Chapter 4  West Virginia Community Voices and Healthy New Orleans – Case Study Findings

Designed to contribute knowledge to understand and improve the practice of partnership as a strategy to create healthy communities, this research involved two case studies of ‘partnership’ in practice, West Virginia Community Voices and Healthy New Orleans. The research addressed the usefulness of a community health partnership model developed to provide a better understanding of the practice of partnership. Bringing together the public health and organizational development disciplines, the model provides a framework based on the determinants of health, as well as open systems and institutional theories. Because partnerships represent a form of organization, open systems and institutional theories can provide new insights often lacking from a public health perspective.

Partnership represents one form of organizational affiliation or the way organizations work together. Varying levels of affiliation exist on a continuum with full integration at one end and complete independence at the other end. Between these two extremes, other types of affiliation represent steps toward more formal affiliation, such as partnership
(Himmelman 2001; University of Wisconsin 1998). This will be discussed more
thoroughly in Chapter 5. The community health partnership model comprises three main
elements; that is, a transformation process based on open systems theory, an
environmental analysis using institutional analysis, and collaboration effectiveness
characteristics. Choice of partners within the transformation process is informed by a
determinants of health framework. A definition of partnership provides a goal for the
partnership strategy within the model. This definition, as revised on the basis of this
research and discussed in Chapter 5, describes partnership as a social system based on an
agreement between participating organizations to collaborate on a common goal, in
which benefits and risks, as well as resources and power, are shared (adapted from

Opens systems theory is useful in understanding how participating organizations
contribute resources and transform them into products and services, while at the same
time developing sub-systems (adaptive, boundary spanning, maintenance, management,
and production) to establish a partnership organization capable of responding to changing
environmental demands for survival (Katz and Kahn 1978). Partnership represents one
strategy to deal with the complexity created by the multi-sectoral nature of health. This
complexity calls for organizations from the sectors influencing health, as well as from the
national, state, and local levels, to join together to enhance their individual efforts in
pursuit of a common health improvement goal (Evans and Stoddart 1990). Partnership
also represents an organization or social system, made up of sub-systems within broader
social systems, all affecting each other. A long-term systems level change goal may
require multiple sub-goals, calling for a dynamic partnership that can accommodate a variety of forms of organizational affiliation that are appropriate for different sub-goals. Institutional theory contributes a fuller understanding of the influence of the environment on an organization’s ability to participate in partnerships (Powell and DiMaggio 1991). In reaction to earlier theories that organizations survived solely as a result of rational decisions based on competition and efficiency, institutional theory recognized that, in addition, organizations reflected requirements of their institutional environment made up of organizations that influence them (Meyer and Rowan 1991). Responding to incentives within their institutional environments, organizations adapt their structures, processes, and procedures to gain societal acceptability. However, organizational responses established to meet earlier demands might be at odds with more recent environmental demands for local partnerships. For example, federal agencies distribute funds through categorical grants that lead recipients to set up fragmented, complicated bureaucracies and programs, prohibiting the sharing of funds called for by partnership (Gans and Horton 1975, Kagan and Neville 1993). Even where a federal agency does not participate in a partnership, its requirements influence the ability of recipients of its funds to participate. Partnership calls for coordination of these influences and deliberate adjustments to accommodate requirements of working together, while less formal levels of affiliation such as networking do not (Axelrod 1984; Gray 1985). The model therefore includes an analysis of impediments to partnership development to define the kind of change required to facilitate partnership, with a focus on both the organization and its institutional environment. Identification of these impediments should then allow a
determination of whether this change is possible and if not, a search for alternative strategies can be undertaken.

If the partnership strategy is to contribute to improved health, it must be implemented effectively (Yin 1994). Criteria for the effectiveness of the collaboration (formalization, intensity, reciprocity, and standardization), therefore, provide a framework within the model for understanding whether the partnership strategy added value to individual organizational health improvement efforts (Hudson 1987). Finally, a combined analysis of the three elements of the model; i.e., the transformation process, the environmental analysis, and analysis of the effectiveness characteristics, defines the level of institutionalization of the partnership and the contribution of the partnership strategy to improved health.

Chapter 4 presents a description of both research sites and research informants, followed by a summary of analysis of the data and discussion of findings from the two separate case study sites. The tables constructed to organize evidence for each site can be found in Appendices 3 and 4; the full case studies are in Appendices 5 and 6 for Community Voices and Healthy New Orleans, respectively. Discussion is organized around the three main elements of the model discussed above. Following the iterative nature of the research, discussion within each section starts with the first research site, West Virginia Community Voices, followed by Healthy New Orleans. Within each element of the model, the discussion follows the format set out below
• A short description of each element of the model and sources of data collected
• A description of each element with its components for the site under study and supporting quotations and
• A summary regarding the state of the element under discussion

Given the importance of local health departments in assuring conditions for healthy communities, their role in the ‘partnerships’ under review is examined, as well as the evidence of environmental influences that affect their ability to participate in partnership. At the end of each of three elements of the model, a summary analysis is offered of the findings from the two research sites. At the end of the discussion of each of the three elements, a summary synthesizes the three separate elements for the two sites.

4.1 The Research Sites and the Informants

As discussed in Chapter 3, the researcher chose two sites for this research from 17 suggestions made by experts familiar with the practice of partnership in the U.S. Before moving to the discussion of the sites, a word is required about the use of the term ‘partnership’ in this chapter. Expert site suggestions reflected a more generic use of ‘partnership’ and included sites practicing any form of organizational affiliation. Recognizing this dichotomy, the discussion that follows reserves the use of the term ‘partnership’ for discussion of the community health partnership model and only those instances where the definition was met, while respecting the generic use of the term in quotations by interviewees.
4.1.1 West Virginia Community Voices

West Virginia Community Voices, one of thirteen learning laboratories across the country sponsored by the W.K. Kellogg Foundation, sought to experiment with ways to serve those with inadequate or no health care by developing a coordinated health and social services system shaped by local organizations. In line with this goal, Community Voices aimed to create a more coordinated system of health and social services, as well as to increase the health insurance coverage rate of children. However, over the life of the initiative, Community Voices shifted from long-term systems goals to short-term goals of filling perceived gaps in minority, mental, and oral health programs, for example, as identified by the Kellogg Foundation.

Site research included review of Community Voices documentation, nineteen interviews, and a focus group. In addition, the researcher observed a quarterly conference call between Community Voices participants and the funding agency, the W.K. Kellogg Foundation. Table 3 lists the types of and numbers of informants and discussed in Chapter 3. The partnership coordinator and core partner categories will be combined in the discussion to protect confidentiality. Three key informants represented the university system, the state and local health departments, and a consultant to Community Voices.
Table 3  West Virginia Community Voices Informants

<table>
<thead>
<tr>
<th>Role</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partnership coordinator</td>
<td>1</td>
</tr>
<tr>
<td>Partner Liaison</td>
<td>8 (of whom 2 were core partners)</td>
</tr>
<tr>
<td>Partner Executive Directors</td>
<td>6 (of whom 4 acted as partner liaisons)</td>
</tr>
<tr>
<td>Key Informant</td>
<td>4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>19</strong></td>
</tr>
</tbody>
</table>

4.1.2 Healthy New Orleans

Healthy New Orleans (Healthy New Orleans) is one of 41 local Turning Point partnerships sponsored by the W.K. Kellogg Foundation to strengthen the public health system for the 21st century through experimentation and partnership. The Community Public Health System Improvement Plan, prepared by Healthy New Orleans participants, states the aim as “to improve the health status of New Orleans through a collaborative that develops and implements a Community Public Health System Improvement Plan focusing on individuals, families and community with children as a priority.”

Community wellness represented the ultimate goal in an effort to shift the city’s slogan from ‘the city that care forgot’ to ‘the city that cares.’

Site research involved eighteen interviews, review of documentation, and a focus group. Given the lack of organizational partners, Healthy New Orleans became the focus of study, with individual volunteers acting as staff. Interviewees suggested three key informants who had provided support to Healthy New Orleans, including the Healthy New Orleans training contractor and representatives from The Louisiana Public Health Institute (the state Turning Point initiative) and Tulane University. The co-chair and
executive committee members categories will be combined for discussion to safeguard anonymity. Table 4 summarizes the type and number of informants in the Healthy New Orleans research, as discussed in Chapter 3.

**Table 4 Healthy New Orleans Informants**

<table>
<thead>
<tr>
<th>Role</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Co-chair</td>
<td>1</td>
</tr>
<tr>
<td>Executive committee members</td>
<td>2</td>
</tr>
<tr>
<td>Community Resident</td>
<td>12</td>
</tr>
<tr>
<td>Key Informant</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

**4.2 The Transformation Process**

As discussed in Chapter 2, open systems theory provides a framework to describe organizations that are influenced by their environments. Properties of open systems include inputs, transformation processes, and outputs (Katz and Kahn 1978). Partnership represents an open system, where systems maintain themselves through contact with the environment by transforming resources into products and services. An open system is defined as a coalition of shifting interest groups, strongly influenced by environmental factors, which develops goals by negotiating its structure, activities, and outcomes in the form of an organization (Scott 1981). Given the importance of the environment in the model and the use of institutional theory to identify environmental influences, a separate section is dedicated to discussing its influence on Community Voices and Healthy New Orleans.
Although the transformation process also involves health improvement activities within
the community health partnership model, discussion focuses on the partnership
development transformation process, including participants, resources, and activities
required for developing the partnership as a social system with five sub-systems
(adaptive, boundary spanning, maintenance, management, and production) required for
organizational survival (Katz and Kahn 1978).

4.2.1 Participants and Their Roles

Given the multisectoral nature of health, the community health partnership model
proposed that a health improvement goal called for organizations from the multiple
sectors influencing health, in addition to organizations from the community, the state, and
the national levels that interact and influence each other. The determinants of health
framework that underpins this element of the model posits that health (or lack of health)
results from the interaction between genetic endowment with social and physical
environments and health care services to determine individual biological and behavioral
responses (Evans and Stoddart 1990). Organizations, joining together for common health
improvement goals, do so for a variety of motivations, ranging from seeking additional
resources (financial, expertise, and technology), increased credibility, better
understanding of community needs (Kreuter and Lezin 1998; Kagan and Weissbourd
1994), increased power (Pfeffer and Salancik 1978; Porter and Fuller 1986), economies
of scale (Logsdon 1991), to an improved ability to respond to an increasingly complex
environment (Katz and Kahn 1978). Evidence sought through interviews and a review
of documentation included a list of partner organizations, along with the sector to which they belonged, their role in the partnership, and the specific motivation(s) for their organization to join. For a fuller discussion, please see the full case studies in Appendices 5 and 6.

4.2.1.1 Community Voices

The proposal to the W.K. Kellogg Foundation set out a leadership strategy for West Virginia Community Voices that had prominent organizations in West Virginia, connecting state policy making with local input, lead the initiative. These core partners included the Higher Education Policy Council (HEPC), the Department of Health and Human Resources (DHHR), the Governor’s Cabinet on Children and Families, and Community Council of Kanawha Valley (later merged with United Way and renamed Lifebridge).

The core partners identified and recruited the early participating organizations, but, as they, with the exception of Lifebridge, decreased their level of participation, selection of organizations was taken over by the Community Voices’ director. A key informant explained, “Early intentions to have busy executives act as core partners and attend were unrealistic.” Using knowledge of the local social sector, the director selected organizations, inviting them to join coalitions in exchange for financial incentives to work toward the changing goals pursued by the initiative. The director and her predecessor recruited approximately 26 organizations over the life of the initiative for
their expertise in health or mental health services (West Virginia Primary Care Association, the Mental Health Association of Kanawha Valley, Partners in Health) or for their outreach capacity (Lifebridge, the regional Family Resource Networks, the media, and the African American churches). As activities and grants supported by Kellogg were completed, organizations ceased participating in Community Voices, evidenced by the list of organizations currently participating and the list of interviewees proposed for this research. Participating organizations were concentrated in the health care sector, as well as organizations that could improve outreach for health messages or services. Until recently, Community Voices experienced problems in attracting private sector organizations, such as health care providers. Table 5 lists organizations participating at the time of this research, their sector, and the level at which they worked.

The Kellogg Foundation, not only exerted an environmental influence by mandating partnership as a grant condition, it also played a central role in deciding priority interventions. Confirming this, an author of the grant proposal and partnership coordinator/core partner stated, “Originally we did not intend such a broad participation but Kellogg kept broadening the scope.” These changing priorities explain the necessity to recruit different organizations for the different goals. Retention of control over allocation of funds has implications in terms of Community Voices’ interpretation of the term ‘partnership’ and will be discussed later under the management sub-system and the reciprocity effectiveness characteristic sections. A relationship where the funding agency maintains control and the community acts in an advisory capacity ensures that the status quo in terms of power is maintained (Himmelman 2001).
Table 5  List of Organizations Participating in Community Voices

<table>
<thead>
<tr>
<th>Participating Organizations\Level</th>
<th>Local</th>
<th>State</th>
<th>National</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAMC Corporate Health Services</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAMC Research Institute</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Services of Kanawha Valley</td>
<td>Social Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kanawha Coalition for Community Health Improvement</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifebridge Inc.</td>
<td>Social Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Association of Kanawha Valley</td>
<td>Mental Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partnership of African-American Churches</td>
<td>Religious/Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Partners in Health</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>American Friends Service Committee</td>
<td>Social Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Governor’s Cabinet for Children and Families</td>
<td>Multi-sector</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy Kids Coalition</td>
<td>Health/Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marshall U Research Corp and Prevention Research Center</td>
<td>Academic/Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Minority Health Program</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regional FRN</td>
<td>Multi-sector Outreach</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rural Health Access Program</td>
<td>Health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Welfare Reform Coalition</td>
<td>Welfare/Social services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WV Center for Civic Life</td>
<td>Advocacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WV DHHR/Offices of Women’s Health and Minority Health</td>
<td>Public health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>WV Institute for Healthcare Policy &amp; Research</td>
<td>Academic/Health</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In line with the community health partnership model, Community Voices included partners who worked both horizontally at the local and state levels and vertically between the local and state levels. For example, the West Virginia Healthy Kids Coalition (state), the Regional Family Resource Networks (regional), the West Virginia Center for Civic Life (state), Lifebridge (local), and the Kanawha Coalition for Community Health Improvement (local) worked together to assess the extent of the uninsurance problem through regional dialogues and to increase outreach to identify children eligible for the
state health insurance program. The Kellogg Foundation linked West Virginia Community Voices to the national level initiative by providing opportunities to access national-level meetings and expertise. More recently, Community Voices began work with Wider Opportunities for Women, a national organization, to develop a self-sufficiency standard. This may represent a broadening of understanding of the influences on health.

