DURABLE CDCs AND OPERATING SUPPORT

A summary of the proceedings of a conference organized by the Local Initiatives Support Corporation
May 3 – 5, 1999 in Minneapolis, MN

"The trouble with Cecil (B. de Mille, his brother) is that he always bites off more than he can chew – and then he chews it."

-- William de Mille

The same may be said of the growing cadre of community development corporations (CDCs) whose remarkable achievements in revitalizing America's poorest neighborhoods are garnering increased attention and admiration from public and private sectors alike. What helps to explain their against all odds success is the passion, conviction and perseverance they bring to their work. In order to achieve success, CDCs – like Mr. de Mille – have needed to exhibit these qualities in abundance. To have been more "realistic" -- that is, to lessen the mouthful -- would probably not have spawned an estimated 550,000 units of new affordable housing and 71 million square feet of commercial retail space across the nation.

Community development work, precisely because it focuses on communities that the mainstream market has temporarily abandoned, will always involve more than its share of risk. The issue is how to manage it. Fortunately, recent research is providing us with increasing clarity on predictors of success. We know that the most successful CDCs not only have effective programs, they have high performing *organizations*. This concept of effective nonprofit organizations has been clearly articulated and put forth by Christine W. Letts, William P. Ryan, and Allen Grossman in their book, <u>High Performance Nonprofit Organizations: Managing Upstream for Greater Impact</u> (1999 by John Wiley & Sons, Inc.). Their research demonstrates that key to maximizing program impact is a commensurate investment in human resources, infrastructure and systems, and benchmarking. In this way, organizations grow their *capacity* to deliver needed programs and services and to adapt to changing circumstances. **It is the strength of the organization that determines durability and contributes to the likelihood of success** – both in risk taking and in maintaining a healthy level of achievement over time.

Operating support programs have played a special role in providing the long-term, capacity-building support that has been unavailable, or not sufficiently available, to CDCs. With their unique perspectives and the question of how best to maximize durability on their minds, the operating support program administrators of the Local Initiatives Support Corporation held a conference titled, "CDC Durability and Operating Support," on May 3 – 5 in Minneapolis. LISC invited a cross-section of leaders in the industry to analyze select case studies and apply the derived learnings to general recommendations whenever consensus was attained. Among the fifty participants were CDC Executive Directors, LISC staff who administer CDC operating support programs, LISC Program Directors, and foundation and corporate funders. Also in attendance was a representative of a United Way agency, a city government official, and an organizational development consultant.

A prime motivation in organizing the conference was a recognition that organizations go through certain stages in a growth process, and that transitions from one stage to the next can be difficult. Because failures – as well as situations that exhibit "clear and present dangers" but successfully avert disaster – have a unique way of sharpening hindsight, the conference was organized to study select cases that helped to clarify some of these issues.

"CDC Durability and Operating Support" is the second conference organized by LISC to explore such issues. The first, "Building Durable CDCs," occurred on September 27 – 29, 1998 in Glen Cove, Long Island (see last page for how to request a copy of this report). Participants there identified preventive actions, warning signs, intervention strategies, and the potential impacts of outside forces on CDC effectiveness. The similarities between the two conferences are extensive: both used the case study approach to analyze threats to the health of a select group of CDCs, and all participants agreed to keep confidential the details and perspectives that case presenters so generously provided.

There are also notable differences. The Minneapolis conference focused on the role that operating support collaboratives (OSCs) play in building stable CDCs. OSCs – a broad term used to describe various programs that provide funding and other support for CDC operations and capacity-building – have focused long-term financial and technical assistance on increasing production output while simultaneously expanding organizational capacity. As such, they fill an important gap in CDC support and face a distinct set of issues in this role. Secondly, this conference widened its participating audience because of its emphasis on operating support and, thus, those who make it available and those who receive it. The Minneapolis conference attracted a larger group of both CDC leaders and funders.

Although many of the themes that came out of Minneapolis reaffirmed those that arose in Glen Cove, this conference began, in many ways, where the other left off. In Tony Proscio's summary of the "Building Durable CDCs" proceedings, he ended his report by writing, "The principal conclusion of this conference was that continuous work to improve those relationships [between the support community and CDCs] – including expanding the circle of mutual information and consultation between CDCs and their funders and investors – is the surest route to raising the success rate of an already remarkably successful industry." The following May, in the spirit of trust, sharing, and discovery, a dedicated group of individuals from different places and positions came together and took another step along this route.

