

Engaging Coalitions to Improve Health and Health Care



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Editors' Introduction

For the past 20 years, the Robert Wood Johnson Foundation has funded programs involving state and local coalitions that aim at improving services, advocacy, systems, and changing unhealthy behaviors. These include coalitions to improve tobacco control policies, prevent substance abuse, contain health care costs, expand access to medical care, promote healthy behaviors and lifestyles, expand long-term care options, strengthen mental health services, provide health care services for the homeless, and, most recently, halt the epidemic of childhood obesity and address racial and ethnic disparities in health care.

The Robert Wood Johnson Foundation Anthology has featured a number of chapters that examine the work of coalitions: Irene Wielawski, “The Fighting Back Program” in Volume VII and “The Free to Grow Program” in Volume IX; Karen Gerlach and Michelle Larkin, “The SmokeLess States Program” in Volume VIII; Susan Parker, “Reducing Youth Drinking: The ‘A Matter of Degree’ and ‘Reducing Underage Drinking through Coalitions’ Programs” in Volume VIII; and Paul Brodeur, “The Injury Free Coalition for Kids” in Volume VII.

In this chapter, Laura Leviton, a senior program officer, and Elaine Cassidy, a program officer, at the Robert Wood Johnson Foundation, examine the Foundation’s efforts to build and strengthen community coalitions as a way of bringing about social change. They not only examine what has worked and what has not worked but also explore some central issues, such as the kinds of social change that are suitable for coalitions, the kinds of membership appropriate for coalitions, and the factors that contribute to a coalition’s working effectively.

Coalitions have existed in the United States since the 13 colonies banded together to share power and address a common problem.¹ Alexis de Tocqueville was the first to note the distinctly American tendency to form associations to deal with specific problems.² When a single association cannot solve the problem by itself, it is but a small step to forming a coalition.³ Over the past 40 years, governments and foundations have found it useful to engage state and local coalitions in efforts to improve health and health care. Their approach—including that of the Robert Wood Johnson Foundation—has evolved considerably.

To the best of our knowledge, the first large-scale national initiatives to bring about social change through local coalitions occurred in the 1960s with the initiation of Community Action Programs in the War on Poverty. The Economic Opportunity Act of 1964 required that Community Action Agencies provide for the maximum feasible participation of the poor, members of groups serving the poor, and local public officials. In comparison to the War on Poverty programs, community development programs of the late 1970s and early 1980s put much more power into the hands of government and less in the hands of community coalitions. In the mid-1980s, the federal government and foundations developed a renewed interest in coalitions, particularly comprehensive community coalitions, as a way of bringing about social change.

Comprehensive Community Coalitions

Beginning in the mid-1980s, the federal Centers for Disease Control and Prevention, the Center for Substance Abuse Prevention, and occasionally the National Institutes of Health began to place coalitions at the center of some of their efforts to promote health and to prevent disease. Two programs from the 1970s had stimulated their interest in a comprehensive approach to community improvement. The North Karelia, Finland, and the Stanford Five-City projects had achieved notable success in modifying risk factors for heart disease by employing comprehensive approaches that included working with schools, businesses, media, churches, and other community institutions to reduce community-wide rates of smoking, lower high blood pressure, and improve diet.⁴ The comprehensive, multifaceted health promotion and disease prevention approach has been an important model ever since for programs ranging from preventing HIV/AIDS and violence to encouraging people to call 911 when they have heart attack symptoms.⁵ In the community development arena, both the federal government and a variety of foundations have turned to coalition models. Congress authorized Empowerment Zones/Enterprise Communities in 1993 and provided flexible grants to promote the revitalization and growth of 105 distressed communities. Along with economic and community development, Congress required broad participation by all sectors of the community.⁶

At roughly the same time, foundations such as Annie E. Casey, Edna McConnell Clark, Ford, John D. and Catherine T. MacArthur, Charles Stewart Mott, Pew Charitable Trusts, and Surdna adopted the approach of Comprehensive Community Initiatives as a way to improve poor urban neighborhoods. Comprehensive Community Initiatives strive to improve distressed neighborhoods through a variety of economic and community development activities. An essential element of this approach is the community coalition that draws together organizations dealing with housing, the local economy, education, health and human services, and other community needs. At the same time,

Comprehensive Community Initiatives emphasize participation of the more informal associations and institutions of these neighborhoods' leaders and residents.