The concentration of participating organizations in the health care sector and outreach organizations may have been appropriate for the goal of expanding access to health care, but made it difficult, if not impossible, to work on improving health more generally at the systems level. Although called for in the Kellogg proposal, participating organizations did not represent the diversity required by the determinants of health framework. Only the partnership coordinator/core partners expressed an awareness of a broader understanding of health within Community Voices. One mentioned, “Kellogg provided opportunities to attend national meetings to develop an understanding of systems connections.” When asked specifically about the determinants in the focus group, a partner liaison offered, “The main way to impact is to give people the knowledge for this understanding. Before Kellogg, social determinants didn’t mean anything to me.”

In response to a query about partners missing from Community Voices, the partnership coordinator and partner liaisons listed the private sector, men, and educators. An important omission, with the exception of the recent work with Partners in Health, involved the private health care sector, explained in part during the focus group
discussion when one participant suggested business resisted anything “that would affect their bottom lines.” A key informant confirmed, “Within the health care industry, organizations are competitive. Collaboration is not natural within an industry that has adversarial relationships.” A partnership coordinator/core partners suggested that private providers were reluctant to share any decision-making, a prerequisite for partnership, in exchange for grant funds. A small initiative was underway at the time of this research to bring Partners in Health, a network of private and non-profit health care providers throughout West Virginia, to the table. In exchange, Partners in Health received a small financial grant to support an experiment to create patient support groups, where medical providers could more efficiently deal with patient education and follow-up.

Part of the research process involved identifying the need for improvements in the community health partnership model. Analysis of informant responses pointed to the need to adjust the partners set out in the model. Although the local level was listed as one of the levels that should be represented in any partnership, the Community Voices proposal, reports, and evaluations pointed to the importance of breaking this down to include the community. This mainly involved community-based organizations and the Regional Family Resource Networks, with residents participating only in a consultative role through a series of public discussions to solicit their input for establishing priorities within the health care sector. Several partner liaisons confirmed the importance of involving the community “through forums to understand uninsurance around the state” and “through organizations and their members that represent populations such as the disabled.” The literature confirms that including the community can help ensure the
appropriateness of activities and that the community is committed to any resulting proposal (Israel et al 1998).

4.2.1.2 Healthy New Orleans

The Community Public Health System Improvement Plan provides evidence that Healthy New Orleans’ membership comprised individuals, rather than organizations, stating, “Interest in the partnership that emerged as Healthy New Orleans was inspired by a common desire and vision among individuals for a healthier New Orleans and an improved public health system.” Over 75 stakeholders attended a forum convened to develop a response to a Call for Interest from the W. K. Kellogg and the Robert Wood Johnson Foundations Turning Point national initiative. Membership in Healthy New Orleans drew from these stakeholders, as well as others who joined during the strategic planning process and later. Describing the nature of this participation, a co-chair/executive committee member pointed out, “There is no formal partner list. Some participate more than others.” Although this presented problems in constantly needing to provide education to bring people up to date, participants viewed this flexibility as a benefit. Confirming this, a volunteer suggested, “We can always go back after dropping out for a while.” While all interviewees agreed that “partners represent the community and not so much their organization,” some ambiguity remained as evidenced by one volunteer. Referring to her employer during the focus group discussion, she suggested, “So while [participation of my organization] hasn’t been formalized, I think we can say it is involved.”
Community Health Networks (CHNs) represented Healthy New Orleans’s empowerment strategy and an important link between neighborhoods and Healthy New Orleans at the city level. CHNs involved residents who worked together to identify small changes in neighborhoods to which they could contribute. A volunteer and focus group discussant observed, “The [empowerment] process is so powerful because each person is as important as, say, a CEO. Empowerment is not political power but rather the power of first the individual.”

The two co-chairs of Healthy New Orleans were able to make resources available informally from their organizations, given their positions as directors. No agreements, however, existed between their organizations, the New Orleans Health Department and Excelth, Inc., and Healthy New Orleans. One co-chair/executive committee member asserted, “Healthy New Orleans doesn’t exist formally but organizations come together. Excelth, Inc. donates financial staff.” Similarly, the New Orleans Health Department provided a ½ FTE for administrative support to Healthy New Orleans. The provision of this administrative support ended and further participation was put in doubt upon the departure of the director, and will be discussed later under the local health department discussion within the environmental analysis.

Although Healthy New Orleans established important links with city neighborhoods, few links were found to exist vertically to state and national programs and organizations, with the exception of the Turning Point national initiative. The Community Public Health System Improvement Plan described involvement in the State Turning Point initiative,
where both co-chairs served on the State Steering Committee. Members of Healthy New Orleans participated in training sessions organized by the Louisiana Public Health Institute (LPHI, the state Turning Point initiative), in conjunction with the Louisiana Office of Public Health (OPH). A key informant pointed out that this involved “sessions to understand what health is broadly and assessment tools” during the development phase. OPH scaled down its participation after political changes at the state level. At the national level, Healthy New Orleans participated in a number of national Turning Point working groups, including one on Community Health Governance.

According to the community health partnership model, the determinants of health framework should guide selection of participating organizations from the multiple sectors influencing health. The analysis that use of this framework calls for in partner selection did not occur, given the lack of formal organizational partners and the self-selection of individual volunteers. A Healthy New Orleans report prepared for a Community Health Governance Working Group suggested participants missing from the initiative. This report pointed to business, environmental health agencies, law enforcement, youth, and school administrators and teachers. The Community Public Health System Improvement Plan also mentioned managed health care providers and politicians. Other Healthy New Orleans reports mentioned the need to seek new partners from non-traditional health sectors, such as the Chamber of Commerce, architects, postal employees, truck drivers, and youth.
While the multiple sectors influencing health were not represented in Healthy New Orleans, all volunteers had a clear understanding of the broader determinants of health. One volunteer summarized this awareness, “Healthy New Orleans seeks to transform the public health system by broadening an understanding of health and empowering the community through awareness of what they can do to make the system work for them.” However, the Healthy New Orleans Community Public Health Improvement plan contradicted this broad view of health by providing a provider-oriented list of those involved in the public health system, including “the New Orleans Health Department, community-based providers, two academic tertiary care systems, the state Offices of Public Health and of Mental Health, private hospitals, and private practitioners.”

The emphasis within Healthy New Orleans on a membership made up of community volunteers confirmed the need to identify the community separately in the community health partnership model as a participant at the local level, as suggested by the previous analysis of Community Voices’ partners. This analysis suggested that ‘community’ can be represented not only by community-based organizations as in Community Voices but also by individual volunteers or residents. In addition to including the community, this research confirmed the need to define the role of each participant so that strategies could be included to support that role. For example, in line with its goal to empower individuals, Healthy New Orleans sought participation of the community as a full partner and in pursuit of this, concluded that empowerment and capacity building strategies would help realize their slogan of “the power is within you to make a difference.” A recently developed model for using collaboration to broaden community participation
might provide useful insights into this aspect of the community health partnership model (Lasker and Weiss 2003).

4.2.2 Resources

During the transformation process, participating organizations or individuals contribute money, personnel, equipment and supplies, knowledge/technology, and social legitimacy that are used in pursuit of organizational goals. Additional resources from government agencies or foundations, for example, can complement these resources. Where informants represented an organization, they provided information about the organization’s contribution. In Healthy New Orleans, where organizations did not formally participate, respondents provided information about ad hoc contributions by organizations for which they worked or about their own contributions. The partnership coordinator or co-chair and documentation such as the grant proposal budget and the most recent yearly budget, where available, provided confirmation. As will be seen, a large differential in grant size to the two sites existed; this will be discussed in Chapter 5. For a fuller discussion of resources available in both sites, please see Appendices 5 and 6.

4.2.2.1 Community Voices

According to documentation, the W.K. Kellogg Foundation provided approximately $2,790,765 between 1998-2003 for personnel costs, grants for partnership initiatives, and
a local evaluation. The original core partners provided in-kind support in the form of office space, administrative staff salary, and office operating costs, approximately equivalent to $1,184,602 over the five-year period. The Benedum Foundation provided an additional $75,000 over three years to support the West Virginia Oral Health Policy Task Force and the Healthy Kids Coalition.

The availability of grant money enabled the director of the Community Voices initiative director to attract and influence partner organizations. Using grant funding to complement their own, participating organizations offered specialized knowledge of the different issues addressed by Community Voices and in-kind resources such as staff time and meeting space. One example of this commingling of resources suggested by a partnership coordinator/core partner involved “the ongoing Parents-for-Teachers program offered by Lifebridge, [where Community Voices] provided approximately seven to eight percent of total funding.” Partners also brought their own constituency to the partnership. However, there were no resources available to sustain Community Voices at the end of the grant, perhaps reflecting the use of Kellogg funds as incentives for short-term organizational participation and a low priority of these organizations for the integrative role. This will be discussed more fully in Chapter 5.

Access to other organizations’ social legitimacy or credibility provided a strong motivation for organizations to join together, seeking to improve chances of success in the various advocacy efforts of the initiative. As stated earlier, proposal designers chose core partners for their legitimacy to improve chances for success in receiving funding.
The Vice Chancellor of Health Sciences, an author of the Kellogg proposal, was well-known to the Kellogg Foundation, the Governor’s Cabinet on Children and Families provided connections to the highest political offices, and both the Cabinet’s regional Family Resource Networks and the Community Council of the Kanawha Valley/Lifebridge provided connections to the community. Organizations participating in common activities brought their specialized expertise and a long history of working with their communities, helping to bring a citizenry wary of outsiders into the regional community dialogues, for example.

In summary, participating organizations combined resources and expertise with the financial resources of the Kellogg Foundation and other funding agencies. Legitimacy of partner organizations helped to ensure funding for the West Virginia Community Voices, that the right doors were opened for advocacy efforts, and that the community was willing to participate.

4.2.2.2 Healthy New Orleans

The W.K. Kellogg Foundation has been the sole funding agency for Healthy New Orleans, having provided an initial $60,000 planning grant over three years. This was followed by a $100,000 grant to implement Community Health Networks, and a $170,000 grant to establish the Center for Empowered Decision-Making (a non-profit set up to institutionalize community participation in planning, research, policy making and leadership development). Individual volunteers provided manpower for Healthy New
Orleans on top of their normal duties, where they held jobs. The two co-chairs made in-kind resources available from their organizations. The New Orleans Health Department (NOHD) provided a ½ FTE administrative support, while Excelth, Inc. provided financial services for Healthy New Orleans. Other in-kind resources, such as meeting space, were provided on an ad hoc basis by volunteers’ organizations. Membership in Healthy New Orleans was voluntary, providing an opportunity for any resident to become involved in improving the health of their community. As such, the process did not generally involve seeking out partners who could bring legitimacy to Healthy New Orleans. A key informant confirmed, “People in Healthy New Orleans are not the powerful.” Healthy New Orleans did, however, benefit where volunteers had credibility of their own, with important contributions by the director of the Department of Health and of Excelth, Inc. whose reputations made it easier to attract participants into efforts to improve health, as suggested by one community volunteer.

Although Healthy New Orleans accomplished several tasks set out in its community wellness framework, limited resources and dependency on volunteer and ad hoc contributions reduced the potential for work at the systems level. All volunteers mentioned lack of time as a constraint, with most also mentioning limited resources. One volunteer stated, “The consensus decision-making process is time consuming and people are not always comfortable with this.” A key informant suggested that “Kellogg needs to be careful regarding the difficulties in forming partnerships. Perhaps they were over ambitious for it takes a lot more resources to entirely rearrange a public health system.”
Looking to alternative sources of funding, a co-chair/executive committee member suggested that organizations associated with Healthy New Orleans volunteers would find it difficult to contribute, given “their already squeezed budgets.” With regard to other funding agencies, he stated, “It is hard to describe what Healthy New Orleans is doing and match it with interests of funders.”

4.2.3 Sub-systems Development

As discussed previously, the community health partnership model comprises transformation processes for both health improvement and for partnership development. The focus of this research is, however, on the development of a partnership and the resources and activities needed for the development of five organizational sub-systems to ensure survival of the partnership. These sub-systems involve mechanisms to gather feedback from the environment (adaptive); to maintain relations with the environment (boundary spanning); to reduce variation within the organization (maintenance); to coordinate and control organizational activities (management); and to produce goods and services, as well as develop the organization (production) (Katz and Kahn 1978). Specific kinds of evidence sought through interviews and a review of documentation are listed under the discussion for each sub-system below. The existence of components of each of the five sub-systems helps to describe each in terms of its stage of development (rudimentary, formative, implementation/maintenance, and institutionalization), contributing to a fuller understanding of how the participants work together.
The discussion that follows represents analysis of evidence for the development of sub-systems by Community Voices, an affiliation of participating organizations, and by Healthy New Orleans, an organization of individual volunteers. For a fuller presentation of evidence and discussion of the transformation process, please see Appendices 3, 5, and 6.