The Case Studies

The case study method, with presentations by people with direct involvement in the issues being described, fueled the discussions upon which participants trained their inquiring and analytic minds. The cases highlighted problems and challenges directly related to the growth of the CDCs in question, as illustrated by the following case summaries.

> **Case #1**: When the Executive Director (ED) of a growing east coast CDC conducted a fiscal analysis of the agency, he learned that it had been operating at a significant loss which would, if the trend were allowed to continue, render the organization insolvent within six to seven years. To help diminish the deficit, the board asked him to develop a plan for the CDC to assume in-house property management of its rental properties, which at the time was contracted out to a private fee-for-service manager. He spent the next several months developing a business plan, which he submitted to the properties' lenders and limited partner, whose approval would be necessary to go forward. Some of the financial stakeholders, however, initially opposed the plan, and negotiations

became extremely contentious. The role of the operating support collaborative became crucial. It supported a feasibility analysis, and later provided grant support for building systems and training staff. Today, the ED reports that self-management has benefited the CDC, including generating a $50,000 net profit.

Case #2: When this mid-western CDC was formed to address issues of social and economic change largely caused by the closing of several large local manufacturing businesses, the neighborhood population had been mostly white and blue-collar. In the decade that followed, however, it would experience a significant demographic change, creating a more racially and ethnically diverse population and an increased number of low-income residents. During this time, the CDC grew quickly, partly due to a large federal grant. For much of this growth period, the CDC was directed by an ED whose leadership brought national and local recognition to the group and whose vision and energy was in demand by other community development leaders in the city.

By the mid-1990s, however, the CDC began to experience serious signs of stress. Externally, the CDC's intensified organizing efforts and plans to develop rental housing unleashed controversy, particularly among a neighborhood citizens' organization, which was opposed to further development of low-income housing. Internally, the CDC's organizational infrastructure was revealing weaknesses: reports were not generated on time, staff had become restive and morale was low. An organizational assessment sponsored by the Operating Support Collaborative correctly identified some of these problems but also heightened some of the tensions. Staff reported that factual errors had been made in the report and that confidences had been exposed. Within six months, the ED and two other key employees had resigned.

Case #3: In two decades of promoting affordable housing, this southeastern CDC experienced many notable successes, for which it received several public commendations. Its charismatic Executive Director, who led the organization for much of this time, had earned the respect of public and private figures alike. Its reputation for getting things done led to numerous invitations for the CDC to become involved in other programs, including some outside the original geographic focus. Pursuing these endeavors, however, contributed to an institutional financial crisis as well as fissures on the Board of Directors.

Meanwhile, the Board of Directors had not been receiving information for adequate oversight of the organization nor was it conducting annual performance appraisals of the Executive Director. And although several organizational assessments revealed that the CDC would crash if it continued on this path, the Board of Directors did not take substantive action until a new Chair was elected and the organization was put into what many perceived as a form of receivership by the funding collaborative. The collaborative took on board-like oversight functions, becoming intensively involved in the organization's activities. With new leadership, the Board of Directors put the Executive Director on probation. The following month, the Executive Director resigned, and the collaborative provided material support to hire an interim director. As the interim director put in place new structures and processes, and the Board searched

for a suitable permanent replacement, the organization appeared to be turning the corner at the time of this conference.

Case #4: When the founding Executive Director of a mature and successful CDC located in the Midwest gave two years notice of his resignation, he was hoping to avoid serious transitional problems that could disrupt the organization. Among his actions were engaging a consultant to build senior staff teamwork and hiring two capable, young community development professionals, one or both of whom might emerge as a potential replacement. What he did not anticipate was that the founding Board Chair would step down during this transition and that the organization would experience significant financial losses on property management, real estate, and construction. Under new board leadership, a decision was made not to consider internal or local applicants for the Executive Director position. Dealing a serious blow to staff morale, several senior staff resigned, including the two hired as potential replacements.

Alarmed by the poor performance of the CDC's properties, the operating support collaborative recommended that the organization participate in an assessment by LISC's Organizational Development Initiative. The results of the assessment became the basis for the board to make a number of hard decisions in order to stem cash losses, including layoffs and suspension of most development activity. The collaborative assisted by supporting the cost of a property management professional, who was hired utilizing an outcomes-based contract that included specific portfolio performance expectations. These decisions were made prior to the new Executive Director walking through the door and helped to stabilize the organization.

