West Virginia Community Voices Case Study

I. Background

West Virginia Community Voices, one of thirteen learning laboratories across the country sponsored by the WK 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, West Virginia’s Community Voices (CV) aimed to create a more coordinated system of health and social services, as well as to increase the health insurance coverage rate of children.
1.2 The State of Health in West Virginia

West Virginia is a rural state with two-thirds of the population living in areas with a population of less than 2,500. During the recession in the 1980s, the state lost about eight percent of its population, leaving an older and poorer population. In 2000, 15.3% of the population was aged 65 and older, compared to 12.4% for the country as a whole. The state median income of $27,432 in 2000 was well below the national median income of $35,005. People living below the poverty line accounted for 16.8% of West Virginians, compared to 13.3% for the nation. This percentage varies from 9.5% in Putnam to 26.8% in Clay County. Children under the age of 18 living in poverty accounted for 24.7% of children in West Virginia. The unemployment rate for the state in 2000 was 6.6%, compared to 4.2% for the US. Of the total population, 24.7% had less than a high school diploma.

West Virginia Community Voices operated at two levels—the state level in Charleston and the county level in Boone, Clay, Kanawha, and Putnam counties. These four counties make up 15.8% of the total population of the state and are representative of the economic and geographic diversity found throughout West Virginia. Putnam County is one of the most prosperous counties, while Boone and Clay counties are among the poorest and most isolated regions in the state. The largest concentration of the African American population is located in Kanawha County (7.0%), compared to the state percentage of 3.2%. Selected indicators for the four counties are presented on the next page.
### Selected Indicators for the Four Community Voices Counties

<table>
<thead>
<tr>
<th></th>
<th>Median Income</th>
<th>Inactivity</th>
<th>Obesity</th>
<th>Smoke</th>
<th>No Health Ins.</th>
<th>%&lt;Poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone</td>
<td>$26,808</td>
<td>62.0%</td>
<td>29.8%</td>
<td>35.1%</td>
<td>24.8%</td>
<td>19.7</td>
</tr>
<tr>
<td>Clay</td>
<td>$21,172</td>
<td>56.1%</td>
<td>17.2%</td>
<td>30.8%</td>
<td>28.3%</td>
<td>26.8</td>
</tr>
<tr>
<td>Kanawha</td>
<td>$32,546</td>
<td>36.3%</td>
<td>22.5%</td>
<td>27.4%</td>
<td>18.0%</td>
<td>14.3</td>
</tr>
<tr>
<td>Putnam</td>
<td>$40,649</td>
<td>38.5%</td>
<td>24.0%</td>
<td>20.8%</td>
<td>16.3%</td>
<td>9.5</td>
</tr>
<tr>
<td>West Virginia</td>
<td>27,432</td>
<td>42.7%</td>
<td>21.3%</td>
<td>27.0%</td>
<td>21.5%</td>
<td>16.8</td>
</tr>
<tr>
<td>US</td>
<td>$37,005</td>
<td>29.7%</td>
<td>17.0%</td>
<td>23.0%</td>
<td>16.9%</td>
<td>13.3</td>
</tr>
</tbody>
</table>


### Leading Causes of Death

<table>
<thead>
<tr>
<th></th>
<th>Infant Mortality /1,000 (1994-98)</th>
<th>Heart Disease per 100,000 (1989-1998; 2000 adjusted)</th>
<th>Cancer</th>
<th>Diabetes</th>
<th>Stroke</th>
<th>COPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boone</td>
<td>3.1</td>
<td>352.6</td>
<td>249.6</td>
<td>27.7</td>
<td>54.5</td>
<td>59.0</td>
</tr>
<tr>
<td>Clay</td>
<td>8.0</td>
<td>362.2</td>
<td>264.4</td>
<td>32.0</td>
<td>72.7</td>
<td>58.5</td>
</tr>
<tr>
<td>Kanawha</td>
<td>6.3</td>
<td>324.9</td>
<td>240.5</td>
<td>31.0</td>
<td>59.0</td>
<td>46.4</td>
</tr>
<tr>
<td>Putnam</td>
<td>4.2</td>
<td>313.1</td>
<td>203.7</td>
<td>29.0</td>
<td>51.7</td>
<td>38.8</td>
</tr>
<tr>
<td>West Virginia</td>
<td>7.7</td>
<td>344.1</td>
<td>224.6</td>
<td>28.8</td>
<td>60.9</td>
<td>50.2</td>
</tr>
<tr>
<td>US</td>
<td>7.3</td>
<td>918.7</td>
<td>213.0</td>
<td>22.7</td>
<td>63.1</td>
<td>40.5</td>
</tr>
</tbody>
</table>

