Building Advocacy Capacity: Where Grantees Started

Consumer Voices for Coverage Evaluation

Prepared by:

Jung Kim
Debra A. Strong
Judith Wooldridge
Margaret Gerteis

Mathematica Policy Research, Inc.

September 8, 2009

MATHEMATICA
Policy Research, Inc.

Robert Wood Johnson Foundation

Nearly 50 million Americans lack health insurance. In response, many states and the federal government are considering options to expand health insurance coverage. To promote health care policies that will achieve meaningful increases in coverage at the state or federal level, elevate the consumer voice in health care reform, and strengthen state-based consumer health advocacy networks, the Robert Wood Johnson Foundation is funding the Consumer Voices for Coverage program. The goal of this 12-state initiative is to support networks of consumer organizations and build their capacity to advocate effectively on health insurance coverage issues. This report describes the level of core advocacy capacity among the leadership teams at the beginning of the initiative. Measures of capacity are subjective. They do not apply to the grantee organization itself, but to the entire leadership team, which in some states included organizations inexperienced in advocacy, or partners that had never before collaborated together. Data collected in 2009 show substantial increases in specific capacities at many sites. Therefore the measures reported here should be viewed as a snapshot in time only, and should not be attributed to the CVC grantee organizations or any individual members of their coalitions. Rather, this information is provided to help CVC stakeholders determine the best opportunities for increasing network capacity.

Despite the current economic downturn (and in part because of it), momentum has increased for achieving health care reform. Even traditional opponents of government- or consumer-led reform efforts are now engaged in the issue (Pear 2009). The capacity of consumer organizations to participate actively in state or federal reform debates will affect their success in shaping health coverage policy in ways favorable to consumers. Building and sustaining such capacity within strong, statewide networks of consumer organizations is the core strategy of the Consumer Voices for Coverage (CVC) program funded by the Robert Wood Johnson Foundation (RWJF). Therefore, assessing advocacy capacity among grantees and their leadership team members at baseline, and measuring how it changes, is a crucial goal of the evaluation.

This report describes findings from early assessments of the advocacy capacities of CVC leadership teams during the first year of the grant program (2008). The report also combines data from that assessment with baseline evaluation data collected from other sources to consider implications for the CVC grant program.

A. What Types of Capacity Are Needed for Effective Advocacy?

In its October 2006 report, Consumer Health Advocacy: A View from 16 States, Community Catalyst described six core capacities common to successful advocacy organizations and efforts. Paraphrased, these capacities are:

1. Building coalitions and maintaining strategic alliances ("coalition building")
2. Building a strong grassroots base of support ("grassroots support")
3. Analyzing issues to develop winnable policy alternatives ("policy analysis")
4. Developing and implementing health policy campaigns ("campaign implementation")
5. Designing and implementing media and communication strategies ("media and communications")
6. Generating resources from diverse sources to sustain efforts ("resource development")

Mathematica Policy Research, with input from Community Catalyst, the national program office for the CVC program, developed an instrument to assess these six core capacities within the CVC leadership teams. To measure each capacity more concretely, Mathematica identified five or six specific elements of each core capacity, based on characteristics identified in the Community Catalyst report (Table 1). For example, two of the elements of the core capacity of coalition building are (1) the leadership team's ability to achieve alignment and buy-in among leadership team and other partners around common policy principles, and (2) the leadership team's ability to develop working relationships with nontraditional allies.

Methods and Approach to the Analysis

A representative of the grantee at each of the CVC sites was asked to complete the assessment of his or her leadership team, independently or with input from other staff or leadership team members. In addition, Community Catalyst and Mathematica staff independently completed a capacity assessment.[1] Respondents were asked to score the leadership team's current overall capacity and each individual element on a scale from 1 to 5, with 1 being little or no capacity and 5 being very strong capacity.[2]

Of the respondents, grantees might be the most familiar with their leadership team's capacities; however, using a self-assessment approach poses several potential challenges and risks. Grantees at different sites might have interpreted the scale in different ways such that a score of 5 at one site could reflect a different level of capacity than the same score at another site. Grantees might have also overstated their capacities based on their perceptions of the assessment; some might have felt the assessment was a judgment on their performance. Furthermore, Community Catalyst and Mathematica staff members' knowledge of the leadership teams' capacities varied because it was early in the program. For these reasons, we focus our discussion of findings first using the analysis of capacity scores averaged across all three respondents. Then we describe findings from analyzing only the grantee's scores, to look at the relative distribution of capacity development for each site independently; this analysis adjusts for variation across sites and for the potential to overstate capacity. These limitations and the method for looking at relative capacity development are described more fully in Appendix A.

[1] Mathematica had limited contact with the leadership teams; Mathematica staff reviewed CVC grant applications and observed the leadership teams during one site visit early in the grant period. Mathematica did not complete the survey for two sites that staff had not visited.

[2] Respondents were not asked to rank the capacities or the elements, so respondents could have given each capacity the same score. For each core capacity, we asked respondents to score the leadership team's overall capacity and the capacity for more-specific, concrete elements related to the core capacity. To keep the survey to a manageable length, we limited the number of individual elements to five or six; the individual elements were not intended to represent each core capacity in an exhaustive fashion. We anticipated that some respondents might feel they were expected to match their scores for overall capacity to their scores for the individual elements, or vice versa, but we felt providing any instruction could introduce more bias. Thus, respondents were not given any instruction on aligning the scores for individual elements with the score for the overall capacity.