A note of thanks: Before launching into a summary of the rich and lively discussions that followed these case study presentations, the conference planners wish to thank the presenters for their involvement in the "CDC Durability and Operating Support" conference. Their willingness to share their stories – and with exceptional candor, perspective and analysis – generated rich discussions and valuable learnings that will no doubt contribute to more effective collaborations among CDCs and members of the CDC support community. We have attempted to convey their experiences and insights as fully as possible while also respecting the confidentiality that they – and all conference participants – were promised.

We are also very appreciative for the considerable time they invested in order to serve as presenters and participants. Indeed, lack of adequate time to do all that one is charged with was cited during these two days as a challenge by all partners in the drive to create strong community-based organizations. We are indebted to them for finding a way to make this investment of their most precious resource.

On the second day of the conference, participants were divided into groups (ensuring a fairly balanced representation of CDC executive directors, funders, OSC administrators, and LISC program directors) and asked to list their top learnings from the previous day's presentations and discussions. What follows are a summary of those learnings. Where opinions reached consensus, it is noted, and where opinions diverged, an attempt has been made to present all varied perspectives.

1. Support for Executive Directors

It is undisputed that the job of CDC Executive Director is perhaps the most challenging in the entire industry. It demands a unique and complex skill set and bestows a great deal of responsibility for how external and internal stakeholders view and support the organization. It was roundly agreed by conferees that the community development industry does not provide sufficient support for Executive Directors (EDs) as managers. When this support is lacking, EDs can become overwhelmed and burned out.

Indeed, the most salient remarks on this subject came from the CDC EDs (current and former) themselves, who said that their jobs are made even more difficult by the relative loneliness of the position. One case study focused on an ED who ultimately resigned and whose key learnings included the importance of what she called "the trusted other" role – someone to help combat her "isolation." She described her situation this way: "While drowning, I was afraid to ask for help. Crying uncle would have jeopardized my reputation, the organization's reputation, and my relationships. It was a big hubris problem. I also feared funders would have taken us over."

A former ED, who is now an OSC administrator, recalled her experience and characterized EDs as being "on an island by themselves." Another ED cited the lack of a peer network as contributing to the loneliness of the position -- a situation, she said, that exists due in large part to the competition for limited funds and the need to distinguish one's organization from others.

EDs are often driven to do more than they and their organizations can feasibly accomplish. When a journalist who, although clearly impressed with the accomplishments of one of the CDCs studied, said, "this is just a drop in the bucket," the ED looked around the neighborhood and saw not the successes but only the needs, marked by rising racial tensions and crime reports. And then she said to herself, "we need to do more." This unrealistic pursuit of the loftiest of goals was echoed by others. These pursuits are fueled in part by the against all odds success they have achieved. But, as one conference participant said, "EDs walk on water, but they can't do it every day."

EDs aren't alone in injecting the aura of invincibility into their jobs; they get help – and mostly from their admirers and supporters. Many EDs, especially the most successful ones, are often encouraged to do more. The ED who felt herself "drowning," for example, was asked by a LISC program director to join the local LISC Advisory Committee. It was much later that he realized just how thinly stretched she had become. In fact, early signs of strain were disregarded in large part because of his confidence in the strength of her leadership.

In two other cases, charismatic EDs had gained such high levels of confidence that their boards of directors had become uninvolved in governing the organization, rubber-stamping most policies and initiatives. While demonstrating moral support, this had the negative consequence of limiting the boards' knowledge of what was going on within their organizations and, therefore, minimizing their ability to affect important matters.

The discussion about what could be done to improve support for EDs centered around the following three issues: a coach, mentor, or trusted other – someone in whom the ED can confide; adequate staffing, including a second in command; and a board of directors that has the commitment and competence to fulfill its governance responsibilities.

A Coach, Mentor, "Trusted Other"

Among the candidates for the position of mentor or confidant were board members, funders, other EDs, and operating support collaborative administrators.

In response to the concern about competitiveness limiting the relationship between counterpart EDs, it was proposed that peer mentorships be established between the leaders of mature and nascent groups located in different cities within the region. This idea was received favorably by the EDs in the room.

When asked if an appropriate mentor could be someone from a non-profit that was not a CDC, an ED responded that the unique qualities of CDCs make it highly preferable to have a coach or mentor with experience leading a CDC, even if that person is no longer in an ED position.

Whether or not the OSC coordinator could serve in this role was debated, with no clear consensus emerging. At least one former ED, who now administers a program, said that she always relied upon her local LISC contact to provide advice and guidance and that LISC "needs to convince CDCs that we're trusted, best friends."