Source: West Virginia County Health Profiles 2000
Many West Virginians suffer from poverty and the isolated nature of the state’s rural areas. In terms of behavioral risk factors, residents of West Virginia rank worse for obesity, smoking, and sedentary lifestyle than the U.S. average. Mortality rates for heart disease, cancer, stroke, diabetes, and chronic obstructive pulmonary disease are higher in West Virginia than in the US. Rates for disabilities are also higher than U.S. rates. This overview of the health status of West Virginians points to the need to take a broad, preventive approach in addressing these health issues, given that these health problems are affected by influences outside the control of individuals and the health care system.

1.3 The Informants

Site research included review of Community Voices documentation, nineteen interviews, and a focus group. In addition, the researcher observed a quarterly conference call between CV participants and the funding agency, the WK Kellogg Foundation. The nineteen interviews included fourteen suggested by the project director from the list of nineteen organizations, mainly community-based organizations within the health sector and outreach groups, currently participating in Community Voices (See Table 1 at the end of Section 2.1 for a list of organizations participating in Community Voices at the time of this research). Representatives of these fourteen either acted as the contact between their organization and Community Voices (partner liaisons - twelve, of whom four executive directors) or as executive directors of organizations involved in CV but who did not serve as partner liaison (executive directors - 2). The five other interviewees included the current project director (partnership coordinator) and knowledgeable
stakeholders (key informants - 4). Suggested by the project coordinator and partner liaisons, key informants represented the university system, the state and local health departments, and a consultant to Community Voices. Only two partner liaisons represented organizations that participated from the beginning of Community Voices; one of these also served as the previous project director and writer of the Kellogg proposal. Both of these interviewees will be referred to as ‘core partner’ to designate their longer association with Community Voices. The partnership coordinator and core partners categories will be combined in the discussion to safeguard anonymity. The length of involvement of the remaining partner liaisons reflected when they were recruited for the changing priorities pursued by CV. This limited their familiarity with Community Voices, as did the fact that their own efforts focused on specific coalitions in which they participated. The semi-structured questionnaire was therefore adapted to provide opportunities for partner liaisons to talk about their coalition work with which they were more familiar. A focus group provided an opportunity to clarify outstanding issues from the individual interviews. Seven people participated in this focus group, one of whom who had not participated in the individual interviews.

II. Community Health Partnership Model – the Transformation Process

The community health partnership model posits that partnerships are social systems that are made up of sub-systems, all of which form part of broader social systems and interact with each other. Partnership represents a strategy to add value to individual organizational efforts by sharing resources and decision-making for a common goal with
other organizations. This theoretical framework guided development of the specific research questions, the research design, and instrument development, as well as the data analysis plan. The analytical technique involved in this case study involved an interpretation of evidence provided by informants and documentation in terms of the partnership model.

Elements of the community health partnership model include the transformation process, the institutional and macro environments, and the effectiveness characteristics. This case study is organized around these elements as follows:

- A short description of each element of the model and source(s) of information
- A description of each element within Community Voices and supporting quotations
- A conclusion regarding the state of the element under discussion

### 2.1 Community Voices’ Participating Organizations and Their Roles

Given the multisectoral nature of health, the community health partnership model argues that a variety of organizations from the sectors influencing health and from the different levels—the community, the state, and the national level—must be involved. Organizations join together for a variety of motivations, from seeking additional resources (financial, expertise, and technology), increased credibility, better understanding of community needs, increased power, economies of scale, to an improved
ability to respond to an increasingly complex environment. During the interviews, the partnership coordinator was asked to name the partner organizations, the sector to which they belong, and their role in the partnership. Partner liaisons were asked about the specific motivation(s) for their organization to join Community Voices.