Table 1. Core Advocacy Capacities and Their Individual Elements

Core Capacity	Individual Elements
Building coalitions and maintaining strategic alliances (Coalition building)	1. Leadership team's ability to work together on health advocacy 2. Ability to engage and include core constituencies in coalition's efforts 3. Ability to achieve alignment and buy-in among leadership team and other partners around common policy principles 4. Ability to share decision making and reach working consensus 5. Ability to lead, inspire, and keep network members unified 6. Ability to develop working relationships with nontraditional allies
Building strong grassroots base of support (Grassroots support)	1. Leadership team's ability to organize and mobilize grassroots constituencies 2. Ability to recruit and train consumer advocates 3. Ability to engage grassroots constituencies reflecting the ethnic and demographic diversity of the state 4. Ability to engage grassroots constituencies that represent all geographic areas of the state 5. Ability to obtain and use input from grassroots constituencies in developing policy alternatives 6. Ability to gain visibility and credibility in key communities
Analyzing issues to develop winnable policy alternatives **(**Policy analysis)	1. Having substantive expertise on legal and policy issues related to health care coverage 2. Ability to monitor emerging legislative, administrative, and legal actions related to health care coverage 3. Ability to analyze emerging legislative, administrative, and legal actions and quickly assess their potential impacts 4. Ability to develop consensus on key health coverage policies or policy issues 5. Ability to gain visibility and credibility with key policymakers 6. Ability to influence the state's policy agenda
Developing and implementing health policy campaigns (Campaign implementation)	1. Ability to develop coalition vision and health coverage policy goals 2. Ability to plan an advocacy campaign to achieve coalition goals 3. Ability to implement the advocacy campaign 4. Ability to respond nimbly to opportunities or threats affecting policy goals 5. Ability to build and maintain relationships with policymakers across parties and viewpoints 6. Ability to build and maintain relationships with opinion leaders in the state
Designing and implementing media and communication strategies (Media and communications)	1. Ability to develop talking points and messages for each target audience 2. Ability to train messengers and media spokespersons 3. Ability to develop relationships with key media personnel 4. Ability to use appropriate media (print, broadcast, internet, or other) in an effective way 5. Ability to monitor media coverage and identify advocacy opportunities 6. Ability to convey timely information to grassroots organizations, advocacy organizations, and other supporters
Generating resources from diverse sources to sustain efforts (Resource development)	1. Ability to raise funds for advocacy from more than one source 2. Ability to raise funds from different types of sources (such as memberships, private contributions, foundations, or other sources) 3. Ability to gain visibility and credibility with potential funding sources 4. Ability to market successes to potential contributors 5. Ability to dedicate staff for fundraising and development

Source: CVC Advocacy Capacity Assessment Instrument, Mathematica Policy Research 2008.

Capacity areas are interrelated and often build upon one other. For example, the capacity for analyzing issues to develop winnable policy alternatives overlaps with, and to some degree precedes, the capacity for developing and implementing health policy campaigns. Leadership teams with the capacity to develop policy alternatives or build consensus on key issues are more likely to have the capacity to implement a campaign or respond to opportunities or threats to their policy proposals. Because the CVC program selected organizations that have been leaders in health care reform efforts in their states, however, most or all sites will likely have some level of capacity upon which to build (Consumer Voices for Coverage 2008). In addition, leadership teams might rely on other groups to provide expertise in certain areas, or there might be other factors that affect a leadership team's ability to conduct effective advocacy. Therefore, the focus of this assessment is to understand the baseline capacities of the leadership teams. Future evaluation activities might explore the interconnectedness of the core capacities and whether the presence or absence of specific capacities or other factors affect coalition activities and effectiveness.

B. Key Findings

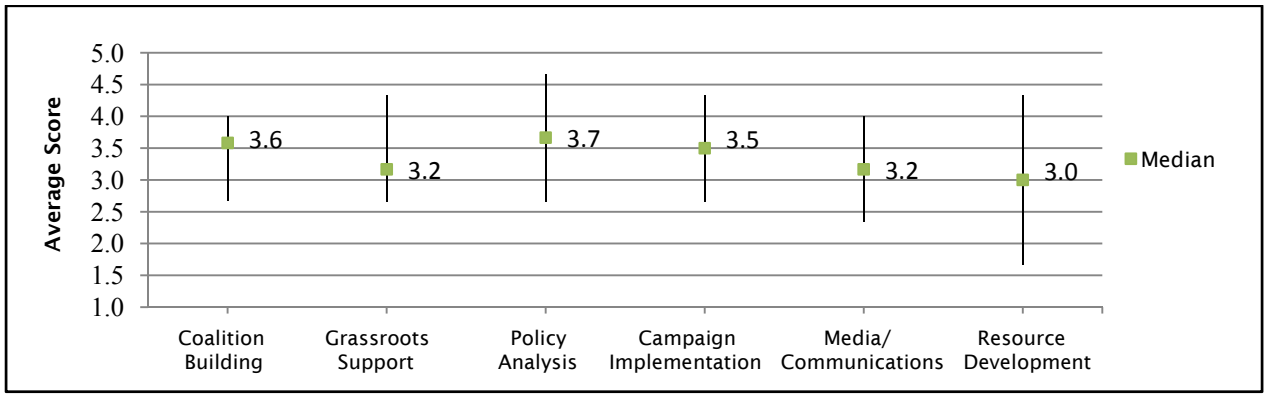
We focus our discussion of findings using the capacity scores averaged across all three respondents (grantees, Community Catalyst, and Mathematica). We first describe the capacity areas respondents identified as the most and least developed. Then we discuss the capacity areas the grantees identified as priorities for the evaluation to assess during the first year of the CVC program. Finally, we discuss how we used only the grantee scores to look at the relative distribution of capacity development for each site, in order to provide a more-complete picture of capacity development.

