few as three people to as many as 40 people. These numbers changed over time as residents entered and exited the teams for reasons that included relocation, change in employment, and frustration with the process (e.g., lengthy planning periods, limitations on advocacy and involvement in political campaigns, and real or perceived delays receiving the stipends they were promised).

Beyond the community teams, other residents were engaged when the teams were gathering information about issues, needs and priorities (e.g., conversations and surveys with hundreds of residents) or when they mobilized people to attend a public meeting or event (e.g., school board or town council meeting) or work on a joint project (e.g., build a community kiosk).

Community team members—especially in CNDC communities, because of expectations of the phased approach—learned about the social determinants of health and health equity and developed skills to create meeting agendas and run meetings, communicate with people who had different perspectives and cultures, manage conflict, organize people to act, develop and administer surveys, and use technology. Community Science learned how many individuals on community teams built various capacities in these areas. In some cases, Trust staff taught community team members (e.g., in Hillside and Craig) how to develop a

meeting agenda and run meetings by modeling the behavior and then coaching them. Trust staff also connected some community team members to external community organizing training and leadership courses (e.g., Midwest Academy). CNDC community team members shared how they learned about evaluation and developing survey questionnaires from their community evaluators. By the end of the CPHE strategy, several individuals were equipped to start their own businesses or become organizers and reported more confidence in speaking out and expressing their concerns.

All the community teams elevated and built awareness about key issues related to the social determinants of health that are most critical locally; it was difficult for the evaluation to determine the degree of awareness built beyond the community teams. The community teams drew on their passion and interest areas to lift an issue for others on the team and draw the larger community's attention to the issue. For example, in one community, members discussed the importance of addressing early childhood literacy because one of them—an educator—is passionate about it and involved in efforts to address illiteracy among children. In most of the communities, the teams also conducted surveys, one-on-one conversations and focus groups to find out about the most pressing issues for their broader communities. They were intentional about hearing from groups that were not typically heard, including youth, senior citizens and people with limited English proficiency. In three communities where surveys were conducted, between 300 and 600 residents were reached. Some community teams, particularly those in the CNDC communities (because of expectations for creating a health equity plan), analyzed secondary data to identify issues affecting their communities.

The range of issues concerning communities included inadequate early childhood literacy, economic and food insecurity, public safety concerns, unaffordable housing and gentrification, poor-quality education, low sense of community or social cohesion, and lack of recreational opportunities. Many communities focused on issues affecting youth, especially because youth have lacked opportunities and resources for recreation, quality education and career development, particularly in rural places. Exhibit 2 shows the most critical issues selected by communities. It is difficult to ascertain the degree of awareness that has been built. Based on Community Science interviews and reports, awareness was sometimes raised among community teams only, and sometimes, it was introduced more broadly among the networks to which the team members belong. Awareness depended on the scale of activities and events conducted by the community teams.

4.2 Making a Difference
Community teams that focused on improving social cohesion or a sense of community likely accomplished these goals to some degree. Some community teams planned and conducted events, such as Día de los Muertos, Summer Solstice Gathering, Manito Christmas, and lunches and dinners that served the traditional foods of people from different cultures in the community. The team in Alamosa rented a bus, conducted a tour of the San Luis Valley, and facilitated discussions on heritage, family and culture. These events brought community members together and raised awareness about the cultures of certain historically marginalized or invisible populations who live in the community, their histories, and the disparities they experience. These events also provided community members the opportunity to interact but were not likely to improve social cohesion or the sense of community in any sustained way.

On the other hand, some community teams extended their efforts beyond events and brought people together to work on a project. Based on extensive literature about building relationships, this approach was more likely to improve people's sense of community or social cohesion over time. For instance, the Avondale community team worked to bring a mobile food market to the community and then to secure property to build a grocery store. The team in Lago Vista collected signatures and held a community meeting during which residents shared that they did not feel safe because there were no sidewalks in a heavy traffic area. The Hillside community team advocated for the city to renovate a neighborhood park named after Leon Young, the first Black mayor of Colorado Springs. The Dog Patch community team in Pueblo held several community meetings during which residents were encouraged to share their perspectives on the content and design of a mural. Once consensus was reached, the mural was painted on the south wall of the La Gente Youth Sports building.

Some community teams raised institutions' awareness about the lack of language translation and interpretation assistance, and successfully promoted language justice. Language barriers are prevalent in many CPHE communities that have large numbers of immigrants with limited or no English proficiency. These barriers prevented such residents from accessing services, attending public meetings (e.g., school board meetings), and participating in political advocacy.