4.2.3.1 The Adaptive Sub-system

An adaptive sub-system, recognizing that organizations are open systems that affect and are affected by their environments, comprises mechanisms to allow the organization to identify the need for change for survival. An adaptive sub-system includes the feedback loop represented in the community health partnership model. It includes a plan and mechanisms that allow an organization to scan the environment for opportunities and threats and to track progress for internal improvements (Child and Faulkner 1998). It also includes a feasibility analysis for the form of affiliation to be adopted (Kreuter and Lezin 1998).

4.2.3.1.1 Community Voices

In the case of Community Voices and development of a plan, the grant proposal set out broad goals for Community Voices, although the director’s 2000 annual report pointed out, “Another challenge was the lack of a comprehensive plan. The WV Community Voices initiative has broad goals and outcomes but each of the many partners pursues
their own strategies towards these goals and outcomes.” Instead of a comprehensive plan setting out the needs addressed, long-term goals, roles and responsibilities of participating organizations, and activities to accomplish goals and measure progress, a partnership coordinator/core partner stated, “yearly budgets served as annual action plans with new priorities added at the request of the Kellogg Foundation.” These changing priorities contributed to a short-term view, perhaps diverting attention from the need for a long-term plan. Confirming this short-term view, one of the directors saw her role as a “facilitator to open opportunities” to build relationships in line with the intent of the national initiative to focus on building networks of complementary organizations.

Formal mechanisms to scan the environment did not exist, other than ad hoc studies, with the exception of a survey that served as a baseline for health insurance activities, as pointed out by most respondents. Several partner liaisons suggested, “We are constantly talking to the public in health care settings,” which allowed them to provide informal information based on their familiarity with their own specialized issue and constituency. One asserted “Diverse members keep their fingers on the pulse.” An evaluation reported that during the first two years, monitoring occurred quarterly through self-reports provided to a Marshall University consultant, who consolidated results for the director and the Kellogg Foundation. A partnership coordinator/core partner explained, “This took too big a chunk from the grant,” so this function was incorporated within a national evaluation of Community Voices commissioned by Kellogg. The partnership coordinator and several partner liaisons pointed to quarterly conference calls and the yearly retreat that “provided opportunities to reflect over the past year’s activities and to
celebrate successes.” Feedback within Community Voices was, therefore, informal for both tracking of environmental changes and for internal activities.

Attention to partnership development in this research calls for an assessment to determine the form of affiliation appropriate for Community Voices as part of the adaptive sub-system. Although the proposal to the Kellogg Foundation set out a management committee structure, a feasibility analysis to consider difficulties that organizations might face in participating was not undertaken. One consequence involved the demise of the committee when busy executives were unable to attend. Early efforts by a consultant to define training and technical assistance support focused on the needs of all participants to the exclusion of training needs to improve functioning of the management board of Community Voices.

Based on the above discussion, Community Voices lacked a comprehensive plan and a formal feedback mechanism. In addition, no assessment took place either of the type of affiliation to be pursued by Community Voices or of the training needs once the management board was established. This analysis leads to the conclusion that the adaptive sub-system for Community Voices can be best described as rudimentary, limiting Community Voices’ ability to use feedback to adjust to environmental changes or to improve health-related activities.
In Healthy New Orleans, the Community Public Health System Improvement plan described the planning process followed, starting with a day-long summit attended by over 200 people. From this, a number of teams carried the planning process forward with an analysis of existing health data, a community survey, and a series of community meetings. This served as the basis for an action planning retreat, where over 200 participants set in place a process that resulted in the Community Public Health System Improvement Plan. While this plan is comprehensive in terms of time frame, people consulted and involved, and analysis of obstacles to changing the public health system, it did not assign roles and responsibilities to accomplish activities, nor did it encompass a feasibility analysis to understand the influences in the environment to guide the decision regarding the type of affiliation that Healthy New Orleans adopted. Instead, the plan set out an informal structure with two co-chairs and committees, perhaps reflecting the individual nature of membership in Healthy New Orleans.

In terms of mechanisms to track the environment and progress toward goals, Healthy New Orleans depended on ad hoc information from participants in areas of their own expertise or interest. One volunteer pointed out that, instead of formal monitoring of activities, “Personal commitment makes things work to keep us focused. This may explain why things work when there is no monitoring. Leadership oversight is important.” Confirming this, a co-chair/executive committee member observed “environmental
assessment takes place through business meetings and retreats,” where review of past accomplishments led to celebration of successes to sustain participants’ interest.

Lack of a feasibility analysis to determine the type of affiliation to be pursued and a formal feedback mechanism to track both activities and changes in the environment limited the ability of Healthy New Orleans to adjust to environmental demands. On the other hand, the strategic plan discussed above represented an important element of an adaptive sub-system. Analysis of this mixed experience suggests that the adaptive sub-system was in the formative stage.

4.2.3.2 The Boundary Spanning Sub-system

A boundary spanning structure involves staff who interact with the external world to ensure access to resources and to markets and to maintain good relations (Katz and Kahn 1978). In an organizational partnership, this translates into two levels of boundary spanning, one performed by staff members in a liaison role between his/her organization and the partnership and the other at the partnership level to represent it to the public.

4.2.3.2.1 Community Voices

In Community Voices, each organization designated one person, who attended regularly as that organization’s representative. As the focus moved between Community Voices’ changing goals, a number of coalitions developed with different organizations.
participating in each one. Within each coalition, these staff ensured that their organizations remained up to date and that their organization’s resources were available for joint activities. Regular contacts also afforded representatives an opportunity to build relationships and trust among themselves, an effective strategy where the goal is to motivate awareness and interest in collaboration (Mays 2001).

With regard to maintaining relations with and obtaining resources from the external world, the director stated, “My role is to establish relationships within and between partners, as well as to provide money to make this happen.” Liaison staff ensured availability of organizational resources for temporary joint activities and built relationships between themselves and their organizations. The director fulfilled the function of interacting with the external world. The boundary spanning sub-system was therefore in the formative stage.

4.2.3.2.2 Healthy New Orleans

Healthy New Orleans’ membership comprised individuals and as such, one would not expect to find staff serving in a liaison function between organizations. On the other hand, with regard to the external world, members of the executive committee carried out the external boundary spanning function. A co-chair/executive committee member stated “My role as […] is to act as spokesperson for Healthy New Orleans.” Although members of the executive committee were self-selected and roles and responsibilities had not been
formally agreed, the committee ensured that successful grant requests were submitted for additional funds.

A membership made up of individuals meant that Healthy New Orleans had no need to develop a boundary spanning function between participating organizations. The executive committee’s informal role in representing Healthy New Orleans to the public and in obtaining additional financial resources suggests that the boundary spanning sub-system of Healthy New Orleans was in the formative stage of development.

4.2.3.3 The Maintenance Sub-system

The maintenance sub-system involves a common culture of shared norms and values to reduce variation/conflict within the social structure (the partnership) (Katz and Kahn 1978). Relationships and trust are built and a process for accommodating diversity is developed.

4.2.3.3.1 Community Voices

One partner liaison in Community Voices, responding to a question on motivation(s) for participating, summarized most responses by suggesting, “shared values around a broad goal of social justice” brought organizations together, which Community Voices was able to harness in the interest of efforts to improve health. Other motivations listed by partner liaisons included access to financial resources and expertise, increased influence over advocacy issues, and an improved ability to address complex issues by allying
themselves with those who have complementary skills and perspectives. Several partner liaisons mentioned increased visibility and recognition for their own organizations and access to networking opportunities.

Frequent meetings and yearly retreats served to develop closer working relationships and trust, viewed as precursors to partnership within the model. A partnership coordinator/core partner pointed out, “Belonging to Community Voices allows my organization to develop new relationships.” Where participating organizations had different motivations, one partner liaison suggested, “This does not create a problem because the common goal overrides any differences.” Another highlighted the role of the director, “Community Voices gets different partners to get on the same side of an issue. It brings different perspectives together, resolving competitive issues.” Yet another viewed “differences in policy and service delivery organizations as enriching and complementary.” Several partner liaisons suggested that differences within their coalitions were settled through negotiations, talking and listening. Where differences surfaced, they generally involved organizations with dissimilar cultures such as hierarchical government or the bottom line orientation of private health care providers. A partner liaison suggested, “Where an organization doesn’t value collaboration, time is not given to staff to participate.”

Although participating organizations had similar motivations and organizational cultures, the changing focus of Community Voices interests and, thus, of participating organizations meant that Community Voices had not developed a common culture of
shared norms and values. Although Community Voices strengthened relationships between organizations and coalitions, these organizations remained autonomous with little holding them together other than a short-term goal. These relationships, however, represent the first steps in developing a maintenance sub-system, which is, therefore described as in the rudimentary/formative stage.

4.3.3.3.2 Healthy New Orleans

Healthy New Orleans co-chairs actively encouraged development of a culture, built on common values of an appreciation of diversity and community participation. A member of the executive committee suggested that, “the facilitative, consensus decision-making process makes people feel involved and leads to personal commitment.” Healthy New Orleans paid a contractor to facilitate meetings, as well as to train a core group in the facilitative consensus decision-making process, who could then train other participants. One Healthy New Orleans volunteer felt that “the partnership has established a culture of acceptance and respect…” Universally, interviewees expressed a recognition and appreciation for this participatory culture. One volunteer felt the facilitative training in consensus decision-making “is the most important thing about Healthy New Orleans,” while another felt it “is what made Healthy New Orleans gel.” This training allowed individuals to build meaningful relationships and trust, an important foundation for partnership development. A partnership coordinator/core partner asserted, “Belonging to Community Voices allows my organization to develop new relationships.” However, one member of the executive committee felt that this was limited by the fact that “a lot of new
people with fewer who were involved in the beginning meant that education of new people” was continually required and by extension, new relationships and trust had to be continually established.

This analysis suggests that, although participation was inconsistent, attention to developing a common culture led to a maintenance sub-system in the formative stage.

4.2.3.4 The Management Sub-system

The management sub-system involves an integrative mechanism, along with procedures and processes, such as a partnership agreement, to control and facilitate multiple organizations or individuals working together (Katz and Kahn 1978). Common processes to help a partnership function more smoothly may include decision-making, communications, and mechanisms for accountability, among others.

4.2.3.4.1 Community Voices

Following the original intent in the Community Voices proposal, Community Voices established a management board of four core partners, as discussed under the earlier section on participants and their roles. A key informant explained, however, “Early intentions to have busy executives act as core partners and attend were unrealistic.” Confirming this, a partnership coordinator/core partner commented, “There is no central or core partnership board. Resources are shared but this is written into the grant.”
Management of Community Voices, therefore, transferred to the director, who was accountable to the Kellogg Foundation and not to a central management board.

Describing the various roles played by the Community Voices office, a partnership coordinator/core partner stated, “Sometimes we are the leaders, other times the catalysts, and at other times we provide strategic support.” As each issue took priority, existing coalitions, or a newly developed ones where required, called on their own members to develop policy and implementation strategies to achieve a stated goal.

Because there was no central management board and partner organizations were autonomous, financial controls and other regulatory mechanisms remained at the level of the participating organization, with the exception of funding agreement requirements established between the Community Voices office and each grant recipient. Partner organizations, therefore, did not need to make internal changes to accommodate the needs of the partnership. Common processes were limited to meetings where no minutes were kept, frequent communications, and the annual retreat discussed previously.

The researcher had an opportunity to observe one of the quarterly conference calls required by the funding agency. Although the discussion was collegial and non-directive, this call provided further evidence of the directive role played by the Kellogg Foundation. Discussion during the call mainly involved reporting back to the director, confirming that organizations were accountable to the Kellogg Foundation, rather than to a management board.
With no central body comprised of participating organizations serving as a management board and no common processes or regulatory mechanisms other than requirements of the funding agency, the existing management sub-system, therefore, can be described as rudimentary.

4.2.3.4.2 Healthy New Orleans

An executive committee with two consistent co-chairs coordinated the work of Healthy New Orleans. A co-chair/member of the executive committee commented that “the executive committee has a flexible membership with two regular co-chairs. People attend according to their time and commitment.” The executive committee was self-selected, rather than elected from the general membership, pointing to an informal structure. In addition, the executive committee established task forces dealing with public relations, fundraising, the Center for Empowered Decision-Making, evaluation, data collection, a website, and leadership.

Within Healthy New Orleans, these processes included consensus decision-making, as discussed above, and both formal and informal communication through e-mail meeting announcements, meetings (with minutes), and word of mouth. Although Healthy New Orleans participants trained in facilitative decision-making provided limited continuity between Healthy New Orleans and the Community Health Networks, one community volunteer suggested that “the relationship between the two was peripheral.” Another suggested that “people in the Community Health Networks struggle to understand Healthy New Orleans.” Monitoring and evaluation, other potential common processes
and discussed earlier under the adaptive sub-system section, were carried out informally within Healthy New Orleans. Leadership oversight by the co-chairs served to prod volunteers to fulfill commitments, suggesting that participants felt accountable to the Healthy New Orleans executive committee.

The combination of a well-defined informal structure including a central management board but few management processes, other than consensus decision-making, suggested that the management sub-system was in the formative stage for Healthy New Orleans.

4.2.3.5 The Production Sub-system

As discussed at the beginning of this section, the transformation process within open systems theory involves using resources from the environment to produce goods and services (Katz and Kahn 1978). Within the case of the community health partnership model, two production processes are required, one for improved community health and one for partnership development. Production sub-system activities dedicated to the partnership strategy include development of the sub-systems discussed previously, as well as the operations of the partnership, such as meetings, communication processes and decision-making strategies, and support to a management board. This support could be in the form of training and technical assistance for planning and monitoring, leadership techniques, and board development.
While the focus of this discussion is on partnership development efforts, health improvement activities provide some understanding of the way Community Voices operated. With the exception of reporting on progress and building relationships, most of the work was accomplished within the different coalitions pulled together by the director to address changing, short-term goals. Confirming this, a key informant suggested, “Each coalition is unique to the issue.”