1. Respondents identified many well-developed capacities within CVC leadership teams.

RWJF and its national advisory team selected 12 highly qualified grantees from the pool of 40 applicants. It is not surprising that across the 12 sites, grantees assessed their leadership team's capacities in many areas as well developed. Perhaps because of the selection process, capacity ratings were often clustered at the high end of the scale.

Across all sites combined, respondents (grantees, Community Catalyst, and Mathematica) assessed policy analysis as the most-developed capacity (median score of 3.7) and resource development as the least-developed capacity (median score of 3.0) (Figure 1). After policy analysis, two capacities—coalition building and campaign implementation—had the next-highest median scores (3.6 and 3.5, respectively), followed by grassroots support and media/ communications (median scores of 3.2).

Figure 1. Average Scores for Overall Capacity



Source: 2008 baseline capacity assessment, Mathematica Policy Research.

Note: Scores from all respondents (grantees, Community Catalyst, and Mathematica) were averaged for each overall capacity for each site. The median score across all sites is displayed as the square data point. The vertical line represents the range of scores across all sites.

Average overall scores for the six capacities show that sites vary both in the range of scores across the capacities and in which capacities respondents perceive to be well developed (Table 2). Illinois had the largest range in scores (2.3 to 4.7); scores for Colorado were very similar (ranging from 2.7 to 3.0). Scores for five sites were clustered between 3.0 and 4.5 and for four sites between 2.5 and 4.3.[3]

2. Among all sites combined, policy analysis was perceived as the most-developed capacity.

Policy analysis, both overall and with respect to several individual elements, was assessed as the capacity with the highest score. In 7 of the 12 sites respondents scored policy analysis as the most-developed capacity. In particular, respondents felt the following individual elements of policy analysis were well developed:

- Ability to monitor emerging legislative, administrative, and legal actions related to health care coverage (average score of 4.3)
- Expertise on legal and policy issues related to health care coverage (average score of 4.0)
- Ability to analyze emerging legislative, administrative, and legal actions and quickly assess their potential impacts (average score of 3.9)
- Ability to gain visibility and credibility with key policymakers (average score of 3.8)

[3] We generated an average score across all individual elements of each capacity (not presented in this report). For 7 of the 12 sites, the average score across individual elements differed from the average score for the overall capacity by a score of 0.5 or greater. However, the range of scores using the average across individual elements changed for only 2 sites.

Table 2. Average Scores For Overall Capacity, By Site

Site	Capacity						Range	Difference
	Coalition Building	Grassroots Support	Policy Analysis	Campaign Implementation	Media and Communications	Resource Development		
California	4.0	2.7	4.3	3.7	3.3	3.0	2.7–4.3	1.6
Colorado	3.0	3.0	3.0	2.7	2.7	2.7	2.7–3.0	0.3
Illinois	4.0	3.0	4.7	3.3	3.3	2.3	2.3–4.7	2.4
Maine	3.7	3.0	4.0	3.7	3.0	2.7	2.7–4.0	1.3
Maryland	3.3	3.0	4.5	4.3	4.0	4.3	3.0–4.5	1.5
Minnesota	3.0	3.7	2.7	2.7	2.3	3.0	2.3–3.7	1.4
New Jersey	2.7	3.3	3.0	3.0	3.0	1.7	1.7–3.3	1.6
New York	3.7	4.0	4.0	3.7	3.7	3.3	3.3–4.0	0.7
Ohio	3.5	3.0	4.0	3.0	3.5	3.0	3.0–4.0	1.0
Oregon	3.0	4.0	3.0	3.0	2.5	2.5	2.5–4.0	1.5
Pennsylvania	3.7	4.3	3.3	4.0	3.7	3.5	3.3–4.3	1.0
Washington	3.7	4.3	3.3	3.7	3.0	3.3	3.0–4.3	1.3
Cross-Site								
Median	3.6	3.2	3.7	3.5	3.2	3.0		
Average	3.4	3.4	3.6	3.4	3.2	2.9		
Minimum	2.7	2.7	2.7	2.7	2.3	1.7		
Maximum	4.0	4.3	4.7	4.3	4.0	4.3		

Source: 2008 baseline capacity assessment, Mathematica Policy Research.

Note: Scores from all respondents (grantees, Community Catalyst, and Mathematica) were averaged for each overall capacity. Scores for two sites did not include ratings by Mathematica.

This table provides a snapshot of core advocacy capacity among the 12 leadership teams at the beginning of CVC. Measures of capacity are subjective. They apply not to the grantee organization or individual members, but to the entire leadership team, which may include organizations inexperienced in advocacy and partners that had never before collaborated. Data from 2009 suggest widespread increases in capacities. This information is provided to help CVC stakeholders plan how to increase network capacity.

One grantee respondent commented that "our leadership team includes … some of the leading policy experts in the state, and we are frequently asked for our expert opinions on state health care policy issues."

However, scores for the ability to develop consensus on key health coverage policies or policy issues and the ability to influence the state's policy agenda were near the median (scores of 3.4 and 3.6, respectively). One grantee respondent noted that although its leadership team members had high levels of policy expertise and actively worked with key policy makers, the coalition was in the early stages of developing the capacity to influence the policy agenda. Another grantee respondent said that it was challenging to influence the state policy agenda because of the perception that advocacy organizations are not credible experts, despite having tremendous expertise.