Many communities worked to improve language inclusion for their diverse residents by providing interpreter training, purchasing interpretation equipment, offering interpretation services, and starting language co-ops. Some of these efforts resulted in institutional changes, thereby increasing access to information for people with limited or no English proficiency. For example, Grand Valley's community team successfully advocated translation and interpretation as a regular line item in the school district's annual budget. In Sheridan, two schools hired Spanish-speaking principals to increase the schools' capacity to engage and involve parents. The school board provided interpretation assistance at its meetings, which increased the attendance and participation of parents with limited English proficiency. In Yuma, the community team started a community language cooperative. It provided interpretation training to over 40 individuals in the community who worked in local hospitals, schools, health departments, nonprofits and other places throughout Yuma and northeastern Colorado. The team frequently lent their interpretation equipment and provided interpreters for local groups, including schools, city council and community events. As a result of the team's efforts, the city began featuring more translated materials on its website and offering interpreter equipment at events. The Fort Morgan team similarly funded interpretation support at town hall meetings and worked with the local school district to set up language justice trainings.

Community team leaders reported increased confidence and an increased sense of empowerment to engage with elected and other government officials and to speak up about their concerns and ideas for strengthening local communities. In some communities, The Trust's regional staff encouraged residents to take incremental steps, such as attending a meeting. In other communities, community team members already recognized the need to influence public officials and become a part of the governing entities that drive local practices and policies. They were familiar and comfortable doing so and did it. As a result, community teams in five places (Avondale, Dove Creek, Saguache, Sheridan and Yuma) developed new

and strengthened relationships with elected officials, appointees and other decision-makers with power. Community team leaders intentionally attended meetings (e.g., town hall, county commission, chamber of commerce, school board), often working together to identify common issues to elevate. These efforts and their support of one another built their confidence to speak out publicly in the meetings. For instance, one community team worked with youth to successfully advocate with county commissioners to get internet access at a community center. Team members stated that a major challenge with engaging local leaders was developing relationships with new government officials after local elections and administration changes.

Community team members ran for elected positions or were appointed to governing bodies and decision-making committees. In at least three communities, the evaluation teams heard about community team members working together to bolster a leader or a group of leaders to run for local offices or seek appointments in local governing bodies and decision-making committees. In Dove Creek, the team motivated two residents to run for positions on the town board. (The same elected leaders had dominated the town board for over two decades, and a contributing reason was the lack of candidates.) In Sheridan, two team members successfully ran for the school board, two members joined the district advisory accountability committee and the school board's budget committee, and one was elected to the city council. In Avondale, three community team members served on the county's community energy leadership team and contributed to a community plan for energy efficiency and resiliency. Across the communities, community team members became involved in city planning, zoning and sustainability boards working toward energy efficiency.

Community teams became local go-to resources for decision-makers. Community teams in three communities reported that by building relationships with decision-makers, they became perceived by government officials and other decision-makers as the go-to resources and voices for community concerns. For example, in Dove Creek, the community team was allocated time on the agenda at town board meetings. In Avondale, when the district board for Waterworks held a public meeting to discuss changes in residents' water prices due to the installation of a new pipeline, the board reached out to the community team for feedback and to use their networks to distribute information about the meeting. Forty residents turned out for the meeting, a major change from the few residents who typically attended meetings in the past. In addition, in Yuma, the city manager and a city council member participated in the community team's training on language justice, and they became more aware of the need for translation assistance for public services.

Community teams worked to ensure that residents had access to healthy and fresh food, especially during the COVID-19 pandemic. During the pandemic, all the community teams partnered with organizations to deliver food to the most vulnerable families, including seniors and low-income families. The community teams knew where these families lived. Because the families also knew the team members, there were no challenges in mobilizing volunteers to deliver food boxes to people's front doors or getting families to accept the boxes. The teams played a major role in identifying local nonprofit organizations that The Trust could quickly contact and provide grants to in response to the pandemic.

Beyond the pandemic, some teams continued to address food security in other ways. The Dove Creek, Lago Vista and Sheridan community teams all worked to grow community gardens and distribute fresh fruits and vegetables from their gardens to families. The Avondale community team partnered with Care and Share Colorado to bring a mobile food market to the community. Residents were asked to provide their ZIP code and household size instead of identification, which enabled undocumented families to access this resource. The market was designed to allow residents to "shop" and select their items to preserve their autonomy and dignity, rather than being handed preselected, prebagged food. To ensure a more sustainable solution, the community team obtained a building on U.S. Highway 50 and began working with the building owners to get grants to open a grocery store in Avondale.