The proposal to the W. K. Kellogg Foundation set out an intention to have prominent organizations, connecting state policy making with local input, lead the project. The core partners, therefore, 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). These core partners initially came together as a management committee; however, for reasons discussed later, the idea of a coordinating body was discarded.

The vice chancellor’s office for health sciences within HEPC was responsible for the three medical schools, health projects run through the rural health scholarship program, and many elements of the health care safety net in West Virginia. Funds from the Kellogg Foundation passed through the West Virginia University Foundation, an independent body. After the reorganization of the University System in 1999-2000 and the departure of the vice chancellor, HEPC’s participation was reduced to providing office space and support for the project office.
The Department of Health and Human Services was the state agency responsible for most health and social services in West Virginia. Specific departments designated to participate in Community Voices included the Bureaus for Public Health, Medical Administration, and Children and Families. The change in administration after the 2000 elections meant that many of those familiar with Community Voices were no longer available and that new relationships had to be established.

The Governor’s Cabinet on Children and Families, created in 1990 to focus on preventive services, while coordinating state agencies services for children and families, was to provide a venue for Community Voices to be involved in policy making. Through its Family Resource Networks, set up to develop coordinated plans for services at the community level throughout West Virginia, the Cabinet was meant to ensure community input to policy development. However, the Cabinet was never given the necessary authority to fulfill this role and the State Legislature removed it in 2002, as a partnership coordinator/core partner explained.

The Community Council of Kanawha Valley was a multi-county planning and referral agency, as well as a service provider. Services included an adolescent health initiative and family resource centers located in elementary schools. The Council operated through several hundred organizational and individual members that provided Community Voices’ links to the community.
The core partners identified and recruited organizations early on, but, as they, with the exception of Lifebridge, decreased their level of participation, the Community Voices’ project director took over selection of organizations. 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 project. The director and her predecessor recruited approximately 26 organizations over the life of the project 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 came to an end, organizations involved in those activities ceased participating in Community Voices.

As stated earlier, an important Community Voices’ strategy involved linking local efforts to the state policy-making process. A partnership coordinator/partner liaison pointed out that one of the original roles of core partners was to identify and recruit new partners from among existing coalitions and their extended partners at the state and local levels for each of the changing objectives of Community Voices’ efforts.

The Kellogg Foundation played a key decision-making role in Community Voices, contrary to the community health partnership model, where decisions are made among equal partners. Kellogg took on a role of chief decision maker by choosing priority areas,
a role made clear in interviews and a monthly conference call between participating organizations and the Kellogg Foundation and observed by the researcher. A core partner summarized the views of all partner liaisons by stating “Community Voices is the keeper of the funds” and “Community Voices brings in new partners without consultation.” Confirming this, an author of the grant proposal and 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. 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. Several partner liaisons appreciated another function fulfilled by Kellogg of providing access for Community Voices participating organizations in West Virginia to outside resources. For example, a partner liaison suggested that the Kellogg Foundation was seen as “providing opportunities to attend national meetings [where they could learn about other Community Voices experiences and have access to different types of expertise] and for an understanding of systems connections.”

Although not listed separately in the partnership model, participation of community residents is important to ensure the appropriateness of activities and to gain community buy-in. Community participation in Community Voices mainly involved community-based organizations, with residents participating through a series of public discussions to solicit the community’s input for establishing priorities within the health care sector. The role of community residents, therefore, was limited to a consultative one. Regional
Family Resource Networks were to represent the community; one core partner, however, pointed out that the regional Family Resource Networks “never felt that they were equal decision makers, even though they represent the community.” He continued, “There was a need to involve citizens more through the Regional Family Resource Networks.”