An Educated and Active Board of Directors

In two of the cases, the boards of directors took a passive approach to governance. In one CDC, which was founded by the ED and Board Chair, board meetings had traditionally been short in duration, with members deferring to the Chair on most matters, asking few questions, and, with few exceptions, passing all resolutions. In the other case, the charisma and ability of the ED to "pull money out of a hat" – coupled with the organization's past successes and public commendations -- led the board to dismiss the findings of several assessments that were unanimously critical of the organization and to exhibit what one board member called "apathy."

An ED asked how the marriage between the ED and board could be strengthened so that the board understands that if the ED fails, the board fails too. Different and opposing points of view about how this could happen were offered, including the notion that an ED departure be accompanied by the board's departure. (It was unclear whether this meant *certain members* of the board or the *entire* board.) Others argued that "the cure is not to kill the board."

A CDC board member reported that her organization is discussing asking board members to sign a written agreement that states their responsibilities regarding, for instance, fund raising and participation in committees. This would clarify the terms of their service and the expectations that the organization has of them.

In addition to being clear about their contributions, participants said board members need to be educated about their appropriate roles and responsibilities and be provided with financial and other reports that are easily digestible.

Technical and Financial Assistance to EDs

It was agreed that most mature CDCs – or those in a quick growth cycle – have EDs that are in demand both internally and externally and that this often requires the availability and competency of *another* staff member who can focus on ensuring that backroom operations are running smoothly. One ED recognized in hindsight the importance of this "back-up" support and regretted her dismissal of a board suggestion to turn a program position into a management position -- a move which would have relieved her of the operational responsibilities that were beginning to overwhelm her. (Arguing against it, she reported, was evidence of the "blindness" which she had developed.)

On a related staffing issue, an OSC coordinator suggested that funders invest more substantially, similar to a business loan, so that vital ED supports -- like executive assistants – are covered.

It was also recognized that LISC has not traditionally provided EDs with management guidance on issues including staff recruitment and development, personnel administration, and other areas where they may lack experience.

A funder added that leaders are visionaries who need to be cultivated and supported strongly in operations. He suggested that "the time it takes to get things done" in CDCs is too long, a result of micro-managing and limited risk taking. Although CDCs should not be "propped up," he said that leaders should accept that a certain level of failure is healthy.

---

2. Flexible Funding

A recurring issue raised by the conferees was the need for more flexible funding -- on both use and terms (i.e. multi-year) -- to deal with crises, critical incidents, and the diverse needs of CDCs. This applied to funding for both CDCs *and* the collaboratives that support them.

In the interest of fairness, OSCs and other funders have designed what are often elaborate structures for dispensing funds – structures that have had the unintentional effect of limiting flexibility. One ED, referring to the sometimes overly-rigorous process by which CDCs receive funding, said, "we put greater value on the money we get than the work we do."

The subject of funding came up during the discussion about organizational assessments, and the following sentiment was repeated a number of times: grants should be linked to the findings of the assessment. This requires that funding be made available <u>after</u> the assessment to procure technical assistance and other supports that the CDC will need in order to address weaknesses and opportunities identified by the assessment.

In one of the case studies, this was exemplified by LISC's provision of salary support for a property manager position on the staff of the CDC. The need for the property manager had been uncovered by a LISC organizational assessment. As a result of filling this staff position (and using an outcomes-based approach), the CDC's portfolio has experienced measurable improvements.

There was general agreement that the type of funding offered to CDCs often reflects pre-conceived notions of what CDCs need while offering little flexibility to support initiatives "outside the box." For example, one ED asked that funders recognize that cash flow problems are not the same as solvency problems and suggested that operating lines of credit would be an effective type of assistance to rectify such problems. Another ED asked that the collaborative explore with the CDC whether a consultant or staffmember is necessary rather than assuming one or the other on its own.

The appropriateness of funding was called into question in this way and in regard to the process by which grants are administered. One participant suggested a fluid approach that would permit investments at critical moments in an organization's life but conceded that this would be difficult to administer.

A collaborative administrator said these restrictions reflect a need for LISC to seek flexible funding from its funders, as well. Another participant reminded others that the more LISC accepts government support, the more red tape LISC – and its constituent CDCs – will endure.

---

3. The Organizational Assessment

Generally, conferees expressed a need to learn more about how organizational assessments are conducted and used across the industry before attempting to offer broad recommendations. There were, however, significant learnings shared -- specifically related to use, ownership, confidentiality, quality and credibility -- that warrant attention here.