In 1990, for example, the Ford Foundation funded the Neighborhood and Family Initiative. Its aim was comprehensive improvement of specific poor neighborhoods in Detroit, Memphis, Hartford, and Milwaukee. Ford awarded grants to the community foundations of these cities to bring together those governmental and non-governmental organizations with power to improve the neighborhoods. The centerpiece of the Neighborhood and Family Initiative was a neighborhood collaborative with the authority to determine what improvements would be made and how they would be made.

Two organizations have provided intellectual leadership to Comprehensive Community Initiatives. The Aspen Institute's Roundtable on Community Change is a forum of experts in the use of community coalitions for social change, and the Chapin Hall Center for Children is a research and development center at the University of Chicago. Both institutions have long argued that a strong theory of change is vital to the work of coalitions, both to guide efforts at comprehensive community improvement and to enable evaluators to reach fair conclusions and draw lessons from the experience.⁷ Andrea Anderson, a research associate at the Aspen Roundtable, has written:

Community initiatives are sometimes planned without an explicit understanding of the early and intermediate steps required for long-term changes to occur; therefore, many assumptions about the change process need to be examined for program planning or evaluation planning to be most effective. A theory of change creates an honest picture of the steps required to reach a goal. It provides an opportunity for stakeholders to assess what they can influence, what impact they can have, and whether it is realistic to expect to reach their goal with the time and resources they have available.

Anderson then goes on to define the theory of change:

A basic [theory of change] explains how a group of early and intermediate accomplishments sets the stage for producing long-range results. A more complete [theory of change] articulates the assumptions about the process through which change will occur and specifies the ways in which all of the required early and intermediate outcomes related to achieving the desired long-term change will be brought about and documented as they occur.⁸

After evaluating a number of Comprehensive Community Initiatives, the Chapin Hall Center offered some recommendations for philanthropic grantmaking that could apply to coalitions as well:

- Take extra time to understand communities before making investments.
- Have realistic expectations and align goals accordingly.
- Accept the fact that change is messy, so conflict and risk are inherent to the process.
- Use a more disciplined process for strategy development, including a better theory of change, better recognition of barriers to change, and an intervention that is of high enough quality, power, pervasiveness, and duration.⁹

The Evolution of the Robert Wood Johnson Foundation's Work with Community Coalitions

Since 1981, the Foundation has invested \$775 million in programs to build and strengthen community coalitions. (For a representative sample, see the appendix.) Among its earliest efforts was *Community Programs for Affordable Health Care*, which was funded initially in 1981 and continued through 1989.

Community Programs for Affordable Health Care

Co-sponsored by the American Hospital Association and the Blue Cross Blue Shield Association, the purpose of Community Programs for Affordable Health Care was to restrain the rise of health care costs through broad-based coalitions of health care and other organizations. Intended to be an alternative to the two approaches then being discussed to control costs—government regulation or the wholly voluntary efforts of hospitals and other providers—the program brought together a wide range of stakeholders, such as business, labor, insurers, hospitals, physicians, and consumers, all of whom would work together to keep costs down in their community.

Although the community coalitions were supposed to be the focal point, local control was undermined in two ways. First, the program's national advisory committee was highly prescriptive in its requirements and recommendations. Second, most of the local coalitions did not develop imaginative or aggressive strategies to contain costs. Among other issues the program raised was a tension between top-down leadership and bottom-up control and direction of a program.

The evaluation concluded that the program had produced few measurable effects and presented a variety of reasons that local coalitions were simply not capable of containing costs by themselves.¹⁰ The most important reason was that only the federal government could have achieved a change of the magnitude originally envisioned; local coalitions simply did not have enough clout. The evaluators pointed out that there were probably many health goals that local coalitions *could* achieve, but that they were ill suited as vehicles for containing medical costs. In other words, the premise behind the program—its theory of change—was flawed.