Efforts to open a grocery store in Fountain began in the mid-2000s. When Fountain residents came together to establish the community team, the team became part of the effort and helped to bring to fruition the plan to bring a grocery store to the community. The team held community meetings to draw residents' support and then advocated for the city government to bring a grocery store to downtown Fountain. In March 2023, the city announced that a local grocery store chain would open a new store in 2025.

Youth in smaller and more rural communities did not have much support, and the community teams in these places helped to fill gaps—including providing recreational programs and bringing Wi-Fi access to assist youth with academic activities. Youth was the population of interest in eight communities because of the lack of opportunities and available resources, especially in smaller and rural communities. These community teams intentionally engaged youth members as advisory or council members to inform their youth engagement strategies. These teams focused primarily on filling service and program gaps. For instance, the Craig community team chose to host summer events and provide youth with access to recreational opportunities to address their mental health. The team in Lago Vista bought a trailer for the mobile home park for after-school tutoring programs and created a youth center. In Avondale, because an internet connection was important to help youth academic activities, the community team successfully advocated for Wi-Fi in McHarg Park Community Center to enable students to do their homework there.

Beyond recreational activities and other needs, youth in some smaller and more remote areas also needed connections to career pathways, leadership opportunities and other postsecondary resources, which some community teams were able to provide. Filling immediate program and service gaps was essential, but more was needed. Youth also needed support to expose them to opportunities and resources that could ensure a successful transition to adulthood. The community teams in Antonito, Avondale, Saguache and San Luis partnered with schools to teach young people about different types of careers, opening their own businesses and education paths. The teams provided internship and job-shadowing opportunities and opportunities to interact with businesses to discover what young people wanted to know and what kind of training or education companies required for a job. In Saguache, the community team conducted a workforce skills assessment to identify local businesses and collect information to inform future workforce development training. It also developed a semester-long entrepreneurial class for high school students as an elective credit

toward graduation. The team hosted a career fair for middle schoolers across three schools for three years to explore career opportunities in San Luis Valley. The community team in Avondale also created partnerships with the county high school technical trade program and Pueblo Community College to provide information on trade programs and concurrent enrollment.

Community teams connected residents to employment opportunities, including bringing Wi-Fi connectivity to communities to improve information access. Many CPHE communities historically relied on one or two primary industries, and when these industries deteriorated, the communities' economic security was weakened. Communities like Avondale, Craig, Grand Valley and Olathe share this experience and have struggled to recover. Community teams worked to increase residents' employability by teaching new skills and increasing access to job fairs and workforce pipelines. Community teams from Avondale and Dog Patch partnered with local businesses to host job fairs to promote networking and access to employment opportunities. In contrast, the Fort Morgan community team held classes to teach residents tailoring and seamstress skills. The team sought to build workforce capacity for local women of color to create a business while being self-sufficient. The digital divide also contributed to economic disparities; recognizing this challenge, the community team in Olathe built a coworking space to increase the community's access to the internet. The space, Conexión, had signage and written communication in English and Spanish. In Avondale, the community team created a community technology center.

Some CPHE community teams used their funds to create long-term community changes by addressing infrastructure to support transportation, recreation and other needs. Evidence of physical infrastructure changes was emerging at the time this report was written. The community team in Lago Vista Mobile Home Park helped to convince the county commissioner to build a sidewalk at the entrance of the park; the sidewalk has yet to be built. The Hillside community team held a community build day, where residents helped construct and install a community kiosk. This team also applied for and received a Community Development Block Grant to renovate a park. In Avondale, the community team worked with Pueblo County, McHarg Park Community Center, Pueblo schools and local churches to develop a collaborative granting strategy to fund a sidewalk project. Clifton's community team started planning a community hall and recreational center to provide a safe, accessible space for youth, families, elders and those with disabilities to gather, recreate, learn and access services to counter health inequities. Finally, the community team in Dove Creek renovated the local baseball field to allow teams to play locally instead of traveling to other towns. The community team members knew the renovated baseball field would attract teams from neighboring towns who could travel to play in Dove Creek while bringing revenue to the community. The team also worked with a local trails expert to develop a plan for biking, off-highway vehicle and jeep trails to the area.