Maximizing Use of Assessments

There was agreement that although the purpose of the assessment should be defined before it begins and that clear outcomes should be conveyed to the consultant, this often does not happen. In at least one of the cases studied, there was no articulated end result for an assessment that ultimately proved more harmful than helpful. To maximize the use of assessments, early conversations with the assessor should cover the type of information that the client wishes to learn, the client's expectations for how the assessment will be used, and the status of initiatives already under way. Too often, organizational assessments focus on issues that the CDC has already begun to address rather than introduce new information and insights.

It was agreed that organizational assessments should be tied to support going forward and used as a tool for building organizational capacity. One suggested approach was to link the assessment directly to a business plan or a strategic plan. Timing then becomes a critical issue.

One participant said that the collaborative she administers encourages the CDC to determine when to embark upon an assessment in order to maximize the usefulness of the results. A funder suggested that more research into organizational cycles might help the support community and CDCs to take advantage of "identifiable moments for change" and "opportunities for teachable moments." Finally, a LISC program director concluded that "doing assessments while the patient is in the emergency room doesn't make sense." Routine, periodic assessments could be part of an effective prevention strategy.

Several individuals cited a need to provide ongoing consultant support to a CDC once the assessment is completed in order to assist the group in responding to the findings. A few caveats were offered in return, including recognition that the trust between the consultant and the CDC cannot be easily transferred to a third party once the consultant's contract expires, pointing to the need for LISC to remain involved at some level during this time period. Another participant warned that the person involved in strategic planning is not always equally well equipped to implement the plan. Lastly, the issue of cost was raised as an impediment to making this support possible. Often, consultant costs are unaffordable for extended periods of time.

Ownership and Confidentiality

The questions of ownership and confidentiality were addressed separately. Regardless of whether the collaborative or the CDC purchased the assessment, it was reported that there is generally an easy sharing of information between the two. In order to ensure that the CDC owns the consultant's work, one collaborative provides the funds to the CDC along with lists of approved consultants and leaves the choice about sharing the report up to the CDC. Most share the entire assessment with the collaborative.

The ownership issue is more closely related to the quality of the reports. When one collaborative switched from having LISC-owned assessments to CDC-owned assessments, they found that the resulting documents were patronizing to the CDCs. As a result, the collaborative is experimenting with LISC and the CDC co-owning the assessment.

Confidentiality problems were discussed in regard to a case in which the consultant "named names" of several disgruntled employees in the final report. The ED herself regretted having been very open and honest with the consultant. As a result of the assessor's lack of discretion in what were private and personal issues, the Board and ED agreed to distribute only a summary report of the assessment. This, however, further fueled rumors. Other stakeholders requested the report, which the CDC declined to distribute.

All agreed, however, that the consultant's ability to ask hard and penetrating questions and the client's willingness to provide full disclosure are integral to conducting an assessment that is relevant and useful. This requires a high degree of trust between the client and consultant, and anything less than absolute clarity on the confidentiality issue makes such candor difficult to achieve.

Quality and Credibility

In one of the cases discussed, it was the ED's belief that the consultant was driven by "a need for drama" and an "ego which got in the way," resulting in downplaying successes and emphasizing conflicts. This, along with the lack of confidentiality and no clearly stated outcome for the assessment, led to the assessment further weakening the ED's leadership and the CDC's stature. Also, the timing was such that the assessment provided little new information that could have reversed any of the serious damage that the CDC had already suffered.

Speaking generally about the quality of assessments, one conferee warned that asking the same consultant to conduct numerous assessments in a short period of time will "get you what you pay for." Nothing can replace, he said, a consultant team that is both familiar with the organization and is focused exclusively on it.

An OSC administrator suggested that if LISC structured grant agreements that clearly define organizational outcomes, the groups would be in a better position to work and negotiate with consultants. A program director added that technical assistance providers should be held accountable for making change happen by adopting outcome-based contracts.

The lack of locally-based consultants was cited as another obstacle to delivering assessments that are both insightful and credible. Importing consultants has its drawbacks. One CDC was assessed by an organization from outside the city, and although the report was on the mark, the board downplayed the findings by saying, "They're from out of state and don't know how difficult it is to do affordable housing in this area." (It should also be mentioned that this CDC had undergone several assessments in a relatively short period of time, and by one board member's account, the board had become apathetic and unwilling to confront the problems that were facing the group.)

---

4. Clarity Around Operating Support Processes and Roles

In at least two of the case studies, the lack of clarity around processes and roles relating to the operating support collaborative threatened to further complicate situations that had become untenable for the CDCs. The telling of these stories triggered discussions around the importance of clarifying roles, how operating support collaboratives can add the most value, what kinds of information should be exchanged between the CDC and the collaborative, how benchmarks should be used, and in what ways the collaborative should be held accountable to its constituent CDCs.