The preceding discussion of the other four sub-systems described the adaptive and management sub-systems as rudimentary, the maintenance sub-system as rudimentary/formative and the boundary spanning sub-system as formative. Partnership operations included regular meetings and frequent communication, as pointed out by all partner liaisons. An initial core partner management board gave way to quarterly conference calls with the Kellogg Foundation, quarterly meetings among participating organizations to share information, build relationships, and discuss upcoming activities, and an annual retreat. The partnership coordinator and partner liaisons listed e-mail, telephone, fax, in that order, as the primary means of communication between meetings. A website provided the outside world an opportunity to learn about West Virginia Community Voices.

A key informant mentioned, “Attention was paid to partnership development during the first two years.” This attention involved technical assistance and training from a
Marshall University consultant for all participants. In addition, the director arranged for participants to attend conferences on an ad hoc basis. There was, however, no evidence of efforts, such as leadership training or board development, targeted specifically to improve the functioning of the management board while it existed. This minimal development of other partnership sub-systems, in combination with lack of attention to developing a central management board, points to a production sub-system that can be described as rudimentary.

4.2.3.5.2 Healthy New Orleans

The preceding analysis of Healthy New Orleans and development of the other four sub-systems suggested that all four were in the formative stage. Regular Healthy New Orleans meetings and communications contributed to the building of relationships and trust among individual volunteers. As discussed earlier, all participants had an opportunity to participate in Healthy New Orleans training in the facilitative, consensus decision-making process. A key informant involved in the state Turning Point initiative pointed out, “During the first year, we provided training and technical assistance to understand health more broadly and for assessment tools.” The national Turning Point initiative set up a number of work groups through its two offices in the National Association of County and City Health Officials (the local Turning Point initiatives) and the University of Washington (the state initiatives), including one on governance, in which representatives of Healthy New Orleans participated. However, no one mentioned, when asked, any training, such as board or leadership development, to enable members of
the executive committee to perform their management functions better. The national Turning Point initiative, recognizing the importance of leadership development, set up a Turning Point Development National Excellence Collaborative, targeting public health leaders in general (Wilson 2002).

In summary, the production sub-system of Healthy New Orleans involved an active management committee, with regular meetings and communications among itself and with the full membership, and development of all other sub-systems to the formative stage. This, in combination with lack of attention to improve the functioning of the executive committee, leads to the conclusion that the production sub-system was also in the formative stage.

4.2.3.6 Changes to the Model Suggested by Evidence

Part of the research process involved identifying key concepts or activities that had not received adequate attention in the community health partnership model.

4.2.3.6.1 Community Voices

Analysis of Community Voices interviews revealed the importance of relationship building and leadership development activities within the production sub-system. Interviewees repeatedly confirmed the importance of stressing both, with a partner liaison commenting, “It’s more about collaboration than funding” and still another underlined
the importance of “building relations among members.” Leadership was mentioned almost universally as a key factor in the success of Community Voices, with some interviewees pointing to the need for a strong leader and others pointing to the need to develop leaders throughout the partnership. A key informant suggested, “A successful partnership depends on the personality of the leader. Without a strong leader, a coalition risks degenerating into turf issues.” A partnership coordinator/core partner, on the other hand, pointed to the opportunities made available by the Kellogg Foundation “to develop leaders by providing resources to attend national Community Voices meetings focusing on understanding systems and bridge building.” The importance of relationship building and leadership development activities within partnership efforts is also confirmed in two reviews of the existing literature on partnerships (Kreuter and Lezin 1998; Roussos and Fawcett 2000).

4.2.3.6.2 Healthy New Orleans

Evidence from Healthy New Orleans confirmed the importance of relationship building and leadership development as part of the transformation process. Underlining this, one volunteer suggested, “Healthy New Orleans is an invisible entity that allowed [Community Health Networks] to do their own thing. You make more progress by developing indigenous leadership than by doing it yourself.” Recognizing the importance of leadership development, another stated, “A problem in my Community Health Network involved pushing individuals to leadership positions too quickly and didn’t follow through.” An additional focus revealed in the Healthy New Orleans analysis
involved training within the transformation process in the model. As discussed earlier, training provided the strategy for creating a common culture holding Healthy New Orleans together.

4.2.3 The Transformation Process – Summary Analysis

The transformation process addresses questions set out in the research proposal regarding the usefulness of open systems theory in the study of partnership in practice and the importance of attention to the partnership development strategy.

Reflecting a broader understanding of health, the community health partnership model called for organizations to join from the multiple sectors and levels that influence health and from the multiple levels that influence an organization’s ability to participate in a partnership. Analysis in both sites pointed to efforts to increase awareness of these broad determinants of health, rather than to a membership that reflected the diversity called for within this framework. Although the Community Voices proposal acknowledged the multiple influences on health, it may have been difficult to translate into practice in terms of partners and interventions, given the limited awareness among participants and the short-term goal of expanding access to health care services. Community Voices made good use of linking different levels of influence by combining community interventions and state-level policy change efforts. The strategic plan and participants in Healthy New Orleans demonstrated a much broader awareness of the determinants of health than those in Community Voices. Translated into practice at the Community Health Network level,
volunteers contributed to diverse efforts to improve their community such as improving nutrition by bringing in a neighborhood grocery store. At the city level, Healthy New Orleans efforts focused on establishing the Center for Empowered Decision-Making, part of its empowerment strategy. Healthy New Orleans concentrated on local efforts to the neglect of links to state and national entities with the exception of the Turning Point initiative. This may have stemmed from the focus on empowerment of individuals and the lack of organizational partners within Healthy New Orleans. However, lack of organizational partners made it impossible to work at the systems level, where it was important to involve organizations from multiple sectors influencing health.

Recognizing the importance of social legitimacy as a resource, the Community Voices director used Kellogg funding as an incentive to bring organizations with the relevant expertise and legitimacy together to ensure that the right doors were opened for advocacy efforts and that the community was willing to participate during the life of the Kellogg grant. Healthy New Orleans, on the other hand, used a Kellogg planning grant to stimulate individual volunteer efforts, augmented mainly by resources that its two co-chairs were able to make available given their senior level positions within their own organizations. Community Voices validated the need to include partners who brought their own legitimacy to improve chances of obtaining the grant and of gaining access to key decision makers. While the two co-chairs provided their own legitimacy, the empowerment strategy of Healthy New Orleans meant that membership was designed to comprise those who did not hold power. The two sites, therefore, provided mixed evidence, where Community Voices successfully used existing social legitimacy in its
various efforts and Healthy New Orleans attempted to create a voice for the powerless, perhaps a kind of legitimacy.

Interpreting ‘partnership’ as building relationships, the Community Voices office used Kellogg funding as an incentive to bring organizations together around goals that it determined. Providing opportunities to build relationships and trust through the regular contact between organizational representatives, boundary spanning represented the only sub-system in the formative stage of development. Because organizations remained autonomous with little holding them together other than a short-term goal and similar motivations, the maintenance sub-system, which results from relationship building, was described as rudimentary/formative. West Virginia Community Voices paid little attention to partnership development, leaving in place no structure once Kellogg funding ends. Relationship building, however, represents the first step in organizational affiliation and provides a foundation for further development, if participating organizations so desire.

As with Community Voices, Healthy New Orleans concentrated on building relationships, although this involved individual volunteers rather than organizations. Whereas the research focused on Community Voices and participating organizations as the unit of analysis in West Virginia, research in New Orleans focused exclusively on Healthy New Orleans, given the lack of participating organizations. Recognizing the importance of creating a lasting organization, an informal but structured executive committee ensured that a participatory, comprehensive plan guided Healthy New
Orleans’ efforts. In addition, the executive committee created a facilitative, consensus decision-making training program for all participants to create a common culture. The executive committee also served as the liaison to maintain relations with the external world and to raise funds for Healthy New Orleans. These efforts produced sub-systems all described in the formative stage. Table 6 provides a summary of the sub-systems and evidence provided by interviewees. The full tables can be found in Appendix 3.

Analysis of data provided through interviews suggested several refinements within the transformation process. The Community Voices analysis suggested, and the Healthy New Orleans analysis confirmed, the need to break down the local partners set out in the model into community-based organizations and residents. Defining the role of each ensures that strategies are included to support that role. Within the production sub-system, additions included relationship building, leadership development, and training for individuals and a management board.

In summary, the analysis of the transformation process pointed to mostly rudimentary sub-systems in Community Voices and to formative sub-systems in Healthy New Orleans. Because Healthy New Orleans had no organizational partners, the difference in levels of sub-systems development more likely reflects the differing goals of the two entities. Community Voices focused on short-term goals requiring only that organizations work together as independent organizations until a specific goal was achieved. Healthy New Orleans, on the other hand, set about developing and implementing a strategic plan that required long-term commitment from individual
volunteers to empower the disenfranchised to contribute to improvements in the health of their communities. Although precarious, Healthy New Orleans set about building something that would last. Analysis of the transformation process contributes to an understanding of the type of affiliation practiced in both sites, as well as its contribution to improving health, both discussed later.

4.3 The Influence of the Macro and Institutional Environments

Institutional theory serves in the model to highlight important environmental influences that are often overlooked in partnership efforts and that may provide insights into problems encountered in forming or implementing partnerships. The adaptive sub-system discussed under the transformation process section provides a mechanism for an organization to scan the environment, tracking the need for change. Organizations respond to influences such as funding requirements or government regulations by putting in place structures, processes, and procedures that accommodate these requirements (Meyer 1994). However, these responses may later impede or facilitate their ability to participate in partnerships and may help explain the status of development of the partnership. Many of the same organizations calling for partnership have left in place requirements that now need review and revision to enable partnership development.

This section analyzes information from annual reports and evaluations, as well as results of interviews and focus group discussions, to identify both facilitators and impediments that might be traced back to the macro and institutional environments of the partnership.
## Table 6: Evidence of Organizational Sub-systems in Community Voices and Healthy New Orleans

<table>
<thead>
<tr>
<th>Org. Sub-system</th>
<th>Community Voices</th>
<th>Source (Bold for CV)</th>
<th>Healthy New Orleans</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adaptive</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Environmental Assessment</td>
<td>Partner liaison</td>
<td>Environmental Assessment</td>
<td>CV – Rudimentary</td>
</tr>
<tr>
<td></td>
<td>“We are constantly talking to the public in health care settings.”</td>
<td>CV report</td>
<td>“Env. Assessments take place through business meetings and retreats”</td>
<td>HNO – Formative</td>
</tr>
<tr>
<td></td>
<td>-Plan</td>
<td>Partner liaison</td>
<td>Community Public Health System Improvement Plan with 50-year vision.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“Another challenge was the lack of a comprehensive plan.”</td>
<td>CV report</td>
<td>However, there is no mechanism to adjust plan from implementation feedback</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feedback Mechanism</td>
<td>Partner liaison</td>
<td>Partnership feedback mechanism</td>
<td></td>
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<tr>
<td></td>
<td>“Diverse members keep their fingers on the pulse”</td>
<td></td>
<td>“review of past accomplishments led to celebration of successes to sustain participants’ interest.”</td>
<td></td>
</tr>
<tr>
<td><strong>Boundary Spanning</strong></td>
<td>Person designated in each organization who attends partnership meetings regularly</td>
<td>Partnership coordinator/core partner</td>
<td>Person designated in each organization who attends partnership meetings regularly</td>
<td>CV- Formative</td>
</tr>
<tr>
<td>Each interviewee was designated by their organization to participate in Community Voices</td>
<td>Partnership coordinator/core partner</td>
<td>There are no formal org. partners.</td>
<td>HNO – Formative</td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td>Culture</td>
<td>Partner liaison</td>
<td>Culture</td>
<td>CV- Rudimentary/ Formative</td>
</tr>
<tr>
<td>“Partners have shared values of social justice.”</td>
<td></td>
<td>“The partnership has established a culture of acceptance and respect, …”</td>
<td>HNO – Formative</td>
<td></td>
</tr>
<tr>
<td>Basis of decision-making; conflict resolution; how diversity is accommodated</td>
<td></td>
<td>Basis of decision-making; conflict resolution; how diversity is accommodated</td>
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</tr>
<tr>
<td>&quot;CV gets different partners to get on the same side of an issue. It brings different perspectives together.&quot;</td>
<td></td>
<td>&quot;Consensus building is the most important thing about HNO.&quot;</td>
<td></td>
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<tr>
<td>Relationship building</td>
<td></td>
<td>Relationship building</td>
<td></td>
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<tr>
<td>&quot;CV is seen as a catalyst to build relationships.&quot;</td>
<td></td>
<td>“For example, as a result of working together and building meaningful relationships, there is less mistrust...”</td>
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</tbody>
</table>
### Table 6 Continued  Evidence of Organizational Sub-systems in Community Voices and Healthy New Orleans

<table>
<thead>
<tr>
<th>Org. Sub-system</th>
<th>Community Voices</th>
<th>Healthy New Orleans</th>
<th>Result</th>
</tr>
</thead>
</table>
| **Management**  | Integrating mechanism-board; power sharing mechanism  
“Early intentions to have busy executives act as core partners and attend were unrealistic.”  
Formal agreement between partners with agreed roles and responsibilities  
“There is no central agreement. Each participating org signs a bilateral agreement with the CV office.”  
Common procedures, processes, regulations, e.g., decision-making, communication, etc.  
“CV is an informal networking mechanism to think more broadly and to get orgs to look to other orgs.” | Key Informant  
Integrating mechanism-board; power sharing mechanism  
“The executive committee has a flexible membership with two regular co-chairs…”  
Formal agreement between partners with agreed roles and responsibilities  
“There is no formal agreement but we are looking into a memorandum of agreement.”  
Common procedures, processes, regulations  
Decision-making, communication, etc.  
“relationship between the two [HNO and CHNs] was peripheral”  
“People in the CHNs struggle to understand HNO.” | CV – Rudimentary  
HNO – Formative |
| **Production**  | Development of other sub-systems (see above)  
Support to develop partnership,  
“Attention was paid to partnership development in the first two years; partnership was mandated by Kellogg.”  
Regular partnership activities; quarterly meetings, quarterly conference calls, annual retreat. Core partners met during first two years only. | Partner liaison  
Development of other sub-systems (see above)  
Support to develop partnership  
“During the first year, we provided training and TA to understand health more broadly and for assessment tools.”  
Regular partnership activities: regular meetings of both executive committee and full HNO, retreat. Participants received facilitative consensus decision-making training. | CV – Rudimentary  
HNO – Formative |
Organized around institutional theory, the analysis of the environment is based on the four elements that make up the theory; that is,

1) the macro environment – made up of economic, political, and cultural institutions that influence the specific roles that organizations adopt in the institutional environment.