Community teams that identified affordable housing—a deeply entrenched, systemic issue that required more resources, expertise and time to dismantle—made some headway in bringing resources to residents. Housing affordability and availability are difficult to address because they require deep systemic change and time, yet two of the five community teams that identified affordable housing as a concern made some headway. The community team in Yuma partnered with organizations such as 9to5 Colorado, Colorado Poverty Law Project, Equitable Savings and Loan, and the U.S. Department of Agriculture Rural Development office to help

residents understand renters' rights and the pathway to homeownership. The team provided this information in English and Spanish. The team in Fort Morgan received a $70,000 grant from the Colorado Health Foundation to assess housing needs in the community, resulting in a detailed housing analysis and action plan that will serve as the team's future blueprint. Following the assessment, the team established a knowledge base around housing and the housing process and ecosystem components. The team examined local zoning laws and ordinances and explored the economic challenges of traditional development and funding strategies available to aid in planning and developing various housing options. The Fort Morgan team has begun working with the city council to create a new action plan.

5. FACTORS THAT AFFECTED CPHE AND THE COMMUNITY TEAMS' WORK

Many factors affected CPHE and contributed to its premature conclusion in December 2022. This section highlights the factors that persisted throughout the strategy.

5.1 Internally at The Colorado Trust

A leadership vacuum delayed solving problems and making decisions. The CPOS approach was developed in mid-2020 under the interim leadership of the chief executive officer and chief financial officer after the former vice president of grants left The Trust. Notably, the vice president of grants position would remain unoccupied for more than a year. In the meantime, a director for the CPHE strategy was hired in the late summer of 2021 to oversee its implementation; this director resigned fewer than six months later. A new vice president of grants was hired in the fall of 2021. These changes resulted in a leadership vacuum for the strategy for more than a year and much education of new leadership, which in turn delayed problem-solving and decisions. The evaluation team facilitated seven quarterly learning meetings with the staff that supported the strategy, including Finance & Operations Department staff. The recommendations for midcourse adjustments that emerged from these meetings could not be implemented easily when there was a leadership vacuum because it was unclear who was making decisions about the strategy, or how.

Early understanding of what type of systems change and risks were comfortable or uncomfortable for The Trust's leadership would have helped ensure consistent communication about desired activities, actions and outcomes. Some CPHE community teams were poised and ready to work toward systems change and shift power, but sometimes they had to slow down or pause to give The Trust time to grapple with what it was able and willing to stand behind. At times, the systems change proposed by communities sparked concerns from Trust leadership, including its board of trustees, about the impact on other social determinants of health, economic issues or The Trust's relationships and reputation. For example, one community team wanted to plan action around a contaminated aquifer linked to a local military base. After discussions with leadership, this was deemed an area that The Trust did not want teams involved in because the military base was the largest employer in the area, and action might result in a risk to the local economy. Situations like this led The Trust to create a layer of scrutiny and an extended review timeline for requests from community teams that involved direct action organizing and systems change.

When these types of situations occurred, they represented mixed messages for CPHE staff and community members; The Trust seemed to say it sought systems change, but not *that* system. Initial communication from The Trust had emphasized resident-led grantmaking—that is, the ability of community teams to decide what issues to address. But in cases of direct action organizing and particular systems change targets, The Trust weighed in more heavily. Because the narrative about resident-led grantmaking persisted, especially among the earlier communities that applied the phased approach, The Trust's community organizing staff and some community teams pushed back, expressing their frustration with the mixed messaging and loss of confidence in The Trust's commitment to change philanthropy. Because of the additional time it took The Trust to weigh in on direct action organizing requests, teams disproportionately gravitated to a large number of activities and grants supporting direct services and programs, which were easier to get approved. None of the 36 community requests from CPOC communities used direct action organizing. Additionally, the actions that communities proposed were often time-sensitive. In the small but important number of such cases, the opportunity had passed by the time leadership decided on community actions.

The transition to the CPOS approach happened too quickly and needed more leadership and direction from The Trust, contributing to confusion and concern inside and outside The Trust. Evaluation findings about the transition to the CPOS approach showed a need for more leadership and direction from The Trust. Additionally, the approach was implemented too quickly and without a shared understanding by leadership and staff about the implications of the shift and the internal policies and processes needed to support it, especially when the approach required hiring up to 43 full-time staff, of which 29 were hired. Inconsistencies regarding the expectations of the new positions, unclear funding processes, and insufficient capacity building were named as challenges by staff and community team members. Some of the newly hired community organizers resisted what they viewed as overly structured policies and processes that were not supportive of or responsive to communities. For example, the internal process for reviewing and approving actions felt too lengthy to them and to the community members working with them because it inhibited their ability to address urgent and emerging community needs in a timely way. As mentioned before, this was repeatedly reported as a barrier by community team members and contributed to the strategy's premature conclusion.