Initiatives of the Late 1980s and 1990s

Despite the failure of Community Programs for Affordable Health Care, the initiative did stimulate greater interest in a coalition approach to the Foundation's work. So did the Comprehensive Community Initiatives approach adopted by other foundations. Several of the large Robert Wood Johnson Foundation initiatives of the late 1980s and the 1990s are similar to the Comprehensive Community Initiative approach. For example, the *Urban Health Initiative* engaged broad community coalitions and stimulated community participation to improve children's health in five American cities. The *Free to Grow* program supported 17 Head Start programs by organizing broad-based coalitions to reduce substance abuse in their communities. The *Fighting Back* program focused on establishing community coalitions composed of local citizens, agencies, and organizations that would work together in combating substance abuse.

As with the Comprehensive Community Initiatives, these programs sometimes experienced struggles for control over the direction of planning and implementation when local coalitions had different expectations from those of program directors.¹¹ Other Foundation programs also engaged community coalitions, but did not aim for comprehensive change in neighborhoods. For example, the *Faith in Action* program funded local interfaith coalitions to provide volunteer services such as transportation and household chores to homebound chronically ill people.

In the Fighting Back program, there are echoes of the call for a strong theory of change reminiscent of the Comprehensive Community Initiatives. In brief, the Fighting Back theory of change had two parts:

- Each community had a unique context that affected the nature of its substance abuse problem. Outside experts would not be familiar with the local context, so effective programs were more likely when local grassroots leadership worked with local health care and social service providers and with the police.
- Existing solutions focused on the reduced availability of drugs, but not on reduced demand. It was assumed that local direction of Fighting Back could reduce the demand for drugs. Citizen participation was needed to change community attitudes and behavior about drug use.¹²

The evaluation of the program concluded that the initiative produced little, if any, change in the use of alcohol and illegal drugs—a conclusion that is vigorously challenged by the program’s proponents.¹³

The debate over Fighting Back has been highly revealing about different perspectives on community-based coalitions: on the one hand, some people believe that local coalitions are a way—and perhaps *the way*—to address community health issues. While on the other hand, others doubt that local coalitions can accomplish much of value.¹⁴ These differences of opinion may be easier to resolve than the debaters realize because the theory of change may not have been strong enough for a long enough period of time for the actions of coalitions to be effective. The Fighting Back director, David Rosenbloom, has pointed out that until recently there were no effective strategies—community-based or otherwise—to reduce the demand for harmful substances. Without effective activities to reduce demand, local direction and citizen participation would simply not be sufficient to reduce substance abuse.

For the Foundation, 1996 was a watershed year in thinking about local coalitions, as the Fighting Back program changed both its leadership and its direction.¹⁵ Before 1996, the program was clearly floundering. Coalitions often had cumbersome governance and members had conflicting agendas; proposed activities changed, depending on who showed up at meetings. The new director of Fighting Back guided the remaining coalitions toward more coherent governance and narrower membership, and helped them to focus their program activities. Inclusiveness is an important goal, but at some point there needs to be an agreement to proceed with a plan. Some Fighting Back coalitions were not renewed because they could not change their approach, which discouraged some of their participants from collaborating on projects to address other community problems. The experience has been sobering for Foundation staff members.

Current Foundation Programs

The Robert Wood Johnson Foundation's support of coalition-based programs benefited in many ways from initiatives of the early 1990s. Perhaps the structure and direction of Foundation initiatives have not changed as much as the clarity of expectations from the start of program planning and operation. In the present day, the Foundation strives to convey these expectations in advance. It selects an overall approach, ideally with a strong theory of change, to drive activities. Grantees are expected to adopt the overall direction set forth by the Foundation, but local coalitions have some flexibility to adapt the overall model to their own circumstances. Setting these expectations in advance helps align coalition partners with the Foundation's overall goals and strategies. It also helps avoid some, but not all, struggles for control of the program direction.