Organizations, as set out in the community health partnership model, must represent the wide array of influences on a specific goal to improve health. Alluding to these influences, the Community Voices grant proposal stated “We understand that health is more than medical care. It is intimately connected to the ability to learn, and the effects of poverty and inequity. The healthy development of children and youth is the work of families, schools and communities and extends well beyond the health professions.” One of the reasons for including the Family Resource Networks was their role at the local level in coordinating local development plans between different sectors. Although called for in the Kellogg proposal, participating organizations did not represent the diversity required by the determinants of health framework. Only the two core partners referred to a broader understanding of health within Community Voices, where one mentioned, “Kellogg provided opportunities to attend national meetings to develop an understanding of systems connections.” When asked specifically about the determinants of health 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.” A promising development in terms of a broader, more preventive approach to health involved recent work in determining a self-sufficiency standard, recognizing the link between poverty and health. The national Wider Opportunities for
Women and the state level American Friends Service Committee approached Community Voices to support this work.

In response to a query about organizations missing from Community Voices, the partnership coordinator and partner liaisons listed the private sector, men, and educators. Until the recent work with Partners in Health (a network of local hospitals), an omission mentioned by a partnership coordinator/core partner involved the private health care sector, important in an effort to bring about systems change and to expand access within the health care sector. Explained in part during the focus group discussion, 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 partner liaison pointed out that “large hospitals had been approached but they were not interested.” Another partner liaison suggested that this was because “they were not in charge.” The recent willingness of Partners in Health (PIH) to participate may have resulted from Community Voices’ support for PIH’s application for a HRSA Community Access Program award. Although not mentioned by any informant, local health departments did not participate in Community Voices, an omission that will be discussed more fully under the section on environmental influences.

Table 1 on the next page sets out the participating organizations of the community health partnership model, along with their level (national, state, or local) and the sector to which they belong. In line with the community health partnership model, Community Voices
included organizations that 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. While the Kellogg Foundation at the national level exercised influence as a funding agency and did not act as a partner, it did provide opportunities to access national-level meetings and expertise, as well as guided Community Voices’ choice of priority areas, giving some support to the argument that vertical influences are stronger than horizontal ones (Warren 1967). Following from its name Community Voices, the community provided input through a series of community dialogues to establish priorities within health care.

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 project 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. 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 1998).

Table 1. Organizations Participating in West Virginia Community Voices (7/02)

<table>
<thead>
<tr>
<th>Participating Organizations</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</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</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</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>
2.2 Community Voices Resources

According to the community health partnership model, partner organizations contribute money, personnel, equipment and supplies, knowledge/technology, and social legitimacy. Partner liaisons were asked about the contribution of their organization to Community Voices, which was then confirmed by the partnership coordinator. The grant proposal budget was also reviewed, as well as the most recent yearly budget.

Project documentation indicated that the WK Kellogg Foundation provided approximately $2,790,765 over the five-year period 1998-2003, for project personnel costs, grants for partnership initiatives, and a local evaluation. The Foundation further funded a national evaluation of the 13 Community Voices sites. The core partners provided in-kind support in the form of office space, an administrative staff salary, and office operating costs, approximately equivalent to $1,184,602 over the five-year period. The availability of grant money enabled the Community Voices project director to attract and influence other funding agencies, including the Benedum Foundation, which provided an additional $75,000 over three years to support the West Virginia Oral Health Policy Task Force and the Healthy Kids Coalition.

In addition to specialized knowledge of the different issues addressed by Community Voices, participating organizations contributed in-kind resources such as staff and meeting space and funding that Community Voices then supplemented. As an example, Community Voices supported “the ongoing Parents-for-Teachers program, providing
approximately seven to eight percent of total funding.” Participating organizations also brought their own constituency.