The community organizing staff had been oriented to The Trust's policies and practices as a philanthropic organization; however, in hindsight, the orientation might have been insufficient. Throughout the CPHE strategy, the frontline staff—first the community partners and then the community organizers and project administrators—repeatedly lamented the tension between The Trust's philanthropic processes and policies and what they believed communities need. They also noted how the former was prohibitive for community-led work (recall that CPHE was designed to be a community-led strategy). The Trust's processes and policies were perceived as "red tape" to maintain power. Hiring community organizers directly to implement the CPOS approach quickly brought these contradictions to the surface (e.g., legal restrictions about lobbying and lines of accountability beyond those to community members), contributing to a culture clash inside The Trust. Philanthropy and The Trust itself were early targets of the frontline staff's energy, something not adequately anticipated by leadership. The staff's resistance played out in discreet and sometimes harmful ways, and The Trust and leadership struggled to respond effectively.

The action application process for CPOC communities could have been clearer, and was perceived as a requirement that delayed—rather than facilitated—action planning and implementation. The action application process was confusing and often frustrating for the community teams that used the CPOS approach. The process was perceived as a requirement for The Trust that made it more difficult for community teams to access funding rather than as a process that was facilitative and supportive of their work to shift power. The teams that worked with CNDC were informed that they, too, could access the action fund. However, almost everyone expressed the need to know which actions The Trust would and would not fund, how long it took to process their applications for action funds, and who made the final decision about their applications. For some people, the process did become clearer between 2020 and 2021, but their earlier frustrations affected their relationship with The Trust.

Monetary reimbursement for community team members' time had unanticipated implications. This included how it affected some community members' eligibility to receive public benefits, to legal issues about The Trust paying undocumented immigrants and the ethics of not paying community members for their time when professionals (e.g., Trust staff) receive compensation for similar community activities. Community teams that worked with CNDC were initially reimbursed for their participation. However, teams that used the CPOS approach received a quarterly stipend once they signed a memorandum of understanding with The Trust. The Trust discontinued payments for community team members for CNDC communities about halfway through their implementation process (although some communities kept this practice) but continued to pay for community coordinators as grant-funded CNDC employees. On the other hand, community teams in CPOC communities received payments directly from The Trust for their participation. These community team members appreciated the payment or stipend (even though the payments for some of them were delayed) because they felt that it represented The Trust's recognition and value of their time and expertise. It helped to remove barriers to their participation (e.g., paid for child care and meals at home while they attended community team meetings).

Unfortunately, the reimbursement also contributed to the frustrations of the frontline staff and community team members. Tensions arose between The Trust's operations staff and the frontline staff about paying undocumented residents in the CNDC communities. While the former acknowledged that it would be illegal for The Trust to do this, the latter perceived this as unsupportive for people without access to resources and opportunities. In the CPOC communities, the issue was slightly different. CPOC community team members and frontline staff believed that The Trust promised to send the checks to the members by a certain date, but the payment was delayed. This diminished the community team members' and frontline staff's confidence in the process and The Trust.

The premature conclusion of CPHE was received with mixed feelings; how it was concluded contributed to the disappointment, confusion and frustration already felt in some communities. These feelings continued to be expressed through different channels months after the strategy ended. The Trust's leadership and board decided to end CPHE prematurely because feedback from the evaluation and informal feedback received by leadership, including some of the above points, signaled that the strategy was not being implemented as planned.

Two dynamics co-occurred when the leadership decided to end the strategy and let go of frontline staff, except for four regional managers. Leadership recognized the varying degrees of success among communities using the phased approach and those using the CPOS approach; The Trust could not, however, end one aspect of CPHE and retain another. Thus, significant efforts were made to ease the transition and demonstrate that ending CPHE did not mean The Trust stopped caring about the communities. Community teams were given six months, until December 2022, to wind down their work. Also, regardless of which approach it had used, each community team that had been part of CPHE was eligible to identify a nonprofit partner that could apply for a culmination grant from a pool of $6 million. The board had approved this funding for programs or capital improvements to help advance or sustain community efforts.