These comments underscore the complex and dynamic nature of health policy advocacy and echo the findings from separate interviews Mathematica conducted with policymakers, in which many of them indicated that they would not rely on consumer groups' policy analyses for cost estimates or the impact of proposed policies because they did not perceive such groups to be objective experts (Lipson and Asheer 2009). About half of the policymakers interviewed felt consumer groups have less influence on the policy development process than other major interest groups that have more resources in either campaign contributions or ability to deliver votes. Although a few policymakers felt that consumer groups lacked the technical expertise to propose

practical and realistic policy solutions, others indicated that consumer groups were effective in drafting and generating support for bills and have become "part of the policy fabric" whose input was actively sought. Thus, leadership teams might have the necessary expertise to monitor and analyze policy, but some find it challenging to communicate or get an audience for their policy proposals, given the political dynamics within their states or some policymakers' perceptions that consumer groups are not credible experts.

3. Generating resources to sustain advocacy is not well developed compared to other core capacities.

Respondents assessed that CVC leadership teams had the least-developed capacity for generating resources from diverse sources to sustain efforts (median score of 3.0 across all sites). For 6 of the 12 sites, respondents gave resource development the lowest score. The two individual elements with the lowest scores were (1) the ability to raise funds from different types of sources (average score of 2.9) and (2) the ability to dedicate staff for fundraising and development (average score of 2.7).

CVC leadership teams have different structures and members, which might affect fundraising. For example, some receive dues from their members. Some include members that are affiliates of national organizations, with potentially greater resources or steadier resource streams and less need to seek other funding. Still others seek funding only from private sources (such as, foundations). Furthermore, coalitions had numerous competing priorities during the base year and were not likely to dedicate staff to fundraising until later in the grant period. The respondent from one grantee noted that its coalition's fundraising committee had not yet been formed. Other coalitions had made progress in some elements, but planned to expand or further develop other elements. As one grantee respondent stated, "We have had some great successes with foundation funding, but we have a long ways to go in (1) getting individual contributions and (2) tapping sources in our various regions to strengthen the available staff for those regions."

Results from a separate survey of CVC leadership team members buttress these findings. In that survey, respondents from all six of these leadership teams felt their organization's role in coalition activities was least important for resource development, compared with the five other core capacities (Honeycutt et al. 2009). Leadership team members did not feel they were contributing to resource development activities, possibly because it was not a focus for the coalition at the time of the survey, or because it was a capacity needing further development.

Nevertheless, resource development is a well-developed capacity in a few sites. Moreover, scores for two individual elements of this capacity were above the median for all sites: the ability to raise funds for advocacy from more than one source (average score of 3.5) and the ability to gain visibility and credibility with potential funding sources (average score of 3.4). Respondents scored resource development as among the most-developed capacities for two sites. One grantee respondent commented, "Our [partner] organizations rarely compete, and often collaborate, for funding. We have a range of funding sources, including individual donors, foundations, and contracts."

4. Leadership teams have moderately developed capacity in coalition building and in media and communications.

Mathematica had asked grantees to identify their priorities for the evaluation during the first year of the CVC project.[4] They selected (1) policy analysis, (2) coalition building, and (3) media and communications as their top three priorities. Respondents assessed leadership team capacity for the latter two priorities lower than they rated capacity for policy analysis.

Coalition Building. The median score across all sites for the overall capacity for building the coalition and maintaining strategic alliances was 3.6.[5] Five of the six individual capacity elements received scores near the median:

- Ability to share decision making and reach working consensus (average score of 3.6)
- Ability to work together on health advocacy (average score of 3.5)
- Ability to engage and include core constituencies in coalition efforts (average score of 3.5)
- Ability to achieve alignment and buy-in among leadership team and other partners around common policy principles (average score of 3.5)
- Ability to lead, inspire, and keep network members unified (average score of 3.4)

The leadership team's ability to develop working relationships with nontraditional allies received the lowest score (3.1) among the elements of this capacity.

Although coalition building was not the highest-scored capacity for any of the sites, respondents assessed it as among the more-developed capacities in seven sites. Average scores for this capacity were above the median (4.0) for two sites and near the median (3.3–3.7) for six sites. Results from a separate survey of CVC leadership team members support this finding. In that survey, respondents from six of these leadership teams ranked their organization's role in coalition-building activities as the most important of the six core capacities. Respondents assessed coalition building as the least-developed capacity for only one site.

The widespread but modest confidence in the coalition-building capacity might reflect the long collaborative history among the organizations in many of the leadership teams. As one grantee respondent described it, "The leadership team has a long history of working together on health care reform issues in the state. Working together now is a natural extension of those relationships."

[4] This request was part of the evaluation planning process.

[5] Although median scores for overall capacity were similar between policy analysis (3.7) and coalition building (3.6), we considered coalition building as a moderately developed capacity because scores for its individual elements were closer to the median, whereas scores for the individual elements for policy analysis were consistently among the highest scores. In addition, respondents felt policy analysis was the most-developed capacity for 7 of the 12 sites, whereas none felt coalition building was the most-developed capacity at any of the sites.

Other coalitions formed more recently and are actively nurturing relationships. However, one respondent noted, "Some partners don't seem committed to the project as a collaborative and have trouble seeing the big picture." Developing alignment around policy issues among diverse organizations might be more challenging for coalitions grappling with specific health care reform issues. For example, one grantee respondent reported that, "There is tension between those who state they represent 'true consumers'—the uninsured (particularly the low-income uninsured)—and some leadership team members (those who represent other groups, such as persons with disabilities…). There is also tension between single-payer advocates and those who are willing to work in incremental steps to achieve full coverage."

Incorporating nontraditional allies, such as businesses, hospitals, and insurers, presents additional challenges. Some coalitions have had successes in this area. Others, however, have not made efforts in this area yet or are in early stages of developing relationships with some of these groups, due to a focus on other priorities, lack of resources, or a history of adversarial interactions. However, support from businesses and health care providers is often critical to passing legislation. Although policymakers in some states felt consumer advocates have built effective relationships with small businesses, hospitals, and other providers, some policymakers wished consumer groups were more effective in forging collaborations and bringing their nontraditional allies into the discussion (Lipson and Asheer 2009).