Ideally, programs and grantees address a problem for which there are clearly specified activities aimed at solutions. In order for the program to meet its end of this bargain, the theory of change has to be strong or at least plausible, and needs to take into account what is feasible to do in the communities where the coalition operates. With this in mind, the programs rely on local wisdom to make the activities relevant and effective. Two Foundation-funded programs, *Allies Against Asthma* and *Covering Kids and Families*[®], illustrate the diversity of health and health care problems that are currently being addressed through coalitions.

Allies Against Asthma: A Program to Combine Clinical and Public Health Approaches to Chronic Illness

Of all chronic childhood diseases, asthma is the most common. Although asthma is found in all social classes and racial and ethnic groups, it is most likely to burden children from poor, urban, minority communities. Although significant advances in asthma management have emerged in the past decade, some 6 million children continue to suffer from the disease. Variations in health care recommendations and practices, treatment adherence by patients and families, access to high-quality health services, and exposure to high levels of environmental allergens and irritants all undermine the quality of asthma care for many children, especially those from low-income backgrounds. Treatment and prevention can include pressuring landlords to deal with mold and mildew in run-down housing, making sure that the school nurse keeps medication on hand for acute episodes, and helping families understand the ways they can manage their children's illness. Asthma is a complex disease, requiring complex management and the cooperation of many people—circumstances where a local coalition might be able to bring people together who could collaborate in improving care.

In 1998, the Robert Wood Johnson Foundation authorized \$12.5 million for the Allies Against Asthma program. The program, which runs over a nine-year period, consists of seven coalition grantees, each comprising stakeholders such as local health care providers, schools and day care centers, community advocacy groups, businesses, local government organizations, managed care organizations, academic institutions, parent groups, and other community-based organizations. The coalitions' goal is to improve asthma care for children under 18 years of age, especially those seen under publicly financed systems of care or targeted by safety net providers.

Allies Against Asthma is based on a strong theory of change, both at the level of specific interventions and at the community level. In brief, there is good evidence that asthma interventions are generally effective; what is lacking is a way to get them into widespread use. At the community level, Allies employs the model of comprehensive community-based health promotion, which has often proved more effective than individual, one-on-one patient education. The Allies' theory of change focuses first on developing a manageable and inclusive coalition, which then assesses opportunities for intervention. These interventions are directed toward achieving intermediate results, such as health-provider training or improved management of the disease by the families. The intermediate achievements are expected to affect asthma-related outcomes, including fewer emergency room visits and utilization rates related to asthma. The activities within each of these general components may vary across coalitions, but such variation on the common themes is intentional: the specifics are driven by local context, while the overall model remains the same.

The coalitions have used a variety of strategies to improve pediatric asthma care. Most of the coalitions have educated providers about advances in pediatric asthma treatment and have helped families of children with asthma recognize the conditions that can trigger an attack so as to avoid severe episodes. Allies coalitions also promote policies that help families manage asthma, such as making medication available in schools and child-care settings. Coalition members receive training in policy advocacy and support in implementing changes. Like many recent community-based initiatives, Allies seeks a comprehensive change in the way care is delivered, drawing on the cooperation of many organizations and individuals who have the power and resources to make the changes.

Because the activities of the coalitions need to be relevant to the people who are most involved with the problem—parents and children with asthma—the Allies program requires strong community and parental participation in decision-making about the activities of the local coalitions. Strong community participation offers opportunities for patients and families to make their voices heard. By inviting community members to participate in early conversations about the Allies coalitions, for example, the program learns about different communities' strengths, needs, and political sensitivities.

The *Alianza Contra el Asma Pediátrica* (Allies Against Pediatric Asthma) in Puerto Rico focuses on the Luis Lloréns Torres public housing project. With over 8,800 residents, it is the largest low-cost housing community in the United States and the Caribbean. About 600 of the project's children have asthma. The *Alianza* uses staff members from both the local public health clinic and the housing project's community center to recruit children with asthma into clinical treatment. In addition to numerous clinic-based, community-based, and school-based activities, the coalition provides information to families about their rights to safe housing for their children, as well as educational sessions and home visits from community health workers.