Roles and Relationships

It became clear early in the day of presentations that many OSC and LISC staff erroneously assume that every CDC understands the complicated relationship between LISC and its affiliate organizations and between LISC and the OSCs. Neither assumption, we learned, is warranted.

One ED told conferees that for a long time, he had viewed the collaborative as a funder not unlike the CDC's other funders and said he was "clueless about how NEF fit with LISC." When his CDC proposed making some significant operational changes, he was unaware of the interest that the collaborative had in the decision and the degree to which NEF and the collaborative administrator had been communicating about it. The collaborative administrator said she had not done an especially good job of explaining the collaborative/LISC/NEF relationship – in particular, that collaborative staff communicate with NEF in their role as asset management capacity builder.

She indicated that clarifying the NEF/LISC relationship is further complicated by the fact that some part of the funds generated by NEF are granted to LISC to support various initiatives for CDCs. LISC staff must be extremely careful and respectful in presenting to CDCs the benefits of NEF as a tax credit syndicator, especially in regions where there is competition from local syndicators. This involves LISC staff describing the types of programs – like asset management training, for example – that come with NEF's success as a syndicator and which CDCs have come to value.

The complexity of these dynamics, no doubt, contributes to the difficulty in both explaining and understanding the OSC/LISC/NEF relationship. Indeed, one ED pointed out that the NEF/LISC collaboration can be seen as a conflict of interest by CDCs that are in the collaborative but have not used NEF as a syndicator. It was noted by another administrator that the NEF/LISC relationship is different in every site.

Reported efforts at role clarification ranged from informal to formal methods, mostly involving phone or face to face conversations (semi-annually or when a new ED is hired) between LISC and the CDC (and sometimes NEF) about the history between LISC and the CDC, what LISC and NEF can provide, and the type of information the ED should be getting from staff and giving to the board.

Establishing these understandings is seen as a first step in building a relationship which, ultimately, will be a determining factor in how difficult issues are resolved and opportunities for positive change are identified. A closer relationship, marked by more frequent communication between the collaborative and the CDC, may have prevented one ED from adopting a "bunker mentality" when his proposal was challenged. Collaborative staff agreed that establishing these relationships would help them to see the "big picture" and provide a better context for looking at specific issues. At the same time, however, one ED cautioned that the collaborative administrator cannot be all things – namely partner *and* enforcer. In his case, the role of trusted other was assumed not by the collaborative but by the consultant contracted with support from the collaborative.

This sentiment began a debate about the most appropriate role for collaborative administrators. Some collaborative staff said they wear too many hats to play the role of trusted other, while others said there may be some days when they can perform this function and then other days when they may be better positioned to identify someone else for the part. A large determinant is the degree of confidentiality that can be realistically promised to a CDC. Because the collaborative administrator reports to a steering committee, many CDCs do not know how much

candor they can afford. Both CDCs and collaborative staff felt that a higher level of trust could be helpful. But the uncertainty about where to draw the line clearly prevents disclosures that could be important.

Some of the collaborative administrators pointed out that they are often seen by CDCs as a funder exclusively, rather than a support system that provides technical assistance as well as financial support. This dual function puts the collaborative in a different situation than other CDC funders.

The conversation continued with these questions: should the administrator be an advocate for CDCs? an intermediary who translates between funders and CDCs and provides communication links? or a critical friend? CDCs favored a combination of the latter two.

Specifically, they would like the collaborative administrator to perform the following functions:

- establish clarity around collaborative ground rules on boundaries for interventions;
- cut through bureaucratic red tape;
- offer more flexible funding and encourage others to do the same;
- know what sources of support are available and provide assistance in accessing them;
- provide technical assistance referrals, and
- encourage the funding community to increase non cash services (pension fund investments, for ex.).

Funders who are not part of LISC weighed in with comments on the nature of their relationships with CDCs. Because their customer bases are varied, they need for CDCs to be as aware of funders' needs as funders are aware of CDCs' needs. One funder said that balancing relationships with his board and with the CDC limits his ability to be forthcoming. Another reflected on his dependence on CDCs to do the work that will accomplish his organization's goals. Being respectful, honest, and open about needs will help, he said, to build trust early.

Funders, collaboratives, and CDCs agreed that collaboratives can help to bridge the distance between funders and CDCs, so that funders aren't relying exclusively on the collaborative for information about the CDC. Funders also expressed a desire to be called upon more frequently for their assistance, particularly in advocating for CDCs on the policy level.