Media and Communications. The overall capacity for designing and implementing media and communication strategies received the second-lowest score of the six capacities (median score of 3.2 across all sites). All six individual elements received scores near the median:

- Ability to monitor media coverage and identify advocacy opportunities (average score of 3.5)
- Ability to develop relationships with key media personnel (average score of 3.4)
- Ability to convey timely information to grassroots organizations, advocacy organizations, and other supporters (average score of 3.4)
- Ability to develop talking points and messages for each target audience (average score of 3.3)
- Ability to train messengers and media spokespersons (average score of 3.2)
- Ability to use appropriate media (print, broadcast, internet, or other) in an effective way (average score of 3.1)

None of the respondents scored media and communications as the highest of the six capacities, and for three sites they assessed it as the least-developed capacity. However, scores for this capacity were above the median (3.7–4.0) for three sites and near the median (3.0–3.5) for six others. The leadership survey sheds further light on the media and communications capacity. Representatives of organizations on the leadership team were asked to rank how important their organization's role is in coalition activities related to the six capacities (Honeycutt et al. 2009). Seven leadership teams ranked their role in media and communications as least important (sixth of six capacities) or next-to-least important (fifth of six). For some sites, leadership teams focused their early grant activities on other areas, such as coalition building or policy analysis, and not on media and communications. For other sites, this capacity was concentrated within one or a small number of organizations on the leadership team, which would lead to a lower average ranking across all organizations.

A few grantees commented that their leadership team members are the "go-to" organizations for media requests on health care or coverage issues, suggesting they have developed relationships with key media personnel and have effective media spokespersons. Grantee respondents also commented that they have expertise in some areas, such as gaining traditional or print media coverage, but are improving or expanding expertise in others, such as using the internet to enhance their communications efforts. However, interviews with policymakers revealed some additional areas in which coalitions could be more effective. Policymakers suggested that coalitions would have greater impact if they improved their ability to develop and communicate unified, coherent messages, and if they educated the public and new legislative members on trade-offs necessary for expanding coverage in a sustainable way (Lipson and Asheer 2009).

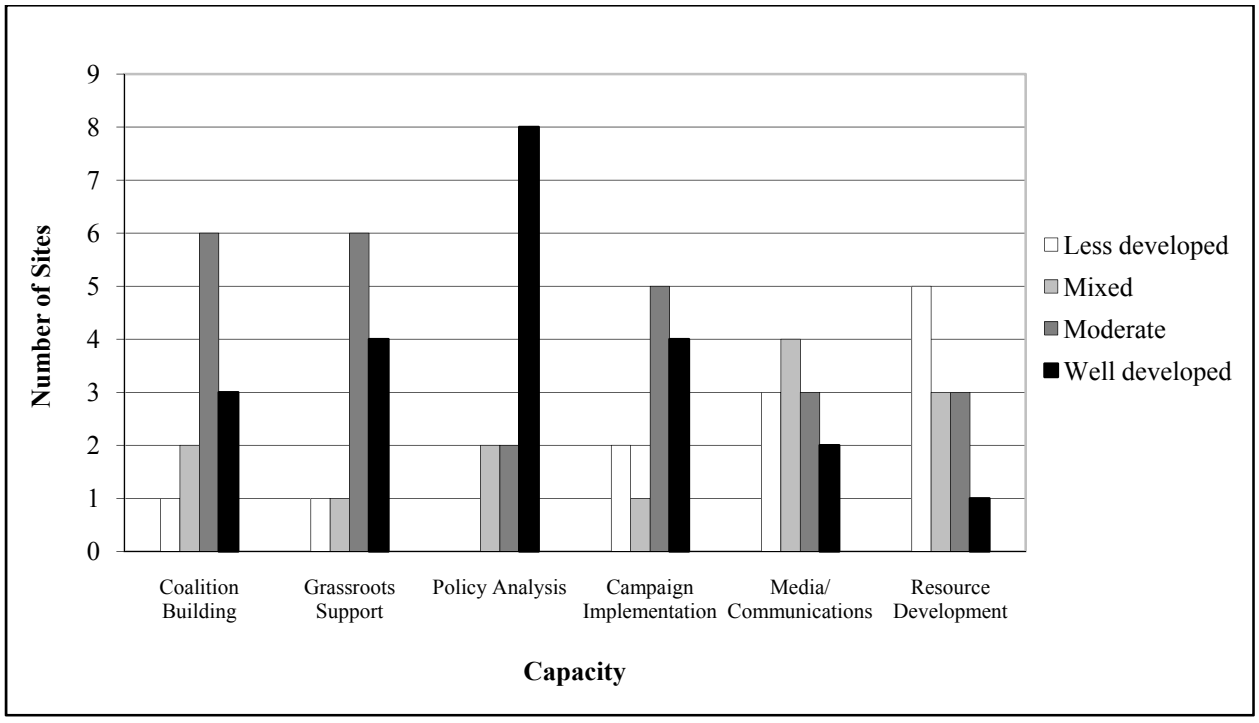
5. All sites have at least one less-developed capacity or one capacity with mixed development.

To adjust for differences in scoring across sites and respondents, we assessed the patterns of grantee scores within each site independently of the other sites (which we call intra-site scoring), based on each site's distribution of relatively higher and lower scores on individual items. For example, if a grantee scored most items 4, then a score of 3 was interpreted to indicate a lower level of capacity; a score of 5 would indicate relatively well-developed capacity. If most items were scored 3, then a score of 4 would indicate a higher level of capacity.[6]

[6] We assigned a capacity as having mixed development when the range of scores for the individual elements within that capacity varied by a score of 2 or more.