The community teams did not anticipate the decision to end CPHE and let go of the staff and, thus, generated the most controversy and criticism of The Trust, based on the feedback that foundation staff and the CPHE evaluator received following the announcement. The controversy and criticism were stronger than expected because communications about the goals of CPHE from the outset centered on relationships and power building. However, some community team members and community evaluators perceived that the announcement about the strategy's conclusion did not reflect this value. For example, the initial announcement to resident team coordinators who were part of the phased approach was brief and delivered by The Trust's leadership,[5] not the frontline staff, who were familiar with and had relationships with community members.

There was an opportunity for a virtual forum the day after the announcement for resident coordinators and community evaluators from CNDC communities, but questions had to be submitted in writing during the forum, limiting the ability for a dialogue. The Trust handled the announcement the way it did for many reasons, including concerns about the spread of misinformation through staff and communities across the state; the ability to manage the number of questions; and insufficient time to develop a process for responding to people's disappointments, hurt, anger and other emotions in response to the news. In hindsight, leadership wished it had a process for community members to follow up and speak directly to them after the announcement.

5.2 Externally in Communities
The following lessons emerged around external factors that impacted CPHE and what community teams could accomplish.

It took time for the teams to build inclusive, stable memberships with a sense of purpose.
Most of the community teams that participated in the interviews included people from populations that experience disparities and inequity—from young people and older adults to monolingual Spanish speakers and low-income residents—and their inclusion is an important factor in the teams' reach and understanding of issues facing their community. It took time to identify, recruit and retain these individuals. Transitions in and out of teams were not uncommon, as people relocated, changed jobs, and dealt with competing priorities in their lives. Some team members also got frustrated with the process, as mentioned in Section 5.1. The approaches that supported the CPHE strategy did not sufficiently consider these real challenges facing community members. These processes did not sufficiently develop solutions to help the frontline staff prepare for and overcome these challenges.

Compared to The Trust's frontline staff, not all community team members were familiar with philanthropy, health equity or community organizing. They did not have the knowledge and skills to lead and implement a community-led effort, contributing to different expectations about their roles. Community Science's interviews indicated mixed understandings among community team members in CPOC communities about their roles and The Trust's staff's roles, particularly about who leads the process, who supports, and who is accountable to whom. The different understandings were likely due to the community members' own readiness to engage and carry out the work, as well as the internal challenges inside The Trust, including the fast transition to the CPOS approach and inconsistencies regarding expectations of the newly created community organizer and program administrator positions. These factors were cited in evaluation data as causes for slowing the pace of community efforts, affecting relationships and contributing to misunderstandings, especially in CPOC communities.

Not all community members understood what health equity meant and how to achieve it when struggling with present-day issues, such as not having a job, living in poor housing conditions, or feeling unsafe due to the absence of sidewalks. The varying degrees of understanding affected the community teams' ability to connect their activities and actions to building power to effect systems change toward health equity. The communities that The Trust selected to be part of CPHE are disadvantaged in many ways—including being geographically isolated and overlooked by elected officials and lacking infrastructure in transportation, economic development, digital connectivity and adequate housing. In almost all the communities, community team members were focused on responding to the most urgent needs of their community members (e.g., in one extreme case, the team wanted emergency funds to assist with important events, such as a funeral). A handful of communities responded to these urgent needs and connected their actions to power building and systems change. In some communities, especially the CPOC communities, The Trust's community organizer staff drove the strategy because of the limited capacity in these communities.

These specific factors emerged in the data analysis as contributors to the variability across communities to design and connect "quick wins" and responses to urgent needs to the longer-term agenda of effecting health equity:

- The Trust's regional staff and community organizers did not sufficiently build the community teams' capacity to connect the urgent needs of their communities to their root causes and systemic challenges. In some instances, the community organizers made the connections but did not appear to make them explicit to the community teams.

- The community was overwhelmed by widespread and deeply entrenched problems (e.g., poverty) and did not know how to begin to tackle the issues.

- The community was not ready—it was too focused on filling the gaps in services and programs. It had to first raise awareness about issues, build residents' ability to engage civically, strengthen the community's sense of cohesion or community, and reduce conflict between residents from different racial and ethnic backgrounds before community teams could deal with systemic issues.

- The Trust's scrutiny of community teams' requests for funds to support direct action organizing, which lengthened the review time, discouraged the teams from planning and implementing actions more directly connected to building power and systems change.