Whether to recruit CDCs to the collaborative boards was discussed, but no agreement was reached.

Information Exchange

To further clarify the process by which collaboratives operate, there was discussion around both the amount and kind of information that CDCs should be expected to provide to the collaboratives. Some CDCs took a more open book approach, arguing that funders are most generous with organizations that are the most up-front and forthcoming with information, generally regardless of whether the information provided is positive or negative. Other CDCs

stressed that information requirements be consistent, respectful of the CDC staff time, and respectful of the CDC's sovereignty.

In one of the cases, obfuscating an impending financial crisis served to heighten tensions, and only when it was revealed was a workable solution agreed upon. The solution, however, called for what the ED felt was an excessive amount of reporting. The result of meeting the requirements, he said, was that he became removed from important internal organizational issues that should have received his attention.

There was debate about what kind of information is most telling -- quarterly financial statements or payment of payroll tax data, for example – as well as what is most appropriate. A program director said he would like to see the board packet that is distributed to the CDC board of directors. An ED, however, strongly opposed providing funders with this material, saying it would cause him to omit certain information from the packets. This might even cause him to withdraw from membership in the collaborative. He did, however, say that he would feel comfortable sharing the board minutes of the meeting. The program director responded that playing the intermediary role puts LISC in a position closer to the CDC than other funders, and, therefore, LISC should not be seen as "just another funder."

Another collaborative administrator said that included in all his contracts is an option to attend any CDC meeting he chooses. An ED responded by asking for reciprocity, saying that this is further proof of the unequal power dynamic between CDCs and funders. She also said that this assumes the CDC is exhibiting some level of deceit and dishonesty and implies that the OSC administrator is uneasy.

All agreed, however, that better efforts to avoid putting onerous and cumbersome requirements on CDCs should be made. Some expressed support for a risk assessment model that CDCs can use to perform their own periodic "check-ups." Others argued, however, that self assessments, especially for boards, are difficult to administer.

Evaluation Criteria and Benchmarks

Perhaps the loudest call among EDs was for clear and negotiated benchmarks, criteria, and standards. Those who spoke on this issue argued that the same standards for reaching benchmarks be applied to all groups, keeping size/maturity of groups in mind when setting criteria. They also recommended that CDCs that fail to meet the benchmarks be cut off from funding, arguing that there are other CDCs that could benefit more from this support. While one collaborative administrator asked what would become of the neighborhood if a CDC's funding was cut, an ED said that it is very difficult politically for CDCs to expand into other areas and that if some of the groups that were "propped up" were let go, another CDC could step in. Another ED compared some CDCs to the Titanic, saying "there's no point in patching it up as it's sinking."

At the same time, these EDs said a broader definition of community building and community health needed to be adopted by LISC and others so that units built are not the only indication of success. This was echoed by collaborative administrators.

A OSC administrator cited his own frustration in measuring progress and knowing when to disinvest. He asked, for example, if most but not all benchmarks are reached, should there be a reward or a penalty?

An ED said that just as important as the decision to withdraw support is communicating this decision to the CDC. Funders need to be up front rather than "string the CDC along."

The question of whether CDCs should be expected to become financially self-sustaining after a certain period of investment remained unanswered. Some EDs argued that there will always be programs that are mission-driven and non-revenue producing, and that operating support collaborates should not sunset. Others asked for latitude in initiating income-generating activities.

Collaborative Responsibility and Accountability

Responding to the power dynamic that usually entails an unequal power distribution in the CDC-collaborative relationship, there was repeated discussion about the responsibilities and accountability of the collaborative – beyond the type of assistance that they are ideally suited to provide and into the realm of *how* and under what guiding principles their services should be made available.

Conferees agreed that CDCs should be included in the collaborative's planning, design, and evaluation and that the "rules of the game" and goals of the collaborative should be clearly communicated.

Collaborative administrators said that in evaluating their own performance, they should ask if they raised enough money to support their goals; if they "delivered the check on time" to their member CDCs; and if the funding and assistance provided was appropriate in terms of the CDCs' needs. One participant also suggested that the collaborative reflect on the notion of neutrality -- are they biased, for example, toward rental versus ownership or self management as opposed to contracting out – and explore their assumptions. By asking these and other searching questions, especially when results are not achieved, collaboratives can mitigate inequalities in the relationships with CDCs.