Using intra-site scoring, the overall story of more- and less-developed capacities is unchanged. Policy analysis remains the most-developed capacity and resource development the least (Figure 2). However, intra-site scoring demonstrates that all of the sites have at least one capacity area that is either less developed or mixed, as might be expected at baseline (Figure 3). For most sites, resource development is the least developed of the six capacities; however, Figure 3 also shows that it is a well-developed capacity for one site. Across all sites, coalition building, grassroots support, and campaign implementation are moderately or well-developed capacities for most sites, but each is less developed for at least one site. For example, coalition building is moderately or well-developed for nine sites, but it is a less-developed capacity for one site and a capacity with mixed development for two sites.

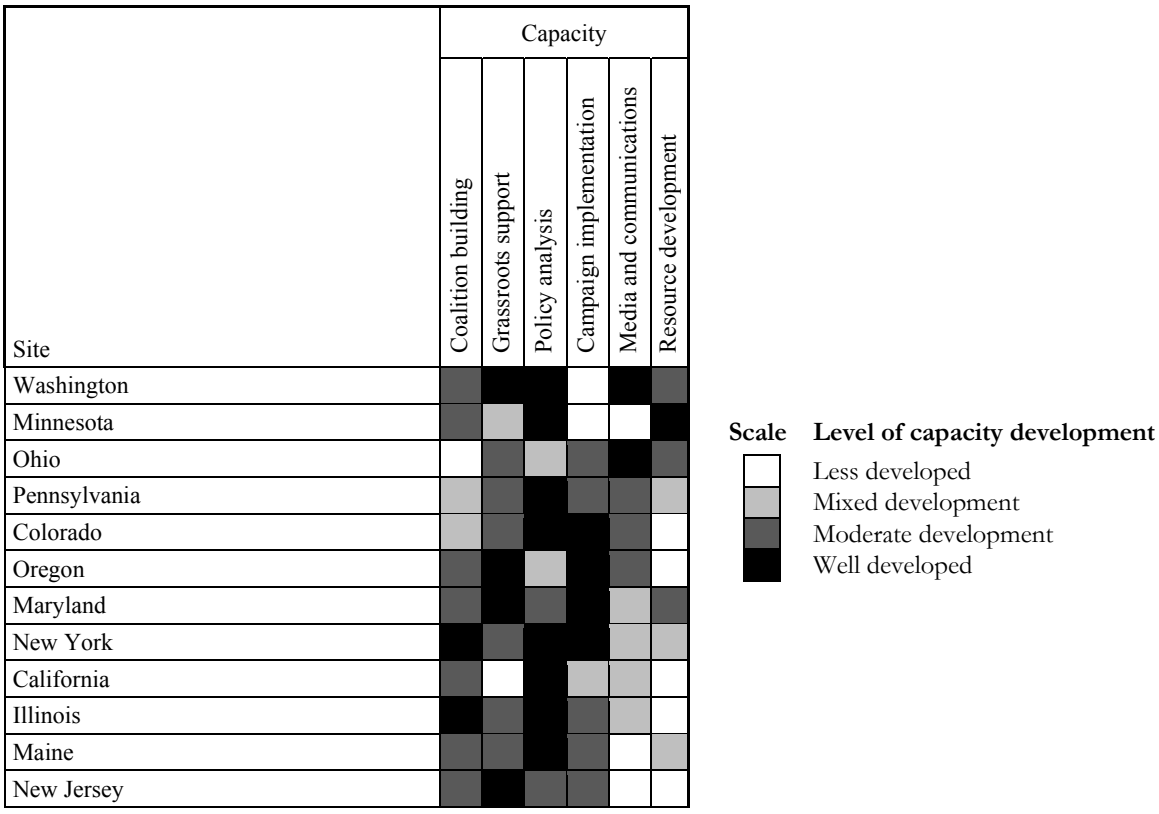
Figure 2. Number of Sites at Each Level of Development, Based on Intra-Site Scores



Source: 2008 baseline capacity assessment, Mathematica Policy Research.

Note: For each site, we assessed the patterns of scores grantees rated themselves independent of other sites and rescored each of the six capacities based on the distribution of relatively higher and lower scores within that site.

Figure 3. Capacity Development Using Intra-Site Scoring, By Site



Source: 2008 baseline capacity assessment, Mathematica Policy Research.

Note: For each site, we assessed the patterns of scores grantees rated themselves independent of other sites and rescored each of the six capacities based on the distribution of relatively higher and lower scores within that site. Sites are not alphabetized in order to show common areas of less developed capacities.

This figure provides a snapshot of core advocacy capacities among the 12 leadership teams at the beginning of CVC. Measures of capacity are subjective. They apply not to the grantee organization or individual members, but to the entire leadership team, which may include organizations inexperienced in advocacy and partners that had never before collaborated. Data from 2009 suggest widespread increases in capacities. This information is provided to help CVC stakeholders plan how to increase network capacity.

C. Lessons Learned and Recommendations

Findings from this assessment, combined with other sources, provide a baseline snapshot of the CVC leadership teams' advocacy capacities and demonstrate that consumer health advocacy requires a dynamic set of multifaceted and interrelated capacities rarely found within one organization. In this section we highlight the lessons learned and recommendations for the CVC program from this assessment of capacity. Future evaluation activities will build upon these findings and explore issues that were not the focus of this assessment, such as how the capacities relate to one another and the types of technical assistance leadership teams have been receiving to help build capacity.