The *Alianza* directors made a presentation that provided information on the project's strengths, challenges, and achievements.¹⁶ The staff members have long experience with a community-centered approach to public health and health care. They brought key local stakeholders into the coalition. These included AmeriCorps*VISTA volunteers, Líderes Independientes de Luis Lloréns Torres, Luis Lloréns Torres Resident Councils, Head Starts, schools, the apartment complex management

corporation, and the police department; islandwide organizations such as APNI (the Association of Parents of Children with Disabilities), ASPIRA (a nonprofit organization devoted to education and leadership development for Puerto Rican youth), Banco Popular of Puerto Rico, Quality for Business Success, the Puerto Rico American Lung Association; and medical care providers and systems, including the Luis Lloréns Torres Diagnostic and Treatment Center, Medical Card Systems, and the San Jorge Children's Hospital.

There were challenges to the coalition's work. The *Alianza* encountered some clashes within the coalition related to differences in attitudes and values, and also to power and role conflicts among community leaders, other coalition members, and the staff. The directors needed to "balance the community's perceptions of need for services and immediate action with the expectations and requirements of the funding agency and the procedures of the academic grantee institutions," and to "develop trust between the community and university partners," according to the *Alianza* presentation. However, the directors pointed out that these conflicts are a normal part of coalition work. They dealt with them by improving communication, clarifying expectations, using principle-guided conflict resolution, and using language that everyone could understand.

The Allies' evaluation is attempting to determine the effect of the coalitions' work at the individual, community, and population levels. Individual health outcomes for the children and families will be compared with those of similar families living outside the program's geographic areas. These health outcomes include the children's quality of life, daytime and nighttime symptoms, and self-reported hospital and emergency department visits. Community-level changes include the degree to which asthma action plans are standardized and the growth of policies that promote better asthma care. At a population level, the evaluation is tracking reductions in asthma-related hospitalizations and emergency department visits.

Because visible changes in population-level health outcomes may not emerge until Robert Wood Johnson Foundation funding of the program has ended, the Allies' evaluation is being conducted in partnership with the federal Centers for Medicare & Medicaid Services and the Agency for Healthcare Research and Quality. They plan to obtain health care utilization data for the Allies' sites and comparison communities for the periods before, during, and after the coalitions' interventions.

Covering Kids and Families

The purpose of Covering Kids and Families is to enroll eligible children and their families in Medicaid and in the State Children's Health Insurance Program, or SCHIP. The original program, Covering Kids, was funded by the Foundation in 1997, and Covering Kids and Families, an extension of the program to involve families as well as their children, was funded in 2001. The program has three goals: outreach to children and families to help them enroll in Medicaid and SCHIP; streamlined state procedures for enrollment and renewal of coverage; and the coordination of benefits across different categories of insurance eligibility. Materials for the program state, "The family should not have to know program details in order to apply for coverage, nor should decisions on coverage be delayed as information is transferred between programs."¹⁷ Funding goes to statewide

coalitions, but each state must also have at least two local coalitions. At least half of the funds go to support local coalition activities, which serve as learning laboratories for the statewide coalitions.

In brief, the theory of change behind Covering Kids and Families is as follows: state and local coalitions can overcome specific barriers to enrollment. By getting in touch with families through the institutions they trust (schools, churches and others), the coalitions can persuade families to enroll. By advocating at the state level for a streamlined enrollment and renewal process, they can overcome bureaucratic barriers to enrollment. By helping to manage the coordination of benefits across different categories of eligibility, the coalitions can prevent the families from being dropped by public insurance. And insurance coverage means that the families' chances to obtain appropriate medical care are greatly increased.

The entire process, however, makes two key assumptions: (1) that the expansion of public insurance eligibility for the poor, seen in the late 1990s, will be maintained; and (2) that publicly insured people will have access to care. The first assumption has been problematic and may have compromised the overall effectiveness of the program. To overcome access barriers, the program's coalitions have undertaken special initiatives to increase access to care.