The availability of grant money enabled the Community Voices project director to attract and influence organizations to participate. Access to social legitimacy, or credibility and acceptance by the community, provided additional motivation for organizations to join together, seeking to improve chances of success in the various advocacy efforts of the project. Core partners, sought for their social legitimacy, improved chances of success for the project proposal. Confirming this, the draft West Virginia input to the national project evaluation pointed out, “The original grant writer and principal investigator, Dr. Dan Weston, was working as the Vice Chancellor of Health Sciences… He has strong connections with Kellogg because he was formerly dean of the medical school at the University of Michigan. In fact, he had come to WV to oversee the Rural Health Education Partnership, a Kellogg Foundation project.” The Governor’s Cabinet on Children and Families brought further legitimacy through connections to the highest offices in the state. At the community level, the Cabinet’s regional Family Resource Networks demonstrated a link to the community that was built on trust. Lifebridge brought its board of influential citizens and its membership of hundreds of organizations and individuals. The two project directors brought further legitimacy to Community Voices, evidenced in a statement in the draft evaluation report that one of the project directors “had expertise in policy development and was well connected to state policymakers” and the other “is a strong leader with expertise in nursing, industrial relations, and leadership development.” Organizations that participated during project
implementation brought legitimacy through their specialized expertise and a long history of working with their communities. The trust developed in these relationships helped, for example, to bring a citizenry wary of outsiders into the regional community dialogues, for example.

This combination of respected participating organizations, operating both at the state level and community levels, was successful in bringing about policy change based on community input, in part because of the social legitimacy offered by participating organizations. The Kellogg grant was used successfully to bring together disparate organizations, which may continue their relationship past the funding period, at least within the coalitions. Participating organizations combined resources and expertise with the financial resources of the Kellogg Foundation and other funding agencies. Legitimacy of participating 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. However, Community Voices will cease to exist at the end of the grant when the financial incentive provided by the grant to draw in new organizations will be lost. The reasons for this and implications will be discussed later under the intensity effectiveness characteristic section.

2.3 Development of Organizational Sub-systems

According to open systems theory, Community Voices, to survive as a social system, had to use the above resources to develop five sub-systems (production, boundary spanning
structure, maintenance, adaptive, and managerial). Interviews with the partnership coordinator and partner liaisons, as well as project documentation, provided evidence for this transformation process and sub-systems development. Questions included planning activities, needs assessments, partnership activities, the role of partner liaisons, structure, processes (decision-making, communication, training, other), incentives and procedures, and any monitoring or feedback mechanism that led to change and improvements.

The existence of elements of each of the five sub-systems helps to describe each in terms of its stage of development, which, taken together, contributes to a fuller understanding of how the participants worked together. Adapting the work on stages of development of partnership from the organizational literature (Butterfoss, Goodman, and Wandersman 1993); the stages of development used in this analysis include

- Rudimentary – Little evidence, if any, is available of elements of a sub-system
- Formative – Elements are being designed and resources are obtained, where required
- Implementation/Maintenance – Elements are formally established and operational
- Institutionalization – Sub-system is ongoing and sustainable

2.3.1 The Adaptive Sub-system

Influenced by their environment, organizations must have a mechanism to plan for and adjust to changing environmental demands. While the grant proposal set out broad goals for Community Voices, the project director’s 2000 annual report pointed out, “another
challenge was the lack of a comprehensive plan. The West Virginia Community Voices project has broad goals and outcomes but each of the many partners pursues their own strategies towards these goals and outcomes.” Lack of a comprehensive plan may be explained by the intent of the national project to focus on building networks of complementary organizations. In line with this, one of the project directors saw her role as a “facilitator to open opportunities” to build relationships. 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, the partnership coordinator 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. The ad hoc nature of implementation was both a strength and a weakness, as the flexibility allowed the project director to take advantage of opportunities as they arose, which in turn shifted the focus to the short term and reduced opportunities to effect change at the systems level.

Within the partnership model, attention must be paid simultaneously to health improvement and partnership development activities. Community Voices, however, focused needs assessment activities on access to health care and community dialogues contributed to ongoing needs assessments carried out by Family Resource Networks in the four participating counties. A local evaluation covering 1999-2000 reported early efforts by a project consultant to define training and technical assistance needs for all
participants. There was, however, no mention of training for the core partners to function as a central management board.

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 subsystem. Although the project proposal to the Kellogg Foundation set out a management committee structure, it did not consider difficulties that organizations might face in participating in Community Voices. The demise of the committee when busy executives were unable to attend might have been avoided if an alternative approach or membership had been adopted in response to identification of this potential problem.