Lessons Learned

- **Grantee selection yielded leadership teams and grantees with many of the target capacities.** The analysis of capacity confirms that most leadership teams are comprised of organizations with many of the capacities needed for successful advocacy. Having these capacities moderately or well developed within organizations on the leadership teams positions the coalitions better to promote state-level advocacy at the beginning of the grant period.
- **All leadership teams had some capacities that were well developed and some that were less developed, indicating that all could benefit from capacity-building assistance.** The intra-site scoring shows that all leadership teams had at least one capacity with mixed development or at least one less-developed capacity. Furthermore, all leadership teams have specific elements within a capacity that are more developed than others. For example, leadership teams might have tremendous expertise in policy and legal issues, but find it challenging to develop consensus on key health coverage policies or policy issues.
- **Policy analysis, coalition building, and campaign implementation were more developed at startup than the other capacities.** It is challenging for leadership teams to focus on all areas of capacity at a given time, due to finite resources and competing demands. Understanding whether these capacities at startup help coalitions advance state health care reform is one area for future exploration.
- **Resource development and media/communications were the least-developed capacities across all sites.** Coalition structure, restrictions on fundraising, and competing coalition priorities can affect the leadership teams' capacity for resource development. Similarly, leadership teams have some expertise in media/communications, but did not focus on media-related activities during startup, were trying to improve specific aspects (such as using the internet to enhance communications), or still need to address their ability to develop and communicate unified, coherent messages to have a greater impact on the public and legislators.

Recommendations

- **Tailored technical assistance and guidance would most benefit leadership teams.** Because leadership teams are comprised of different organizations, each having different capacities, each leadership team might be in a slightly different stage for each capacity. Sites also vary in their perceptions of their own development of the six advocacy capacities, with some being more aware of areas needing development than others. As coalition priorities shift throughout the grant period, the level and type of technical assistance leadership teams need will also change. Thus, leadership teams would benefit most from customized technical assistance and guidance.
- **CVC sites can learn from one another.** Capacity scores suggest that CVC leadership teams are in different stages of development. Some leadership teams have one or two capacities that are clearly more developed than others, such as Maine and Pennsylvania, whose capacity for policy analysis is well developed compared with other capacities.

However, other sites, such as New York and Washington, have equally well-developed capacities in multiple areas. Each core capacity was well developed in at least one site. For example, the Minnesota leadership team has well-developed capacity for resource development, an area that was less developed for most other sites. Thus, there is scope for leadership teams that are less developed in a particular capacity to learn from those that are more developed.

- **Building the capacity to develop resources, particularly funding, may need to be a high priority to sustain consumer advocacy.** Regardless of the progress made expanding health coverage during the life of the CVC initiative, it is likely that continued consumer advocacy will be needed to maintain or continue to make progress. Strengthening the ability of CVC leadership teams to obtain funding may be an important strategy for the Robert Wood Johnson Foundation to ensure continuation of the consumer partnerships they have supported through CVC.

REFERENCES

Consumer Voices for Coverage. "Health Care Reform Advocacy in 12 States Set to Receive a Boost." February 5, 2008. Available online at http://www.voicesforcoverage.org/news/press_releases?id=0001. Accessed June 29, 2009.

Honeycutt, Todd, Jung Kim, Debra A. Strong, and Judith Wooldridge. "Consumer Voices for Coverage, Leadership Team Member Organizations and Coalition Structures: Aggregate Findings from the Leadership Team Network Survey." Princeton, NJ: Mathematica Policy Research, June 1, 2009.

Lipson, Debra J., and Subuhi Asheer. "Consumer Voices for Coverage, State Policymaker Views on the Role of Consumer Advocacy Groups in Health Coverage Policy Development: Summary of Findings." Princeton, NJ: Mathematica Policy Research, January 2009.

Pear, Robert. "Obama Push to Cut Health Costs Faces Tough Odds." *New York Times*, May 11, 2009. Available online at http://www.nytimes.com/2009/05/12/us/politics/12health.html?hpw. Accessed May 12, 2009.