Externally, other nonprofit grantees of The Trust and other organizations that used community organizing in their work expressed anger and concern over the CPOS approach, citing how it negatively impacted the organizing ecosystem and caused harm. The perception from community organizing groups was that The Trust had ventured out of its lane as a funder and hired a cohort of community organizers as staff rather than funding existing organizing groups. The Trust's salaries for its organizers were higher than what nonprofit organizing groups could pay. From The Trust's perspective, this amplified the importance of community organizing and was a signal of the profession's value. However, outside groups felt the move demonstrated condescension and mistrust of the grassroots work of nonprofits. It muddied the lines of accountability wherein organizers should be accountable to communities, not foundations.

In a handful of communities, conflicts between people from different racial and ethnic groups and between immigrants and U.S.-born residents slowed down the community teams' efforts. Community team members and Trust staff reported tensions in several communities, including among community team members, between the members and Trust staff, and between the members and CNDC (for CNDC communities only). These tensions were sometimes due to interpersonal differences (e.g., a community member who was more outspoken and demanding) and sometimes due to intergroup differences (e.g., two community members or coordinators representing different ethnicities and cultures who spoke on behalf of their community members). These conflicts contributed to The Trust withdrawing its support in two communities. In one community in particular, the conflict between two immigrant groups affected the community team's cohesion, and the support from The Trust's regional team was not enough to manage and transform these entrenched tensions and conflicts.

Sustainability was repeatedly brought up as a concern for CNDC communities. CNDC communities expressed concern about the lack of guidance and expectations about sustainability. Some of the community team members from these communities felt "abandoned" or "neglected" since The Trust shifted to the CPOS approach. The lack of clarity and guidance from Trust staff about sustainability likely made the shock of CPHE's premature conclusion even more upsetting, as these communities realized they would not be getting another year or multiple years of funding (depending on where they were in their five-year implementation plan). Although the previously mentioned culmination grant opportunity was open to all of them, culmination grants were required to go to a nonprofit partner or tax-exempt entity rather than to the team itself through fiscal sponsorship. A few CNDC community teams that were part of the phased approach shared in their final reports and with the evaluation team that more frequent communication with The Trust's staff about the culmination grant would have been helpful.

The overall lack of clarity in all the above matters took away time, energy and enthusiasm for the work. It was unclear to Community Science what The Trust's regional staff communicated to community teams about their role or the action process, and whether the explanations were consistent across regions. Some staff had more experience navigating difficult conversations about The Trust, while others were uncomfortable with these conversations. Some of the staff were also unclear because they felt that the policies, procedures and decision-makers at The Trust were not always consistent. The division—real or perceived—between the regional

staff in the field and the management and operations staff in the Denver office added to miscommunications and misunderstandings, impacting the dynamics in some communities. Insufficient clarity and guidance contributed to community teams' diminishing confidence in The Trust, disengagement, loss of community team members, and loss of time and opportunities to build power. A great deal of time and effort was spent on understanding policies and procedures, which took away time, energy and enthusiasm for planning and implementing community change efforts.

6. CONCLUSION AND RECOMMENDATIONS

Our evaluation findings reveal that the CPHE strategy enabled community teams to identify issues affecting people most impacted by health and other inequities and, to varying extents, foster or strengthen a sense of community and increase community members' ability to influence decisions that affect their quality of life. CPHE accomplishments reflected the sequence of change anticipated in the pathway of change (Exhibit 2), suggesting that capacities had to be built before actions could be taken to build power and affect systems change toward health equity.

However, the quality of the change process did not reflect an intentionality toward systems change and a power shift—as conceptualized by The Trust—for the CPHE strategy. The change process experienced by community teams was not a smooth one. There were many reasons for this, including internal challenges at The Trust, community conditions (such as the overwhelmingly urgent needs of residents), and inadequate knowledge among community team members about how to align their efforts with systems change and power building and skills to do so. The strategy also unfolded when a global crisis, the COVID-19 pandemic, impacted the nation. Despite the challenging circumstances, community teams forged forward with their activities and actions. The premature conclusion of the CPHE strategy brought disappointment, hurt and frustration with what community teams perceived as The Trust's unfulfilled promise of the strategy. Internally, the CPHE strategy presented many challenges to The Trust and its staff, as well as moments of excitement about the possibilities of the strategy.

The CPHE strategy offers rich insights into the preparation and capacities needed to implement a statewide initiative to advance health equity. Community Science recommends the following for The Trust's consideration when designing future initiatives with the same intent:

1. The Trust is a grantmaking organization that must work with community organizations to implement its strategies. It should not blur its role across funder, community organizer and intermediary[6] because such blurring causes confusion and strains The Trust—operationally, culturally, structurally and relationally—inside and outside the organization.