2) the institutional environment - shaped by the macro environment and made up of interest groups, professions, public opinion, government agencies, laws and courts, regulatory agencies, and funding agencies relevant to a specific organization, exerts influence through

3) pressures, including coercive (state regulation), normative (professional norms, requirements of trust), and mimetic (desire to be like others, imitation under uncertain conditions), on

4) a specific organization that is influenced by and reflects requirements of the institutional environment in order to gain resources and legitimacy (Powell and DiMaggio 1991).

While the macro environment is generally constant within a given society, the institutional environment of an organization varies depending on the function and local and non-local influences of the organization (Meyer 1994). Institutional theory therefore focuses on the relationship between these influences and the structure, processes, and activities that an organization adopts in response. The analysis that follows is organized around the macro (1 above) and the institutional environment (2 and 3 above), with a discussion of problems experienced by individual organizations that may have stemmed
from requirements or pressures imposed by organizations in the institutional environment. Organizations (4 above) must make changes in their processes and relationships to accommodate the needs of partnership (Bruner and Parachini undated; Brown and Grog 1997). The research, therefore, sought to understand problems encountered during implementation by examining sources of these problems in the institutional environment and efforts to remove these impediments. This section concludes with an analysis of the environment of local health departments, because prominent national organizations frequently identify health departments as an appropriate entity to convene local health partnerships (IOM 1988, 2002). For a fuller discussion of the institutional environment in each site, please see the case studies in Appendices 5 and 6.

4.3.1 The Macro Environment

Organizations develop in response to social pressures emanating from the larger society, such as the American culture or the democratic nation state in the US (Galaskiewicz 1991). The analysis of the macro environment therefore focuses on economic, political, and cultural influences that helped shape the institutional environment in which Community Voices and Healthy New Orleans operated. As stated above, both the Community Voices and Healthy New Orleans analyses included identifying problems and facilitators that can be traced back to the environment. In the case of Community Voices, informants from participating organizations suggested influences on the ability of their organization to participate in Community Voices, as well as on Community Voices
itself. Given the lack of organizational partners, the analysis for Healthy New Orleans focused on the macro influences that shaped Healthy New Orleans

4.3.1.1 Community Voices

Within the macro environment, the economy, changes in the political party in power, and culture represented both facilitators and impediments to organizations participating in Community Voices.

The economy in West Virginia created both facilitators and problems for organizations participating in Community Voices. While creating obvious problems for social services providers, “a crisis in insurance for health care providers and collapse of the local mental health provider” were viewed by several partner liaisons as more of “a facilitator to partnership formation” because it forced organizations to look outwardly for increased resources. Another problem pointed out by a partner liaison involved “difficulty in bringing in new and younger partners,” given a declining economy that led to a population exodus in search of employment, leaving behind a population that was older, less educated, poorer, and more disabled.

The organization of the U.S. political system influences the way states receive a large portion of their financial resources and the flexibility they have in using these resources (Thompson 1981). A partner liaison suggested that the events of September 11, 2001, led to diversion of federal funds for emergency preparedness and consequent cuts in funds
for social programs, adding to the state cuts discussed above. A partnership coordinator/core partner pointed to the influence of social norms and the changing political environment on the ability of the Governor’s Cabinet to coordinate funding and regulations, stating, “The Cabinet was never allowed to exert this authority. This authority of the Cabinet was removed by the legislature during the 2002 legislative session.”

The culture in West Virginia provided both facilitators and impediments for partnership development. Respondents, almost universally, claimed, “Everyone knows everyone,” working within the social sectors in West Virginia. Summarizing the view of most partner liaisons and key informants, as well as evaluation documents, a key informant asserted, “much of the success of Community Voices” in terms of policy change and increased numbers of eligible children for the state health insurance program, for example, “could be attributed to the special circumstances found in West Virginia—the combination of a small state, long-standing relationships, and well connected partners.”

This discussion demonstrates that the current economic and political situation, and the culture of the people may have influenced not only the operation of, but also the ability and desire of organizations to participate in West Virginia Community Voices.
4.3.1.2 Healthy New Orleans

The inclusive empowerment process adopted by Healthy New Orleans was grounded in the history and culture of the city, which led to a feeling of “powerlessness of disenfranchised segments of the city’s population,” as pointed out in a report on governance.

Heavily influenced by its early European settlers, New Orleans experienced a clash of cultures as ‘Americans’ moved in after Louisiana became part of the expanding United States in the 18th and 19th centuries. This clash led to a separation of the Creole descendants of the French from the Americans, who settled west of Canal Street (McNabb and Madere 1997). Although neighborhoods were settled along racial lines, they appear “amorphous between the rich and poor,” according to one community volunteer, with whites settling along the wide boulevards and tradesmen and black servants living on the smaller back streets of the same neighborhoods. A key informant, summarizing most interviewees’ view, suggested, “Decreased community cohesion has made it difficult to pull people together around issues…” and "problems working with disconnected communities continue, making it hard to have an influence at the systems level.” Confirming this, participants in a workshop on the social determinants of health, sponsored in conjunction with NACCHO, recognized the need for increasing awareness of the consequences of institutionalized racism, among other things (NACCHO 2002).
The existence of an official and unofficial political system provided further impetus for the community-based approach. Although run by majority African Americans, power in New Orleans lay elsewhere, as one volunteer asserted, “The business and economic community is mostly white… Vested interests parallel race that hold influence in spite of a black political structure.” A volunteer in a Community Health Network suggested one problem stemming from this polarization, “It’s hard to get whites involved because they’re already empowered.” Corruption among politicians and the police may have also contributed to volunteers in Healthy New Orleans avoiding the power structure. One volunteer suggested, “No attempt has been made to bring in politicians to avoid corrupting Healthy New Orleans’s image.” All interviewees were well aware of the “quiet revolution” being pursued by Healthy New Orleans to “undo racism and change the status quo.”

A declining economy also influenced Healthy New Orleans, when recent state budgetary problems led to funding cuts that “drastically impacted the state Office of Public Health, resulting in a major exodus of key personnel,” as suggested by a community volunteer. Another viewed this as a facilitator to bringing people together, “People saw themselves in such dire straits, they sought revolutionary change and came together around Turning Point.”

The strategic plan pointed to influences that combined to give New Orleans some of the worst health statistics in the U.S. The plan stated, “The city is known internationally for its fine cuisine, hospitality, laid back culture and reputation as a party capital… The
citizens of New Orleans are challenged with behavioral practices that are entrenched as a way of life. This entrenchment coupled with many environmental, social, and economic factors contributes to the ranking of New Orleans and the State of Louisiana at the top of the charts of poor health outcomes.” Other factors affecting health status of New Orleanians suggested by interviewees involved a lack of priority for health issues and the view of health as a medical concern and an individual responsibility.

The sub-tropical climate and pollution from the oil and gas industry also influence the health status of residents of New Orleans. The river between New Orleans and Baton Rouge is “considered a chemical corridor, full of contaminants,” which one interviewee felt provided evidence of “environmental racism, where chemical plants are built near poor areas.”

In summary, institutionalized racism and majority African American elected power with real power in the hands of whites combined to produce the influences that shaped Healthy New Orleans empowerment strategy. A laissez faire culture, an economic downturn, a sub-tropical climate, and pollution contributed to the poor health status of the residents of New Orleans, the improvement of which constituted a main goal of Healthy New Orleans.
4.3.2 The Institutional Environment

Attention within institutional theory focuses on the institutional environment, where influences more directly shape organizational structures, processes and activities (Meyer 1994). Shaped by the macro environment, the institutional environment, made up of interest groups, professions, public opinion, government agencies, laws and courts, regulatory agencies (Hatch 1997), and funding agencies (Gans and Horton 1975), exerts influence through coercive, normative, and mimetic pressures on organizations to adapt (Meyer and Rowan 1991). Because these organizational adaptations in the form of structures and processes may later cause problems for organizations desiring to participate in partnerships, the analysis that follows identifies problems suggested by interviewees that may be explained by elements in the institutional environment. This analysis may indicate where participating organizations must make changes in responsibilities and relationships, for example, required by partnership (Bruner and Parachini undated; Brown and Gorg 1997).

4.3.2.1 Community Voices

Evidence pointed to facilitators and impediments from the institutional environment. A partnership coordinator/core partner reported that there is “a partnership at the federal level between federal agencies and foundations to support similar issues,” such as partnership. This may have prompted the W.K. Kellogg Foundation to mandate partnership as a grant requirement. Kellogg was able to extend this influence in
Community Voices and take over decision-making to establish priorities. Implications in terms of collaboration will be discussed later in the section on the reciprocity effectiveness characteristic.

Another influence from the institutional environment involved professional norms that acted as a barrier in several of the coalitions. For example, a partner liaison reported that her organization encountered a different culture in the juvenile justice system in its work with juvenile offenders that “cannot overcome traditional ways of working and bureaucracy.” Turf issues also arose in the West Virginia Oral Health Task Force between dental hygienists and dentists, who sought either to retain or establish their right to perform certain procedures for Medicaid reimbursement. The difficulty in attracting for-profit organizations might be traced back to organizational culture, where participation in Community Voices “is seen as a cost to business, and loss of control while it’s part of the job of social services providers,” as one partner liaison suggested. Problems in participating for the State Department of Health and Human Resources might be traced to a complicated hierarchy and bureaucracy that reflected requirements of specialized federal departments and regulatory agencies providing its funding. Two key informants involved in government pointed to restrictions placed on federal categorical grants as a limit on their ability to partner. One asserted, “Categorical grants lead to duplication because each grant requires its own accounting and reporting systems.”

A representative of a community-based organization who participated in the focus group suggested that influences from interest groups acted as a facilitator to getting
organizations to work together. This partner liaison suggested that “flexibility in community-based advocacy groups stemmed from few bureaucratic requirements” imposed by the interest groups that supported them.

In summary, the institutional environment exerted numerous influences on organizations participating in Community Voices. Exhibiting a desire to follow national trends, the Kellogg Foundation’s mandated partnership, extending its influence beyond this to decision-making within Community Voices. Interest groups acted as a facilitator for their community-based organizations by exerting few bureaucratic controls and allowing them the flexibility to participate in partnership. On the other hand, turf wars, differing professional cultures, and reporting and accounting requirements of specialized government agencies created differing levels of impediments for participating organizations.

Efforts to address these problems were limited, focusing generally on the symptom rather than on the cause. Knowledge of some of these problems afforded participants in Community Voices opportunities to develop strategies for overcoming them. For example, aware of potential mistrust of the rural people of Appalachia, one executive director asserted, “activists understand that they have to build trust first by listening.” More usually, however, people waited for problems to happen and then looked for ways around them, as indicated in the previous discussion of informal feedback in the adaptive sub-system. This may be a reflection of the culture where those with less power accept the status quo, as a key informant suggested. An executive director pointed to “the loss
of young people, leaving older people who don’t bring new ideas and resist change,” as
another possible explanation. Institutional theory may provide a further explanation in
that it describes organizations as either productive or institutional. Productive
organizations focus on the bottom line and physical outputs, while institutional
organizations, including most members of Community Voices, focus on process and
relationships, depending for survival on their ability to conform to external requirements
(Powell 1991).

4.3.2.2 Healthy New Orleans

Healthy New Orleans also experienced influences from its institutional environment.
Several interviewees pointed to the difficulty of bringing for-profit businesses into
Healthy New Orleans because of differences in organizational culture. A co-chair/
executive committee member mentioned, “We tried to bring in the Chamber of
Commerce but their bottom line is not tied into the community process. Meetings are not
part of their culture unless they are tied to a product.” A volunteer suggested, “Most are
used to hierarchical organizations that depend on their own expertise and competition.”
A Healthy New Orleans report pointed out a similar problem, “It is difficult to legitimize
the community-based approach in the eyes of traditional health professionals.
Ultimately, a common language about community health needs to be developed that
everyone will be able to understand.” Hierarchical organizations that depend on their
own expertise and competition may find it difficult to adopt the participatory approach
employed by Healthy New Orleans.
With reference to the ability of government to participate in Healthy New Orleans, a co-chair/executive committee member, also a former city government employee, suggested that “categorical grants place restrictions on recipients’ ability to participate.” A key informant who formerly worked for state government continued, “It is too difficult to do things in government, where managers think in terms of categorical programs and lack the big picture.” Another, who had worked with the State Turning Point initiative, suggested that many in government had an attitude where government “leaders had the knowledge and expertise [that] prevented any real partnership from developing.”

Acknowledging the influence of the funding source, several interviewees mentioned that “Kellogg mandated partnership within the grant.” In summary, the empowerment strategy adopted by Healthy New Orleans’ addressed influences from the macro environment, including institutionalized racism and power held outside the political system. The poor health status of residents of New Orleans stemmed from a laissez faire culture, a declining economy, and a contaminated physical environment. Influences from the institutional environment included a funding agency mandate for partnership, as well as professional norms and government regulations that limited participation of potential partners from the private sector and local government.