In one case, the collaborative administrator expressed frustration at having watched a CDC slowly unravel, not knowing what the collaborative should do. After a long period of tentative and ineffective responses, the collaborative went to the other extreme and began to micromanage, acted bureaucratically, and pressured the ED and Board Chair to produce large amounts of paperwork. The collaborative created an ad hoc committee, which took on some of the responsibilities that the board should have assumed. Staff came to believe the ad hoc committee was effectively controlling the organization. "We were acting like a finance committee of the board. We had people who were doing construction come in and explain delays to us, for example." While this drastic action may have saved the organization, participants were left to wonder whether this result could have been achieved in a less intrusive way.

Conclusion

As the conference planners and participants expected, the challenges described in each of the four case studies are not unique to these individual groups but are representative of the large and quickly growing community of CDCs. This was confirmed by the spirited engagement of the diverse audience, whose empathetic and insightful comments resulted in the suggestions, questions, and learnings presented here. Many of the difficulties and early warning signs that our case studies demonstrated reaffirmed those that were highlighted at the Glen Cove conference, and others are notable additions to the list.

Among the themes that ran through the Glen Cove conference and which rose again to the surface in Minneapolis were the following: the importance of building patterns of trust and consultation among CDCs and their supporters; showing constructive skepticism about fast, high-risk growth; conducting periodic organizational assessments; and penetrating the charisma of a "legendary" community leader. In addition to these preventive measures, the following early warning signs identified in Glen Cove were demonstrated again in Minneapolis: rapid growth in projects, outpacing the CDC's staff and capacity growth; poor or untimely reporting; lack of second-tier leadership; personal animosities and personality conflicts; and token or non-functioning boards. Participants of both conferences also stressed the need for more effective two-way exchanges of information between CDCs and intermediaries and for more frequent communication between LISC and CDC boards. The power of outside forces -- including race and class conflicts, neighborhood polarization, resistance to change, and shifting neighborhood demographics -- also emerged at both events as factors influencing an organization's health and stability.

Among the issues that were either introduced or given more attention at the May conference as either challenges or early warning signs were the following: lack of funder accountability to "deliver the check on time" and to deliver the precise kind of assistance that is needed; negative organizational assessments dismissed or ignored by the CDC and assessments that further fueled the fire; strong board chairs to which other members defer; and lack of strategic plans that integrate programs with vision.

Additionally, there were two cross-cutting themes that were voiced by members of all parties in nearly every discussion in Minneapolis, and they were: 1) exercise vigilance in tying funding and technical assistance to well defined outcomes, and 2) get and stay ahead of the curve on organizational capacity issues.

Tying Assistance to Outcomes

Tying funding decisions to clearly defined targets and outcomes is already being implemented in different ways by several OSCs. For example, resource allocations can be driven by business plans and other similarly future-focused endeavors. Technical assistance providers can be held accountable for positive change through outcomes-based contracting. Organizational assessments can be an entry point into the organization, and could be accompanied by support for specific and quantifiable improvements going forward.

Staying Ahead of the Curve

Each case, in its own way, suggested that paying attention to infrastructure and systems needs and providing ongoing technical assistance, board and staff training, and other organizational support is necessary to promote stability and strength. While project financing is absolutely necessary for a CDC to succeed, a commensurate investment in organizational development is equally important in sustaining success.

Staying ahead of the curve implies a certain degree of knowledge about what lies ahead. Conferees agreed that more research is needed on the natural growth stages of CDCs. Identifying where a CDC is on the growth curve will help OSCs to provide the right kind of technical assistance at the right time. Remaining ahead of the curve is effectively a form of preventive medicine.

Neither of these strategies is a panacea. Given the ambitions – and the passions – of the leaders in our industry, community development corporations will always be biting off more than they can reasonably expect to chew. Even better research on the stages of growth of CDCs will not prevent occasional imbalances between lofty goals and more modest capacities.

Most of the conference participants were appropriately skeptical of formulaic approaches to highly unique and complex problems. The need for more research and better tools was frequently voiced. Yet the mood of the conference was optimistic. Operating support collaboratives remain one of the most effective vehicles yet devised in our industry for delivering capacity building resources to CDCs. The insight and knowledge that is daily emerging from these living laboratories was clearly in evidence throughout the conference. The optimism expressed by most participants stems from the conviction that the answers we don't yet have will come from the praxis of this vitally important work.

In order to receive a copy of the summary of the proceedings from "Building Durable CDCs," the precursor to "Durable CDCs and Operating Support," please call Maria Esposito, Organizational Development Initiative, LISC, at (212) 455-5635 or send an e-mail to: mesposito@liscnet.org.