2. It would be helpful for The Trust, as a funder, to understand its power to broker or to inadvertently harm relationships and communities because of unclear goals, expectations and communications. Any potential or actual harm should be brought to The Trust leadership's attention and addressed immediately to prevent negative perceptions, feelings and narratives from taking root.

3. To ensure clarity in goals and expectations, The Trust should take the time to align its executive leadership, board, staff, capacity builders, evaluators and community organizations who are eligible to apply for funding on the initiative up front, not after implementation has begun. It also would be helpful to engage the evaluator while the initiative is designed to clarify the theory of change, including the outcomes and measures of progress. The evaluator can be engaged only for this stage of the work, as a commitment beyond that may be difficult for The Trust to make at the time.

4. Relatedly, if health equity is the north star for the initiative, The Trust may want to spend the time to design a strategy that intentionally links discrete activities and events that lay the groundwork for incremental change—quick wins—because effecting systems change to achieve health equity takes time. In this strategy, be clear and consistent about the following:

   a. What systems change and risks are comfortable or uncomfortable for The Trust's leadership to ensure consistent messaging about desired actions and outcomes.

   b. Which type of organizations or communities are most ready to participate in the initiative; criteria for consideration include history of collaboration among leaders and organizations (especially across racial, ethnic and cultural differences), experience with managing and implementing community projects, readiness to effect systems changes and size and location of community.

   c. What constitutes community leadership; The Trust might consider these qualities for community leadership: 1) influence and trust among the groups of people who experience disparities in the social determinants of health; 2) willingness and eagerness to learn and strengthen certain knowledge and skills (e.g., power analysis, organizing, facilitation); 3) commitment to resolving disagreements and transforming conflicts due to differences in race and ethnicity, language, gender, socioeconomic differences and other discriminating factors that keep people apart; and 4) ability to create a vision and implement ideas.

5. It might also be helpful for The Trust to invest in a community capacity-building intermediary to support the range of participating organizations and communities and connect initiatives within The Trust for better coordination and impact. The community capacity-building intermediary must be in place before initiating the grant strategy, not simultaneously or after.

6. With the help of the community capacity-building intermediary, The Trust may wish to engage its leadership, staff and grantees in dialogues about key concepts that tend to be value-laden, which, depending on a person's experiences and their role in communities and organizations, can mean different things. These concepts include leadership and leaders, community, system and systems change, community engagement, health disparities and health equity, evaluation, learning and sustainability.

7. Resources and expertise must be set aside for conflict resolution and transformation because conflicts are inevitable when engaging communities and effecting community and systems change to achieve health equity. These situations can include conflicts due to both interpersonal and intergroup differences.

Despite the challenges that surfaced through the evaluation, there were also many accomplishments that communities were able to achieve throughout the course of the strategy. These community accomplishments are highlighted in a separate evaluation report. We also share lessons learned about the ways that context matters for community and systems-change initiatives in a learning brief. The Trust took a risk with the CPHE strategy. While the process and results did not unfold in the manner anticipated by the staff, the strategy's high and low points over eight years offer many valuable lessons for The Trust and philanthropy about the implementation, management, evaluation and continuous improvement of a complex community-led health equity effort.

7. ENDNOTES

1 The Trust defines "health equity" as being achieved "when every person living in Colorado has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of any socially determined circumstances."

2 To be precise, the approach is referred to as the CPOS; however, it is commonly referred to in The Trust as CPOC. The confusion between the approach and the method illustrates the lack of clarity and poor communication about CPHE that will become evident later in this report.

3 Seven communities from across the state were included in the 2020 interviews and another seven in the 2021 interviews. The evaluation team also interviewed The Trust's regional staff (community partners, senior community organizers, community organizers and project administrators), partners working with resident or community teams, and community evaluators working with the CNDC communities as part of the data collection each year.

4 See the report about communities' responses to COVID-19 submitted in August 2020.

5 The Trust had no way of knowing which residents were from communities that applied the CPOS approach.

6 Intermediaries are organizations that assemble resources from private and public funders, leverage existing expertise and connections, and distribute these resources, expertise and connections to small and midsize community organizations for projects designed to build and strengthen community capacity to achieve health and other forms of equity.

66 *Our evaluation findings reveal that the CPHE strategy enabled community teams to identify issues affecting people most impacted by health and other inequities and, to varying extents, foster or strengthen a sense of community and increase community members' ability to influence decisions that affect their quality of life.* 99

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