Efforts to address these problems were limited to the planning phase of Healthy New Orleans. The strategic plan demonstrated an understanding of ‘underlying contradictions’ that represent major bottlenecks where the ‘solutions lie not within the resolution of any one issue or problem but with elimination of the common underlying
causes.” Analysis of these contradictions led to development of three strategic directions involving empowerment, collaboration between health providers, and improved, accessible information. A member of the executive committee suggested how this was translated into activities, “We have to get rid of the blocks first. We made people aware of the small things that they can do in their neighborhoods.” Little evidence of this level of analysis, however, was apparent for implementation activities, where people preferred to make their own mistakes and learn by doing, using feedback to celebrate success, rather than to improve implementation as discussed in the adaptive sub-system section. The culture of institutionalized racism may have contributed to this approach. One volunteer asserted, “People see lack of jobs and education as normal and don’t look for change,” while another added, “There is a conspiracy of politeness, blacks don’t know how to challenge.”

4.3.3 The Role of Local Health Departments

Local health departments exist at the level where health is created and have therefore been suggested as appropriate entities to play a convener role in partnerships (IOM 1988, 2002). As a convener, local health departments would be expected to participate as equal partners, along with other local organizations and residents. Much of the literature on local health departments, however, points to characteristics that may be perceived as barriers to local health departments performing the convener role or participating in partnerships. Many of these barriers may be attributed to influences in the macro and institutional environments
(Macro 1996; Cooksey and Krieg 1996; Glogow 1973; Schlesinger 1997; Pestronk 1995; Krieger et al 2002). Interviews and documentation provided evidence of facilitators and impediments that might affect the ability of local health departments to participate in both Community Voices and Healthy New Orleans.

4.3.3.1 Community Voices

The interviews with West Virginia Community Voices partners revealed that local health departments were only peripherally involved, if at all in Community Voices. An understanding of why these organizations were not involved might provide useful insights; the researcher, therefore, sought knowledgeable key informants to interview. These key informants represented two local health departments, the state health department, and Marshall University. In addition, a question in the focus group protocol related to the role of local health departments in West Virginia.

During the mid-1990s, public health officials in West Virginia, influenced by normative pressures from the Institute of Medicine (IOM), set about transforming the public health system in line with IOM recommendations to focus on the core public health functions and regionalizing health departments. A key informant reported that during the 1995 legislative session, local health departments were successful in defeating a resulting proposal, as they feared that local communities, especially rural ones, would suffer if clinical services were removed.
A key informant explained that influences from the institutional environment of local health departments include local boards of health, which have most budgetary control over them and for which West Virginia local health departments serve as staff, and the state health department, which has limited oversight through federal pass-through funds. Many West Virginia local health departments are small, with 50 percent having fewer than five staff, usually public health nurses. Most provide personal health care services, reflecting the lack of alternatives in a state that is mostly rural and the influence of federal categorical grants. During a recent crisis in medical malpractice insurance when many practitioners were forced to leave the state, local health departments were the only health care providers left in a few counties.

Representatives of the two local health departments involved in the interviews were aware only peripherally of Community Voices through work with the Healthy Kids coalition outreach efforts. A key informant attributed this lack of local health department participation to a “narrowly focused Board of Health,” which viewed the role of health departments as service delivery. Another key informed described the health department as a series of “fragmented CDC services [that provide] disincentives to work together…” Both representatives from the state health department and local health department reported using “accountability accommodation” or “work-arounds” to ensure that federal resources were available for program needs not financed under categorical grants.
Focus group participants perceived problems in assigning the partnership convener role to local health departments, given limited staffing and other resources, a medical focus, and a traditional way of working. Participants pointed out that they already had partners to carry out the convener/facilitator role (Lifebridge) and the needs assessment role (regional Family Resource Networks). Because local health departments were mainly funded for their provider role, they lacked a funding mechanism for retraining for new roles such as convening the community. One participant pointed out “You cannot take a public health nurse who has been doing immunizations and STDs for 20-25 years and say ok, now I want you to be a convener” with no additional training.

4.3.3.2 Healthy New Orleans

Problems arose in addressing the question of the ability of local health departments to join organizational partnerships because the director of the New Orleans Health Department was not available for interview. In addition to interviewing the director’s previous assistant at the health department, efforts to fill this gap involved identifying knowledgeable key informants and additional relevant documents. The discussion that follows, therefore, describes the role of the New Orleans Health Department in Healthy New Orleans and general problems in the city public health system, which might influence the ability of NOHD to participate formally in the future.

The previous director of the New Orleans Health Department is one of two co-chairs of Healthy New Orleans. She “provides a strong influence with a vision for Healthy New
Orleans,” a co-chair/executive committee member asserted. While the Department was not officially affiliated with Healthy New Orleans, the director was able to make a ½ FTE available for administrative support to Healthy New Orleans. A further benefit of the director’s participation, stressed by a co-chair/executive committee member, concerned the convener role suggested for local health departments by the Institute of Medicine. He stated “this certainly has been one of the stronger attributes of the Department under [the previous director].” One key informant reported, however, that the director’s “participation was outside her government job” and that “her level allowed her to approve the administrative support.” Recognizing that this support might be temporary, a report to the governance task force questioned “whether this support was shared by others in the department.” Another indication of support or lack of support for Healthy New Orleans by the Health Department was the fact that the only person offered for interview for this research from the Health Department was the administrative person who departed along with the director. Participation of the New Orleans Health Department in Healthy New Orleans, therefore, appeared limited to the director and her assistant. A key informant suggested that this level of participation may have been deliberate, given the need to focus on empowerment after a recognition that the community needed skills to enable it to advocate for change in the health system.

The following discussion of the public health system more generally may offer further insights. Sources of information on the status of the public health system included the Healthy New Orleans Community Public Health System Improvement Plan and a task
force report organized to review the state of public health prior to the recent city elections, as well as key informants.

The New Orleans Health Department (NOHD) differs from other local health departments in Louisiana, which are part of the State health department. Operated by the city of New Orleans, NOHD earns almost all income locally through general funds, grants, and income earned from selected services, with state support through pass-through funds only. These sources of income represent influences from the institutional environment on the health department. The director serves as a member of the mayor’s cabinet, reflecting the political nature of the job. Cultural and government influences, including history, the needs of its inner city population, and availability of state pass-through funds, led to a Department that provides mainly direct health care services. The Department supports three community health centers, in cooperation with Excelth, Inc.

Community discussions during the Healthy New Orleans planning process and summarized in the strategic plan pointed to a public health system that was narrowly focused, confusing to the public, under resourced (finances and expertise), fragmented, and uncoordinated. The existing system “emphasizes treatment, not prevention, and traditional medicine prevails…” A report prepared by the Public Health Task Force confirmed that the “Department of Health is heavily involved in the provision of clinical services… however, there remain many large gaps…and there is not a well coordinated city-wide plan for primary and preventive health care services.” A key informant related problems within the public health system to “city difficulties, including lack of priority
for health by politicians and low pay leading to limited skills and poor quality staff.” These problems can be attributed, at least in part, to cultural influences, professional norms, and government regulations.

The public health system in New Orleans remains fragmented, narrowly focused, and characterized by problems associated with a governmental body, which may pose constraints on the ability of the NOHD to participate in partnership without the full support of the director to work around these constraints.

4.3.4 Environmental Influences – Summary Analysis

Institutional theory served in the community health partnership model to understand how organizations adapt to demands in their environments by developing structures, processes, and procedures that meet those demands in exchange for legitimacy and stability (Powell and Dimaggio 1991). A well-functioning feedback mechanism within the adaptive sub-system enables an organization to track these changing environmental demands and the need for change for organizational survival.

Interviewees in West Virginia Community Voices suggested several environmental influences in their work. Facilitators in the macro environment stemmed from a slowing economy that spurred organizations to look to other organizations for resources, while the culture of the social services community in West Virginia further facilitated this joining together. Barriers may have resulted from political influences that impeded the
Governor’s Cabinet for Children and Families from playing its intended role and cultural influences created difficulties in bringing in a rural, Appalachian community to regional dialogues. Within the institutional environment, professional norms, legal requirements, and specialized federal bureaucracies in Community Voices’ participating organizations led to turf wars, to different ways of working and organizational cultures, and to complicated and slow local bureaucracies. The Community Voices experience with flexible advocacy groups suggests the need to recognize that organizations with fewer influences tend to have less bureaucratization and formality (Powell and DiMaggio 1991).

Analysis of Healthy New Orleans pointed to institutionalized racism in the macro environmental that shaped Healthy New Orleans’ inclusive, empowerment approach. A slowing economy limited the state Office of Public Health’s ability to support Healthy New Orleans. Evidence of the influence of the institutional environment was limited to the Kellogg Foundation mandate for partnership and influences on potential organizational partners. For example, professional norms created different cultures between government and the private sector that might clash with the participatory approach employed by Healthy New Orleans. Finally, government organizations might find themselves restricted in their ability to participate, where categorical programs prevent sharing of activities and resources called for by partnership.

Analysis of the environment of local health departments in West Virginia and in New Orleans suggested that, as government entities, they may have difficulty in participating
in partnerships. Analysis in both sites revealed that local health departments focused on delivery of health care services that were fragmented as a result of categorical funding. Evidence from both sites suggested that the full support of the director may be required to work around these constraints.

With regard to the approach to problems and the need for change, both West Virginia Community Voices and Healthy New Orleans adopted a trial by error approach, where participants enjoyed learning by doing rather than using evidence to drive adjustments in activities. The discussion under the adaptive sub-system pointed to the use of informal feedback to celebrate success, to maintain participant interest, and to fulfill a funding agency requirement.

4.4 The Collaboration Effectiveness Characteristics

The third element of the community health partnership model involves criteria to characterize the effectiveness of the collaboration between participating organizations and the contribution of the partnership strategy to a health improvement goal. These include formalization, intensity, reciprocity, and standardization, which in turn contribute to an understanding of the extent to which the partnership is institutionalized (Hudson 1987).

Each characteristic will be described in the following discussion according to its strength along an effectiveness continuum, represented by weak and strong characteristics at each
end. Because Healthy New Orleans did not include organizational members, analysis of these characteristics cannot assess the degree of collaboration between organizations. Analysis may, however, contribute to a better understanding of the functioning and contribution of Health New Orleans’ implementation strategy to health improvement goals. For a fuller presentation of evidence and findings, please see the tables in Appendix 4 and the case studies in Appendices 5 and 6.

4.4.1 Formalization

Formalization is defined as explicit recognition of the partnership by the wider community and the existence of a coordinating body with rules governing operation of the partnership (Hudson 1987). Legitimacy and an ability to raise funds contribute to formalization, as does the existence of a plan and a central agreement with established roles and responsibilities for participating organizations. Participating organizations recognize partnership formally by the degree to which they allow their representatives to speak for and commit resources of their organizations, for example.

4.4.1.1 Community Voices

A partnership coordinator/core partner suggested that evidence for recognition by the wider community for Community Voices included increased ease in getting the media’s attention and improved access to the Governor’s Cabinet on Children and Families, with the recent appointment of the previous director as its head. The ability to raise additional
resources from the Benedum Foundation, among other agencies, further confirmed that Community Voices had some formal recognition in the community. In addition, Community Voices had set up a web site, partly in an effort to gain recognition from the wider community. Recognition, however, was limited by the fact that most partner liaisons felt that the question of social legitimacy for Community Voices was misplaced since it “was not interested in establishing its own identity but rather in building relationships.”

The degree of formality within Community Voices reflected, at least in part, requirements of the bilateral agreements between Kellogg and each member organization. As mentioned earlier, no common plan existed to set out long-term goals or organizational commitments nor was there a central management board. A partner liaison added “There is a formal agreement between Kellogg and each organization but no central agreement.” Asked about their ability to commit their organization’s resources for work within the informal coalitions in which they participated, all but one partner liaison, who was several layers down in a government bureaucracy, reported having “the authority to commit organizational resources,” usually in consultation with a board.

This analysis indicated a weak formalization characteristic, based on the mixed results discussed above. Limited recognition of Community Voices itself, no central management board, and little formal support from participating organizations other than funding agreement requirements countered an ability to raise additional funds and some
social legitimacy. The formalization characteristic falls between none and a quarter on an effectiveness continuum.

4.4.1.2 Healthy New Orleans

This analysis of the degree of formalization within Healthy New Orleans focuses on explicit recognition for Healthy New Orleans, rather than on organizational member support. Healthy New Orleans developed limited social legitimacy of its own. One volunteer suggested, “Healthy New Orleans doesn’t have an identity yet. At the neighborhood level, people struggle to understand Healthy New Orleans.” Evidence of some legitimacy involved the site visit by the Institute of Medicine for its study on public health in the 21st century, with a co-chair/executive committee member claiming, “Healthy New Orleans has more influence outside the state.” As discussed earlier, Healthy New Orleans has only been able to attract additional funding from the original funder the Kellogg Foundation, evidence of limited recognition by other funding agencies. A co-chair/executive committee member explained, “There is no dedicated source to sustain Healthy New Orleans because it has been hard to describe what Healthy New Orleans is doing and match it to interests of funding agencies.”

In spite of existence of a comprehensive plan, there was no formal support or recognition for Healthy New Orleans in the form of agreements, setting out specific responsibilities within the plan, either for individuals or for organizations. A volunteer stated, “Healthy New Orleans work is extracurricular.” Although an executive committee existed, it
remained informal since Healthy New Orleans had not incorporated and members of the committee self-selected. A community resident commented, “The executive committee has a flexible membership with two regular co-chairs. People attend according to their time and commitment.” In addition, a web site was being prepared for Healthy New Orleans. The recent establishment of the Center for Empowered Decision-making represented an effort to formalize an arm of Healthy New Orleans. There was, however, no intention to formalize Healthy New Orleans itself, according to a focus group participant.