As of April 2006, 45 state and more than 140 local Covering Kids and Families coalitions were in operation. The coalitions range in size from five to 232 members, and membership is fluid and changing.¹⁸ The state coalitions, with a median of 52 members, are generally larger than local coalitions, with a median of 24 members. Most of the coalition membership at both state and local levels comes from community organizations that care for and represent the poor. They bring with them volunteers, credibility, and the trust they have gained in low-income communities. Of the three Covering Kids and Families activities—outreach, simplifying enrollment, and coordinating insurance benefits across programs—the local community organizations clearly have the most resources to bring to bear on outreach. At the state level, they are able to work for their constituencies by advocating streamlined enrollment and preservation of public insurance dollars.

Community-based organizations are a particularly appropriate way to reach rural populations and people facing special cultural and language barriers to public health care coverage.¹⁹ Outreach works through the organizations and community associations upon which these populations depend. These organizations can help overcome mistrust of public agencies, as well as the stigma associated with reliance on public programs. Churches and mosques, for example, can reach out to groups of new immigrants and rural populations. Members of coalitions can also use their knowledge of the community to make their outreach more effective. For example, the Chicago coalition's knowledge of the Korean community led it to advertise the need for enrollment in Medicaid and SCHIP on a Korean-language television soap opera in Chicago.

The state and local coalitions have similar membership, except that there are more government officials in the state coalitions and more school and education representatives in the local coalitions. The involvement of government officials in the state coalitions makes sense since government controls the Medicaid and SCHIP procedures. In the same way, schools are important to local coalitions as places to enroll children, especially during annual back-to-school campaigns.

Relatively few Covering Kids and Families coalition members are individual residents of the affected communities. This offers a distinct contrast to the Allies initiative, in which individual parents participated in the coalitions' decision-making. In the context of this program, however, individual community residents bring fewer resources to the table than do the community-based organizations that work on their behalf.

Coalition members provide a variety of resources. In order of frequency, these are: time, help in gaining access to uninsured families and children; help in gaining access to policy-makers and influential people; help in mobilizing a constituency in support of Covering Kids and Families goals; access to the media or the public; and funding.

Collaboration often works to overcome conflicting agendas by providing a win-win scenario. The California and New Mexico coalitions, for example, worked with the U.S. Citizenship and Immigration Service (formerly the U.S. Immigration and Naturalization Service) to clarify policy for new immigrants. This collaboration insured that parents received accurate information that their child's enrollment would not jeopardize their own or their child's immigration status. In Las Cruces, New Mexico, the coalition arranged for immigration officials to speak at community meetings about these issues, and handed out materials that spelled out immigrants' rights.²⁰

Surprisingly little conflict arose out of the operation of the coalitions. This is probably testimony to the clarity of the goals and process, and the extent to which the state and local partners had accepted them. Conflict is more likely when coalitions are first forming, as the partners test each others' intentions and vie for power and leadership. Conflict is also more likely when goals are unclear, as conflicting agendas can play out. Finally, conflict is more likely when members are in a competition for resources.

Although the theory of change underlying Covering Kids and Families is explicit, coalition members have different priorities, depending on their resources and their roles. Outreach to enroll children and families is the most important goal for local coalition members—understandably, since enrollment is where local coalitions make their biggest contribution. State coalitions report that their most important goals are simplified enrollment and avoiding cutbacks in state funding. The state-level directors generally place coordination of coverage—a very different priority—at the top of their list. They are in a position to see how all the other activities can be defeated—outreach, simplification, and state funding—if there is no coordination. Coalitions can enroll thousands of families, but if they are dropped because of eligibility changes or transitions, the effort is wasted.

According to the evaluation of the program, the coalitions have enrolled thousands of families and children, and they have had some success in streamlining eligibility applications and coordinating benefits. However, tight economic times for states have hindered their efforts. Coalition members mentioned barriers that were beyond their control: state funding issues and new restrictions in Medicaid and SCHIP. The state-level coalitions cited day-to-day obstacles to their work, such as politics, the Medicaid bureaucracy, and a lack of support from state agencies. The evaluation reports noted “a palpable sense of frustration” over these obstacles.²¹

Concluding Thoughts

Our examination of the Robert Wood Johnson Foundation's strategy in coalition building raises a number of issues concerning coalitions as a vehicle for bringing about social change. Three of them are of primary importance.