APPENDIX A

LIMITATIONS TO THE ANALYSIS AND INTRA-SITE SCORING

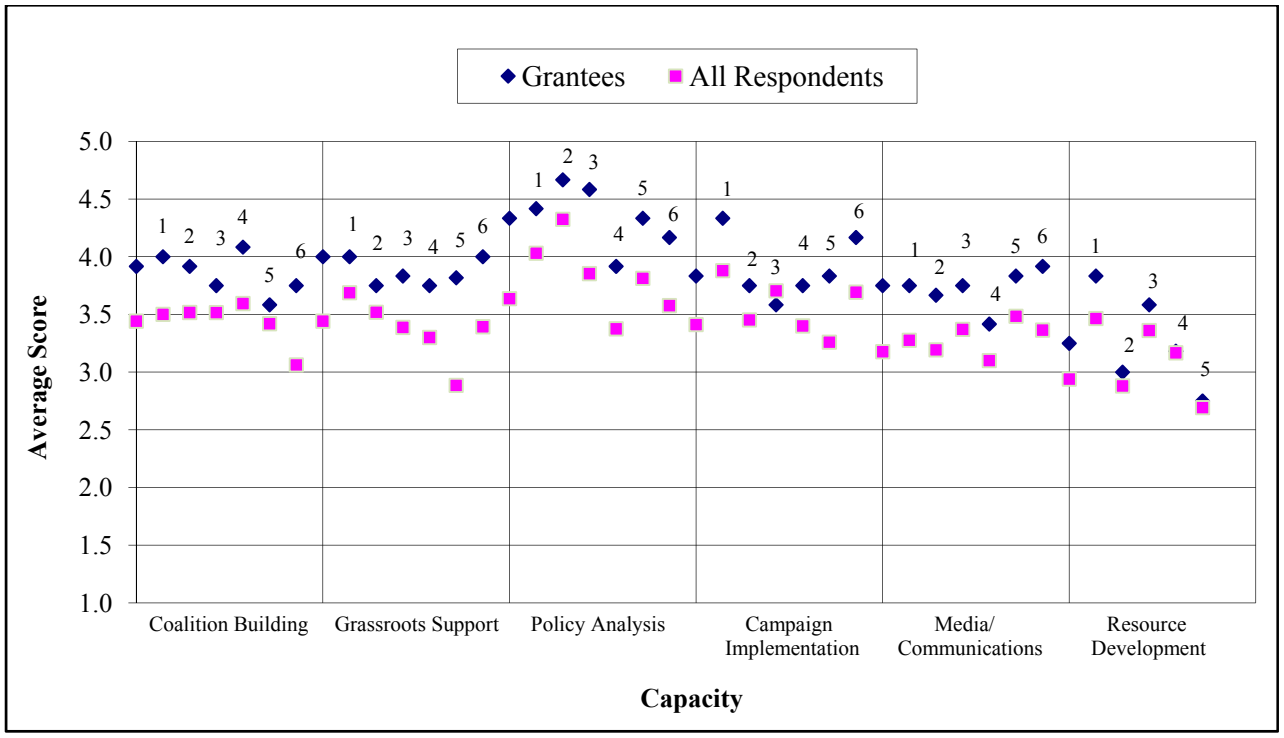
Using a self-assessment approach poses several potential challenges and risks. The first limitation is that there is no perfect instrument to assess capacity. Mathematica considered various scales that could be used for the assessment (such as a 3-point scale or a simple continuum between two end points). We chose a 5-point scale to provide a large enough range to represent varying levels of capacity, recognizing however that respondents often tend to use the middle of such scales. We avoided labeling each point on the scale in order to keep the instrument as neutral as possible. The score of 1 was labeled "Little or No Capacity" and the score of 5 was labeled "Very Strong Capacity." To minimize inaccurate scores resulting from respondents feeling compelled to provide an answer, and to minimize blanks—which would be difficult to interpret—we provided an additional category of "Not Applicable."

A second limitation is the potential for grantees to misstate their capacity. Community Catalyst and Mathematica staff tended to assess the capacity levels somewhat lower than the grantees rated themselves (Figure A-1). One reason for the difference in scoring is that Community Catalyst and Mathematica staff might not yet have been familiar enough with the leadership teams to give them high scores. There are additional possible reasons for grantees to rate themselves higher. First, CVC grantees might regard themselves as being well developed in these capacities, especially compared with other organizations in their states that are not part of the leadership team or broader coalition. Second, grantees might have interpreted the scale as a value judgment, rather than as a continuum of development, and thus might have been reluctant to give their sites a score that connoted what they saw as "poor" or "fair" performance. Third, Community Catalyst and Mathematica staff might have had different perspectives or reference points, such as comparing CVC leadership teams with effective advocacy organizations in other states or programs or with an ideal advocacy organization.

A third limitation is the potential for subjective scoring. An examination of the instruments returned by grantee respondents indicated that each appeared to use different subjective criteria to score items. Some grantee respondents wrote comments that suggested that they scored their leadership teams in terms of their internal relative strengths (using a score of 5 to identify their best-developed areas of capacity); others appeared to score themselves in terms of external benchmarks (where 5 would represent the best achievable capacity). Thus, for example, respondents from seven sites used 4 as the highest score for any overall capacity; five used 5 as the highest score.

Respondents from two sites gave their highest score to only one overall capacity; those from the other 10 sites gave their highest score to two or more overall capacities. Similarly, grantee respondents varied in terms of the number used to score less-developed areas of capacity and in their patterns of scoring for individual elements. For some, the middle score of 3 appeared to represent moderate development; for others it seemed to mean the coalition had not yet addressed, or was just starting to address, issues requiring that particular capacity. Difficulties interpreting this variation in scoring might make it somewhat difficult to use the assessments, as scored, to monitor the development of capacity over time.

Figure A-1. Average Capacity Scores, Grantees And All Respondents



Source: 2008 baseline capacity assessment, Mathematica Policy Research.

Notes: Scores were averaged for each overall capacity and for each individual element, based on a scale of 1 ("little or no capacity") to 5 ("very strong capacity"). Two sets of average scores were created: (1) the grantees' scores, depicted as diamonds, show the average of ratings grantees from all sites gave their own leadership teams; (2) the scores for all respondents, depicted as squares, average the scores from the grantees, Community Catalyst staff, and Mathematica staff. The average score for each overall capacity is shown on the vertical line and the average score for each individual element is numbered 1 through 6 (or 1 through 5 in the case of resource development, which has only five individual elements). These correspond to the individual capacity elements listed in Table 1, in the same order.

To adjust for these differences, we assessed the patterns of scoring within each site independently of the other sites (which we call intra-site scoring), based on their own distribution of relatively higher and lower scores on individual items. For example, if a grantee scored most items 4, then a score of 3 was interpreted to indicate a lower level of capacity; a score of 5 would indicate relatively well-developed capacity. If most items were scored 3, then a score of 4 would indicate higher levels of capacity. In this way, areas of relative strength or need for development could be identified within each site, regardless of the criteria used for assigning a particular score. We then rescored each site, using a single score for each overall capacity: less developed, mixed, moderately developed, and well developed. We assigned a capacity as having mixed development when the range of scores for the individual elements within that capacity varied by a score of 2 or more. For example, the representative of one grantee gave his or her leadership team's ability to develop talking points and messages for each target audience a score of 5 and the ability to train messengers and media spokespersons a score of 3. Thus, we assessed this leadership team's media and communications capacity as mixed.