This analysis pointed to a weak formalization characteristic, falling between the no formalization and one quarter on an effectiveness continuum. Although Healthy New Orleans did develop a strategic plan, the formalization characteristic was weak based on limited social legitimacy of its own, an ability to raise funds only from existing funding agencies, and no formal support in the form of agreements regarding responsibilities within the plan.

4.4.1 Intensity

Intensity is defined as the amount of investment an organization has in relations with other organizations in a partnership (Hudson 1987). It can be measured by the frequency/regularity of interactions, including meetings and communications, and internal organizational support for the partnership in terms of involvement of multiple levels of staff and internal changes made to accommodate partnership needs. These
changes might include incentives for staff to participate or changes in job descriptions to include partnership responsibilities, among others. In addition, a match between the complexity of the goal and the timeframe, partners, and resources contributes to the intensity characteristic.

4.4.2.1 Community Voices

Earlier discussions of the production sub-system within Community Voices demonstrated the regularity of meetings and communications, while the environmental analysis pointed out that participating organizations were not required to make any internal changes to accommodate the needs of the partnership. All partner liaisons confirmed that their job descriptions included outreach or networking generally, but nothing specific for Community Voices participation. Summarizing support for Community Voices from their organizations, a partnership coordinator/core partner stated, “My job description does not mention Community Voices but building relationships is mentioned. My position in located in top management, which is committed to Community Voices.” Kellogg funding acted as an incentive for organizations to participate and access resources supplementing ongoing activities, such as the Parents as Teachers programs of Lifebridge. One partner liaison suggested that additional internal incentives were not required because individuals participated based on “shared values around a broad goal of social justice.”
The stated systems-level change goal called for a long-term effort and partners from multiple sectors influencing health. However as pointed out earlier, efforts reflected the needs of shifting short-term goals, as the Kellogg Foundation suggested new priorities connected to expanding access to health care services. Although awareness of the determinants of health among interviewees was growing, the earlier discussion regarding participating organizations pointed out that they did not reflect this diversity, perhaps due to the short-term goal to expand access to health care services. On the other hand, the link between community interventions and state level policy advocacy efforts, discussed earlier under the partner section, did reflect the importance of involving different levels.

An important point about the short-term coalitions involved the lack of links between them. The West Virginia contribution to a national Community Voices evaluation stated, “In his [the consultant] technical assistance work, the partners had difficulty in figuring out how to knit the pieces together.” The timeframe, partners, and resources made available for Community Voices, therefore, did not yet match the goal stated in the proposal to effect change at the systems level.

The combination of regular meetings and communications, no internal changes by participating organizations, and the weak match between the complexity of the goal and the shifting nature of coalitions brought together for short-term goals meant that the intensity characteristic was weak, falling between none and a quarter on an effectiveness continuum.
Discussion of the intensity characteristic in Healthy New Orleans focuses on individual
volunteers, given the lack of organizational members. Earlier discussions regarding the
production sub-system demonstrated the regularity of meetings and communications
between individuals, rather than between representatives of participating organizations.
Participation by individuals was, however, inconsistent, requiring constantly updating
participants and creating discontinuity in Healthy New Orleans, as discussed earlier. A
member of the executive committee confirmed, “There are a lot of new people with fewer
who were involved at the beginning. We need to constantly educate new people.”

Where volunteers were affiliated with organizations, they did not have the authority to
commit organizational resources, with the exception of the two co-chairs. The ad hoc
nature of organizational participation did not require any internal changes to
accommodate the needs of the partnership. One focus group participant, however, felt
that individual volunteers were beginning to influence their own organizations, stating,
“We are planting the seeds. We are changing our institutions by what we take back, by
what we use, by the people we influence.”

All interviewees spoke to the plan goal to broaden the view of health among residents of
New Orleans, focusing on the social determinants of health to improve the public health
system. Although the strategic plan reflects, in part, the needs of this broad vision by
incorporating a fifty-year timeframe, previous discussion demonstrated the ad hoc nature
of resources and dependency on volunteer staffing, insufficient for addressing this broad vision. One key informant argued “it takes a lot more resources to entirely rearrange a system.” The match between the complexity of the goal and the appropriateness of the timeframe, partners, and resources was, therefore, weak.

A co-chair/executive committee member and a volunteer highlighted an example of internal organizational change required for participation in a formal partnership. A Healthy New Orleans strategy involved adopting organizations that contributed to goals set out in the Community Public Health Improvement Plan. Healthy New Orleans, therefore, adopted a group of medical providers, including the Medical Center of Louisiana at New Orleans, the Daughters of Charity System of New Orleans, and community health centers represented by Excelth, Inc., which decided to work together to improve delivery of health care services. They entered into an agreement to share patients, through an electronic information system, allowing access to patient records for referrals from medical providers in the community health centers to the medical center. In the near future, the reverse process will allow medical center providers to refer patients to the community health centers for outpatient follow-up and care. Stressing the need for this level of recognition within participating organizations, the community volunteer asserted, “You need an institutionalized partnership to ensure that relationships are maintained. It lends legal credibility.”

The combination of regular meetings attended inconsistently by individuals, no internal changes required by the ad hoc nature of organizational participation, and the weak match
between the complexity of the goal and participants and resources brought to bear for its realization points to a weak intensity characteristic, falling between none and a quarter on an effectiveness continuum.

4.4.3 Reciprocity

Reciprocity is defined as the degree of mutual exchange of resources and shared decision-making (Hudson 1987). It includes the degree of risk and power sharing and the ability to deal with differences and conflict and build trust.

4.4.3.1 Community Voices

As discussed earlier in the sections on participants, institutional environment, and management sub-system in Community Voices, decision-making was not shared for priority setting or financial resource allocation among participating organizations. The Kellogg Foundation, based on its influence as the funding agency, participated as key decision-maker, supporting the argument that vertical (power and authority from non-local sources) influences are stronger than horizontal (competition or cooperation among local sources) ones (Warren 1967). This role of the funding agency precluded participating organizations from acting as equal partners. The fact that partnership was mandated also reduced the level of reciprocity since a mandate takes away a degree of decision-making and autonomy of participating organizations, reducing their ability to adjust to changing needs and to innovate (Alter and Hage 1993).
The discussion under the maintenance sub-system pointed out that participating organizations had similar motivations and organizational cultures, but that Community Voices did not have a common culture. Most partner liaisons pointed out, however, that once Kellogg resources were distributed, participating organizations “worked together as equals through a consensus decision-making process within each coalition.” A partner liaison stressed, “Community Voices is more about collaboration than about money.”

Analysis of the reciprocity characteristic leads to the conclusion that this characteristic falls at the weak end of an effectiveness continuum for Community Voices. Lack of a common culture within Community Voices and centralized resource allocation contributed to this finding. Evidence provided by partner liaisons for work within the coalitions making up Community Voices in which they participated pointed to a stronger reciprocity characteristic, where consensus decision-making mainly prevailed.

4.4.3.2 Healthy New Orleans

Organizational participation in Healthy New Orleans involved ad hoc contributions such as meeting space. Organizations were, therefore, not required to assume risks by committing resources on a regular, long-term basis. Because Healthy New Orleans’ members were individuals, analysis of the reciprocity characteristic focuses on the amount of reciprocity between individual volunteers. Adoption by Healthy New Orleans of a facilitative, consensus-building approach helped to establish a view of diversity as complementary and an asset to be accommodated with little conflict. One volunteer
suggested, “Everyone is accepted as a worthwhile participant with something important to say. The challenge is to discover each person’s talents because everyone has a stake in the outcome.” Individual motivations for participation commonly involved “the faith-based foundation, …and the spiritual context and self sacrifice,” suggested by a co-chair/executive committee member as a basis for building relationships and trust. A co-chair/member of the executive committee summarized participants’ views of decision-making by describing the process, “The executive body brings issues to the partnership that then works through a facilitative process to reach consensus,” mainly on the implementation of the proposal.

The involvement of the community, consensus decision-making, and the ability to build trusting relationships based on common motivations led to a high degree of reciprocity between individual volunteers participating in Healthy New Orleans. Because they did not commit resources other than their own time and thus did not assume risk, this characteristic would fall in the middle of an effectiveness continuum.

4.4.4 Standardization

Standardization is defined by the degree to which partnership operations are similar over time, based on well-specified linking procedures (Hudson 1987). Standardization is measured by the existence of common procedures, rules, and regulations between participating organizations that facilitate their work together.
4.4.4.1 Community Voices

As discussed earlier under the management sub-system and the intensity characteristic sections, Community Voices represented short-term coalitions working toward different goals that were not linked in support of the stated systems change goal. Those involved in implementing Community Voices did not develop standardized procedures to facilitate the work of the participating organizations. Reflecting the learning by doing approach, one volunteer stated, “Where failure happens, we redesign the activity.” The only common procedures involved those imposed by the Kellogg Foundation. On an effectiveness continuum, this characteristic would, therefore, fall close to the no standardization extreme.

4.4.4.2 Healthy New Orleans

Linking procedures, rules, and regulations between organizations were not required in Healthy New Orleans, an organization made up of individual volunteers. Instead of searching for common procedures between organizations, analysis within the standardization characteristic looked for evidence of established procedures used by Healthy New Orleans. Several volunteers pointed out that the common facilitative training represented an effort to standardize the work of Healthy New Orleans. One volunteer pointed to the “annual retreat to reflect on the past and celebrate success.” Another admitted that lack of a common feedback system, “…is a weakness.” Given the
lack of other procedures, the standardization characteristic would fall close to the no standardization end on an effectiveness continuum.

4.4.5 The Effectiveness Characteristics – Summary Analysis

The effectiveness characteristics were included in the community health partnership model to provide a framework to assess the level of collaboration practiced by an organizational affiliation (Hudson 1987). Before we can determine the impact of partnerships, we must first understand whether the process of partnership was implemented effectively (Yin 1994; Thompson 1981), as well as of the degree of value added by organizations working together, instead of working alone, to achieve a goal.

The effectiveness characteristics described the extent to which member organizations were able to collaborate for common efforts within Community Voices. In Healthy New Orleans, the analysis provided insights into how well it had established itself, as well as the value added by individual volunteers working together. Figure 5 provides a visual presentation of this analysis for Community Voices and Healthy New Orleans, respectively, placing each characteristic on an effectiveness continuum. Table 7 provides examples of evidence for each of the effectiveness characteristics. The full tables can be found in Appendix 4.
This analysis suggested that effectiveness characteristics were all weak for Community Voices, confirming the analysis of the transformation process where there were few organizational sub-systems established. Replacing partnership as an implementation strategy, the director played the essential role of the ‘glue’ holding Community Voices together during its funding period. As such, the focus shifted to providing incentives for organizations to participate, rather than on establishing a long-term Community Voices partnership. The initial long-term goal gave way to short-term goals that could be achieved through coalitions encouraged by Community Voices. Interviewees pointed to stronger reciprocity and intensity characteristics within the coalitions in which they participated. Although these coalitions were able to realize short-term gains, a closer
examination of each coalition would be required to ascertain whether attention to the coalition strategy contributed to these gains. Healthy New Orleans paid attention to organizational development activities, as evidenced by all sub-systems being in the formative stage. The formalization, intensity, and standardization effectiveness characteristics, describing how well Healthy New Orleans was established, were weak in Healthy New Orleans. Consensus decision-making and a common culture led to a stronger reciprocity characteristic.

Analysis of these effectiveness characteristics, in combination with the previous analysis of the transformation process and the influence of the environment, contributes to an understanding of the type of affiliation practiced and its contribution to achieving a health improvement goal.
Table 7  Evidence of Effectiveness Characteristics for Community Voices and Healthy New Orleans