Coalitions as an Effective Means for Promoting Social Change

Coalitions have a decidedly mixed record of achievement in reaching their goals. Nationally, some people continue to be profoundly skeptical that local coalitions can achieve very much, and they question whether those coalitions are even appropriate to achieve societal change. Some of this skepticism is based on the mixed track record to date. Some of it is also a reaction to the overuse of coalitions to solve a wide variety of problems. One senior staff member at the Foundation has had a great deal of success in working with coalitions. For that very reason, she understands their limitations. As she pointed out, "We keep pushing coalitions as a way to do our work, but they can be a real waste of time. Why have a coalition when I can identify the right organization that can do the job?" Coalitions take considerable time and energy, so they should never be undertaken lightly. They are not the answer to every social problem.

Finally, some of the skepticism about local coalitions comes from a tendency to "overprofessionalize" the proposed solutions by asserting that the problems of health and health care can be solved only by government and by professionals. The debate about the Fighting Back program illustrates the schism: some say the program has not brought about measurable reductions in substance abuse, and others challenge the methodology or say that it has had positive benefits anyway. The critics doubt that community wisdom and commitment can be sufficient to overcome the overwhelming problems of substance abuse and drug trafficking.

The Need for Strong Theories of Change

The debate over effectiveness misses a central issue: strong theories of change are absolute prerequisites to achieve social change through coalitions. Effective (or at least plausible) interventions are the basis for a strong theory of change: if there is no strong theory, there is no "active ingredient," and therefore no change. Fighting Back illustrates the problem. At the time the program was being developed, no one had any solutions to reducing the demand for drugs—not the community, not the professionals, and certainly not the government. A coalition requires an effective strategy of change to apply to a community problem, just as a hospital needs effective therapy if it is to save lives. Saying that coalitions failed to reduce the demand for drugs is like saying that hospitals fail because people die in them. Both the hospital and the coalition are the vehicles for intervention, not the "active ingredient." Hospitals can be of greater or lesser quality, and local coalitions can operate with greater or lesser direction and force. But these are the vehicles for intervention, not the interventions themselves.

Strong theories of change are important, not just for programs that employ coalitions but for health and social programs of any kind. Theories of change (and a closely related concept, logic models) have long been recognized as essential to assure effective programs and to provide them with a fair and constructive test.²² In general, evaluators are concerned that the interventions that are tested are simply too puny to make a difference in measurable outcomes.²³

Interventions need to be of sufficient duration, and be both relevant and powerful enough to produce measurable change. The theory of change highlights these issues for program planners.

We would argue, however, that strong theories of change are especially important in programs that employ coalitions because the coalition members bring a wide variety of other agendas with them. Without a compelling common purpose and way of achieving it—plausible, understandable, and agreed upon by all—coalition members can find it far too easy to capture the effort for their other agendas and divert both resources and activities away from the stated goal. As in the case of certain Fighting Back coalitions, without a central core and agreement to proceed, the agenda and planned activities are vulnerable to constant change.²⁴

How to Create and Manage an Effective Coalition Process

Coalitions do not simply appear; they are built. Either they were functioning before a grant was awarded or else the hard work of coalition building has to begin after the award. It is essential to recognize that people build coalitions, not foundations and not their money. Money can assist coalitions, free up resources and attract attention. Foundations can offer good ideas, skilled facilitators, technical assistance and networks for sharing. But local leaders build the coalitions. The Foundation's most important error in its early community initiatives was to assume that money would be sufficient to build state and local coalitions. On the contrary, the money can make it seem that there is a coalition when there is none. State and local leaders and organizations come together around Foundation initiatives only when they believe that the purpose of the initiative is consistent with their own common purpose. Foundations engage coalitions; they do not build them.