<table>
<thead>
<tr>
<th>Effectiveness Characteristics</th>
<th>Community Voices</th>
<th>Source (Bold for CV)</th>
<th>Healthy New Orleans</th>
<th>Result</th>
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<tbody>
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<tr>
<td>Formalization</td>
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<tr>
<td></td>
<td>- A memorandum</td>
<td>Partner Liaison</td>
<td>- A memorandum of</td>
<td>CV –</td>
</tr>
<tr>
<td></td>
<td>of understanding, contract</td>
<td>Co-chair/</td>
<td>understanding, contract or</td>
<td>Weak (~1/4)</td>
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<tr>
<td></td>
<td>&quot;There is a formal</td>
<td>executive committee</td>
<td>other formal agreement exists</td>
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<td></td>
<td>agreement between</td>
<td>members</td>
<td>&quot;There is no formal agreement but we're looking</td>
<td></td>
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<tr>
<td></td>
<td>Kellogg and each</td>
<td></td>
<td>into a memorandum of agreement to ask each org</td>
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<td></td>
<td>organization but</td>
<td></td>
<td>to commit to participation. Traditional partners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>no central agreement.&quot;</td>
<td></td>
<td>to sign on now because people are changing ~the HD</td>
<td></td>
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<td></td>
<td>- A plan, setting</td>
<td></td>
<td>director...&quot;</td>
<td></td>
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<tr>
<td></td>
<td>out a common goal</td>
<td>- A plan, setting</td>
<td>- Acknowledgment of partnership through</td>
<td></td>
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<tr>
<td></td>
<td>and activities</td>
<td>out a common goal and</td>
<td>explicit support of partners</td>
<td>HNO –</td>
</tr>
<tr>
<td></td>
<td>setting out roles and</td>
<td>activities</td>
<td>&quot;The Healthy New Orleans Public Health System</td>
<td>Weak</td>
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<td></td>
<td>responsibilities</td>
<td></td>
<td>Improvement Plan is the result.&quot;</td>
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<td></td>
<td>&quot;another challenge was the lack of a</td>
<td></td>
<td>- Acknowledgment of partnership through</td>
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<td></td>
<td>comprehensive plan.&quot;</td>
<td></td>
<td>explicit support of partners</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Acknowledgment of partnership through</td>
<td></td>
<td>&quot;HNO work is extracurricular.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>explicit support of partners</td>
<td></td>
<td>- Partnership is recognized in its own right</td>
<td></td>
</tr>
<tr>
<td></td>
<td>I have “the authority to commit</td>
<td></td>
<td>&quot;HNO doesn't have an identity yet. At the</td>
<td></td>
</tr>
<tr>
<td></td>
<td>organizational resources.”</td>
<td></td>
<td>neighborhood level, people struggle to understand</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Partnership is recognized in its own right</td>
<td></td>
<td>HNO.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;CV is not recognized alone but as a partner</td>
<td></td>
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<tr>
<td></td>
<td>among partners, which was CV goal.”</td>
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<tr>
<td></td>
<td></td>
<td>CV report</td>
<td></td>
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<td></td>
<td></td>
<td>Plan</td>
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<td></td>
<td></td>
<td>Partner Liaison</td>
<td></td>
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<td></td>
<td></td>
<td>Volunteer</td>
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<tr>
<td>Intensity</td>
<td>- Frequency of</td>
<td>Partnership coordinator/core partner</td>
<td>Frequency of</td>
<td>CV-</td>
</tr>
<tr>
<td></td>
<td>interactions: communications,</td>
<td>Volunteer</td>
<td>interactions:</td>
<td>Weak (~1/4)</td>
</tr>
<tr>
<td></td>
<td>meetings</td>
<td>Partnership coordinator/core partner</td>
<td>communications,</td>
<td></td>
</tr>
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<td></td>
<td>Quarterly meetings; quarterly conference calls.</td>
<td>Volunteer</td>
<td>meetings, as required.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Individual member orgs - internal changes</td>
<td>Partnership coordinator/core partner</td>
<td>&quot;My job description covers involvement in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;&quot;My job description does not mention CV but building relationships is mentioned.”</td>
<td>Volunteer</td>
<td>programs of compassion.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Partners, resources, and timeframe reflect the complexity of the goal addressed</td>
<td>Eval. Report</td>
<td>&quot;Individual member orgs made internal changes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Wide range of needs with limited resources”</td>
<td>Key Informant</td>
<td>&quot;My job description covers involvement in programs of compassion.”</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;In his technical assistance work, the partners had difficulty in figuring out how to knit the pieces together.”</td>
<td></td>
<td>- Partners, resources, and timeframe reflect the complexity of the goal addressed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>50-year time frame for the strategic plan</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>&quot;It takes a lot more resources to entirely rearrange a system.”</td>
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</tbody>
</table>

CV – Weak (~1/4)
HNO – Weak
CV- Weak (~1/4)
HNO – Weak (~1/4)
### Table 7 Continued  Evidence of Effectiveness Characteristics

<table>
<thead>
<tr>
<th>Effectiveness Characteristics</th>
<th>Community Voices</th>
<th>Source (Bold for CV)</th>
<th>Healthy New Orleans</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reciprocity</td>
<td>. Key stakeholders, including the community, are involved</td>
<td>Partnership coordinator/core partner</td>
<td>Key stakeholders, including the community are involved</td>
<td>CV-Weak</td>
</tr>
<tr>
<td></td>
<td>The community was consulted through regional dialogues.</td>
<td>Co-chair/ executive committee member</td>
<td>Volunteers are community residents</td>
<td>HNO – Middle</td>
</tr>
<tr>
<td></td>
<td>&quot;CV director brings in new partners. “[CV is] not inclusive enough.”</td>
<td>Partnership coordinator/core partner</td>
<td>-Benefits, risks, decision-making and power are shared equally</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Benefits, risks, decision-making and power are shared equally</td>
<td>Volunteer</td>
<td>&quot;Consensus building is the most important thing about HNO.&quot;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Originally we didn't intend such a broad participation but Kellogg kept broadening scope.</td>
<td>Partner Liaison</td>
<td>-Organizational motivations for membership are explicit and mechanisms for dealing with differences and conflict are established.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>-Organizational motivations for membership are explicit and mechanisms for dealing with differences and conflict are established.</td>
<td>&quot;We all have shared values of social justice.&quot;</td>
<td>Motivations: &quot;spiritual context, self sacrifice.&quot;</td>
<td></td>
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<tr>
<td></td>
<td>&quot;We all have shared values of social justice.&quot;</td>
<td>&quot;We all have shared values of social justice.&quot;</td>
<td>-Trust and mutual commitment exist</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Trust and mutual commitment exist</td>
<td>&quot;[CV] is more about collaboration than about $ -</td>
<td>&quot;HNO provides a safe place to feel comfortable voicing their opinion.</td>
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<td></td>
<td></td>
<td>Partnership coordinator/core partner</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Volunteer</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Partner Liaison</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Volunteer</td>
<td></td>
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</tr>
<tr>
<td>Standardization</td>
<td>-Procedures and processes for working together on overall goal are established</td>
<td>Partnership coordinator/core partner</td>
<td>-Procedures and processes are established</td>
<td>CV-Weak</td>
</tr>
<tr>
<td></td>
<td>Quarterly meetings and conference calls, CV sponsorship of training and attendance at meetings, early TA and training for participating orgs.</td>
<td>Co-chair/ executive committee members</td>
<td>Consensus decision-making, Community Health Networks, strategic plan, meetings</td>
<td>HNO – Weak</td>
</tr>
<tr>
<td></td>
<td>-Feedback mechanism exists to allow for ongoing change, as required</td>
<td></td>
<td>-Feedback mechanism exists to allow for ongoing change, as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&quot;Quarterly reports to Kellogg [through Marshall University consultant], but this took up too large a chunk of the grant so [this consultancy] cancelled.&quot;</td>
<td></td>
<td>&quot;This is a weakness…” “There is an annual retreat to reflect on past and celebrate success.&quot;</td>
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4.5 Summary - Contribution to the Health Improvement Goal

The community health partnership model stated that attention to the partnership process leads not only to an institutionalized partnership but also to ensuring that the strategy of partnership was implemented effectively to contribute to a health improvement goal. The following analysis, therefore, combines previous analyses of the transformation process, environmental influences, and the effectiveness characteristics for an understanding of the form of affiliation practiced by Community Voices and Healthy New Orleans and of its contribution to improving health.

Neither Community Voices nor Healthy New Orleans practiced organizational partnership according to the revised definition of partnership used for this research. While revisions will be explained in Chapter 5, this definition stated,

A social system based on an agreement between participating organizations to collaborate on a common goal, in which benefits and risks, as well as resources and power, are shared. The partnership agreement may be formal and in writing or verbal.

Previous discussions provided evidence that organizations participating in Community Voices did not create a social system or organization to share resources and power through a common management board. While Healthy New Orleans did create an
informal organization with a management board, membership was made up of individual volunteers, rather than organizations, who did not assume any risk.

It is important to understand the form of organizational affiliation practiced in both sites because different forms of organizational affiliation are appropriate for different goals and tasks being pursued (University of Wisconsin 1998; Konrad 1996). Different strategies are required for the different forms of affiliation, as well as for the different stages of development within a particular form (Gray 1985). Partnership, near the full integration end of a continuum of organizational affiliation, represents collaboration, where organizations give up some autonomy over resources and power to work toward a shared goal. At the other end of the continuum lies no affiliation/independence. Between the two lie other forms of affiliation that include network (communication to build understanding and relationships), task force/alliance (coordination of resources to reduce duplication), and coalition (cooperation to link resources, while remaining autonomous) (adapted from Himmelman 2001; University of Wisconsin 1998).

4.5.1 Community Voices

Analysis of the transformation process revealed that Community Voices paid limited attention to partnership development. The determinants of health framework played little role in the selection of participating organizations, although the proposal submitted to Kellogg referred to them. Organizations were concentrated in the health care sector or had outreach capacity for health messages. Social legitimacy represented an important
resource sought from participating organizations to increase the likelihood of funding, as well as success in implementation. Resources were not available to sustain Community Voices past the Kellogg grant. Analysis of the sub-systems pointed to lack of attention to their development, with the exception of the boundary spanning sub-system reflecting funding agency requirements and contributing to a potential maintenance sub-system, based on the relationships and trust established. Results of the effectiveness characteristics analysis pointed to weak collaboration, with organizations working together in coalitions within Community Voices demonstrating stronger reciprocity.

This analysis pointed to less developed forms of organizational affiliation of networking and coalition. Networking offered Community Voices participating organizations opportunities for dialogue to develop a common understanding with loose links between members. One partner liaison called Community Voices a “coalition of coalitions.” This represents a misnomer since Community Voices did not create a coalition or links between the coalitions of organizations that brought together resources for changing goals. Coalitions are short term and do not require surrendering autonomy over shared resources and as such, are less threatening. At the level of the Community Voices office/Kellogg Foundation, the relationship with participating organizations was described previously in the participant and management sub-systems sections. This relationship can be summarized as a donor/recipient one, based on the control maintained by Kellogg over priorities, where each organization agreed to certain conditions in exchange for Kellogg funding, as discussed previously.
Development of few sub-systems and weak effectiveness characteristics, combined with a lack of funding after the Kellogg grant and of a central management board, meant that West Virginia Community Voices has not been institutionalized. All interviewees understood the goal of West Virginia Community Voices as building relationships within a goal to improve health, rather than establishing a sustainable relationship. One partner liaison asserted “Community Voices hasn’t been obsessed with its own identity because building relationships was more important.” Confirming this, a partnership co-coordinator/partner liaison stated “Community Voices will disappear but individual partnerships are sustainable, others not.” However, another partnership coordinator/core partner and a key informant expressed concern that Community Voices would cease to exist at the end of Kellogg funding, stating “Many are demanding partnerships, but no one wants to pay for the glue to hold the partnership together.”

One motivation for participating in any form of organizational affiliation is that the end result will be greater than if a single organization operated alone. In the case of Community Voices, a strong motivation for organizations to join together was to improve chances of success in the various advocacy efforts of the initiative. Although not the focus of this research, the networking and coalition strategies adopted by Community Voices may have offered individual organizations an opportunity to increase their contribution to the health improvement goal. Analysis of both sub-systems development and of the effectiveness characteristics pointed to attention to building relationships and trust within the boundary spanning and maintenance sub-systems. According to partner liaisons, the reciprocity characteristic within the coalitions supported by Community
Voices was fairly strong. Within these relationships, the commingling of financial resources, expertise, and social legitimacy contributed to short-term achievements as suggested by interviewees and evaluation documentation. Although relationships built during the Community Voices initiative may continue, a key informant suggested that Community Voices’ “ability to aggregate interests” and to bring in new partners will cease at the end of Kellogg funding.

4.5.2 Healthy New Orleans

Analysis of the transformation process indicated that a membership of individual volunteers, committed to building a voice for the powerless, ensured that Healthy New Orleans survived past the end of Kellogg funding. Attention to developing all sub-systems to the formative stage at the time of this research included putting in place an informal structure for Healthy New Orleans (an executive committee, task forces, general membership of individuals) and a common culture of shared values. Reliance on individual volunteers and ad hoc organizational inputs contributed to weak effectiveness characteristics, with the exception of the reciprocity characteristic that was based on a participatory consensus approach among individual volunteers. Healthy New Orleans recently established the Center for Empowered Decision-Making as a formal arm to carry forward the community empowerment strategy and to carry out community research. The Center, however, will not replace Healthy New Orleans.
Healthy New Orleans combined networking with formative elements of an informal organization, where consensus decisions among individual members led to a shared vision. Networking offered opportunities for dialogue for common understanding with loose links between members. A co-chair/executive committee member confirmed this stating, “Partners represent the community more than their organizations. They come and go and are not too visible because Healthy New Orleans is informal.” A co-chair/executive committee member recognized that this form of affiliation may have reached its limits when the director of the New Orleans Health Department (NOHD) departed. After the director’s departure, it became clear that NOHD was not necessarily committed to Healthy New Orleans participation and that a new relationship with the incoming director would have to be developed. This prompted the co-chair to consider formalization of organizational membership, building on existing individual relationships to develop organizational relationships. He stated, “We are considering memoranda of understanding to commit organizations [associated with individual volunteers] to sign on now because people are changing in organizations.” The recognition of the need to move to the next step in formalizing Healthy New Orleans supports the argument in the logic model of partnership that a series of sequential steps leads logically to development of effective and more formal types of organizational affiliation.

Formative sub-systems, weak effectiveness characteristics, with the exception of reciprocity, and ad hoc organizational support meant that Healthy New Orleans was in the formative stage of developing an informal organization and had not been institutionalized. While several interviewees expressed concern about the financial
sustainability of Healthy New Orleans, the enthusiasm and commitment of individual volunteers working as equals ensured that Healthy New Orleans survived beyond the initial Kellogg funding. One key informant was “not surprised that Healthy New Orleans will last. Considering the amount of money they received, they did a good job.” The value added by Healthy New Orleans’s networking and formative elements of partnership stemmed from an inclusive, participatory process and its ability to build a common culture based on consensus decision-making. The combined commitment of individual volunteers led to establishment of three Community Health Networks, while a committed executive committee ensured the establishment of the Center for Empowered Decision-Making.

This chapter presented the findings from applying the community health partnership model to two research sites in West Virginia Community Voices and Healthy New Orleans. Rather than describing organizational partnership, analysis showed that Community Voices represented a donor/recipient relationship between Kellogg and grant recipients and coalitions and networking among participating organizations. Healthy New Orleans, on the other hand, combined networking with formative elements of an organization made up of individual volunteers. Both benefited from working together, either as organizations in Community Voices or as individuals in Healthy New Orleans, to improve chances for success in achieving health improvement goals. Broader conclusions and implications for practice and future research are the subject of the next chapter.