Community organizers have developed considerable expertise around building and leading coalitions.²⁵ The Comprehensive Community Initiatives and other recent community-based coalitions highlight the importance of building and leading coalitions correctly. Poorly structured coalitions and poorly understood expectations have derailed community-based efforts. On the other hand, expertise in community organization is seen in the two case studies of Allies Against Asthma and Covering Kids and Families. With a change in leadership, Fighting Back was also able to refocus the remaining coalitions on the work at hand. Considering these and other experiences, we would argue that Foundation-funded coalitions work best when the leadership of a national initiative has expertise in community organization.

There is a range of legitimate models for community coalitions.²⁶ The degree of shared power with community participants can vary depending on the goal of the coalition. In some cases, all that may be required is community consent or buy-in. The Covering Kids and Families coalitions tended toward this model. In other cases, the program may be committed to solving the problems that the community residents identify, then building capacity and activities to address these problems. The Allies program tended toward this model (with the proviso that activities had to address asthma). The revised Fighting Back program after 1996 was somewhere between the two.

Participation should be dictated by the perspectives and resources that the coalition needs. In the Allies program, the perspective of family members was absolutely critical to ensure the relevance of interventions. In Covering Kids and Families coalitions, direct participation by families was less relevant to the purpose at hand. Other coalition members are usually asked to the table because they have needed resources, or have the know-how for implementation. Resources and know-how are critical, because community-based problem-solving tends to falter at the transition from planning to implementation.²⁷

There is a strong tendency for those working with coalitions to conflate the coalition itself with participation by the affected parties. Some funders, and many of those who study coalitions, view the quality and the extent of community participation as an outcome of programs, on a par with program outcomes such as community betterment and health and societal changes. Most of us would agree that community participation is a good thing. If the community is not better off, however, what is the value of the participatory process?

Inclusiveness is not the only criterion for excellence in a coalition. Clarity of purpose and effective governance are at least as important. They are especially important when communities are under stress because of poverty, high crime rates, inequality of resources, or a lack of trust. When the Robert Wood Johnson Foundation invites these community partners to the table, they bring precious commodities: limited time that could be used to solve many other community problems, limited resources that could be applied in many other ways, and personal reputations in the communities where they live. A well-functioning coalition and a clear theory of change can assure that these precious commodities are well-used, and even enhanced.

In sum, debates about the effectiveness of coalitions in health and social programming miss the point: no program can be successful if its theory of change is inarticulate, weak, or built on flawed assumptions. At the same time, as the vehicle of social change, coalitions need good governance, a clear focus, and the right participants at the table. Greater attention to these issues at the planning stage will create a winning proposition for communities and improve the track record for effectiveness of coalition-based programs.

Appendix: Some Major National Programs that Engage Coalitions	Initiative	Dates	Amount
	Community Programs for Affordable Health Care	1981–1989	\$13,828,000
	Community Care Funding Partners Program	1981–1997	\$7,151,000
	Health Care for the Homeless	1983–1990	\$18,082,000
	Health Care for the Uninsured	1985–1992	\$6,153,000
	Fighting Back	1988–2003	\$68,365,000
	Free to Grow	1992–2006	\$13,230,000
	Coming Home	1992–2005	\$13,004,000
	Reducing Underage Drinking Through Coalitions	1995–2005	\$19,742,000
	Urban Health Initiative	1995–2006	\$62,911,000
	Covering Kids	1997–2002	\$43,930,000
	Allies Against Asthma	1998–2006	\$12,278,000
	Faith in Action	1999–2007	\$50,500,000
	Covering Kids and Families	2001–2006	\$64,863,000

Note: This list is for illustrative purposes and does not include all of the Foundation-funded programs that engage coalitions.

Notes

1. According to the Center for Philanthropy and Nonprofit Leadership, a coalition is “an alliance of individuals and organizations working together on a common purpose.” (www.npgoodpractice.org) “Alliances” are relationships of shared power, limited in time and scope. In coalitions, individuals and organizations decide that their own interest is served by ceding some power and resources to a larger alliance. The focus of coalitions that emphasize social change is collaboration, “a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that go beyond their own limited vision of what is possible.” (Gray B. *Collaborating: Finding Common Ground for Multiparty Problems*. San Francisco: Jossey-Bass, 1989.)
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