Within Community Voices, almost all respondents pointed out that no formal mechanism existed to scan its environment, with the exception of a health insurance survey that served as a baseline for project activities. Several partner liaisons involved in advocacy stressed that their organizations continually monitor policy and legislation affecting their particular interests, asserting that “Diverse members [of Community Voices] keep their fingers on the pulse.” Another pointed out, “Those involved in emergencies bring attention to emerging … needs.” A Marshall University consultant consolidated quarterly monitoring reports and carried out a local project evaluation in 2001. However, given other priorities and a Kellogg national evaluation of all Community Voices projects, this contract was not renewed, being replaced by quarterly meetings via conference call between participating organizations. In addition, the project director provided a yearly report to the Kellogg Foundation. The West Virginia Community
Voices project was also included in the national project evaluation just completed by Abt Associates for the Kellogg Foundation. It was not clear if and how information from these monitoring efforts was used to improve Community Voices.

Based on the above discussion, the adaptive sub-system for Community Voices can best be described as rudimentary, with no comprehensive plan, only informal mechanisms to scan the environment and track project progress, and assessments of health needs but no assessment of the needs of a management board or of the type of affiliation to be pursued by Community Voices. This analysis points to limitations in Community Voices’ ability to use feedback to adjust to environmental changes or to improve health-related activities.

2.3.2 The Boundary Spanning Sub-systems

A boundary spanning support structure involves those parts of the structure that deal with obtaining materials and maintaining relations both between partners and with the external world. Within Community Voices, this translated into each participating organization naming a staff member to provide liaison between itself and Community Voices and each participating organization. As the focus moved between Community Voices’ changing goals, a number of coalitions developed with different organizations participating in each one. Within each coalition, liaison 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, a partnership coordinator/core partner stated, “My role is to establish relationships within and between partners, as well as to provide money to make this happen.”

The boundary spanning sub-system can, thus, be described as in the formative stage, given the existence of partner liaisons and the project director’s role in the external boundary spanning function. These liaison staff ensured availability of organizational resources for temporary joint activities and built relationships between themselves and other participating organizations.

2.3.3 The Maintenance Sub-system

The maintenance sub-system involves developing a common culture to hold the partnership together, where common motivations for participating help to create this common culture. Responding to a question on their motivation(s) for participating, partner liaisons generally mentioned “shared values around a broad goal of social justice.” Most participating organizations were, thus, “socially conscious and already involved in providing some form of social service,” which Community Voices was able to harness in the interest of its efforts to improve health. One interviewee stated that part of the success of Community Voices stemmed from “the culture of the people involved. Many were women and social workers, thus providing a common process orientation to issues.” Others added that access to outside resources enabled them to accomplish things
that they could not accomplish working on their own. Additional reasons for participating in Community Voices, listed by partner liaisons included 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 project 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.” Where differences surfaced, they generally involved organizations with dissimilar cultures such as hierarchical government or the bottom line orientation of private health care providers. Several partner liaisons suggested that negotiations, talking and listening led to resolution of differences within their coalitions. Another suggested, “Where an organization doesn’t value collaboration, time is not given to staff to participate.”
Within affiliations that meet the partnership definition, a culture of equality and sharing of resources and decision-making must be present. Although a partnership coordinator/core partner suggested that the core group made early decisions regarding resource allocation to the regional Family Resource Networks and the Community Council’s parents as teachers program, at the time of this research, decision-making for financial resource allocation rested solely with the Community Voices project office and the Kellogg Foundation, as discussed earlier. One partner liaison felt that this was contrary to the original intentions, citing that the “community priority to improve access to health care for the homeless was overlooked.” Multiple partner liaisons pointed out, however, that once Kellogg had allocated resources, participating organizations worked together as equals within each coalition.

While participating organizations had similar motivations and organizational cultures, the changing focus of Community Voices interests and, thus, of participating organizations meant that Community Voices did not develop a culture of its own. Although Community Voices strengthened relationships between organizations and coalitions, these organizations remained autonomous with little holding them together other than a short-term goal. The maintenance sub-system is, therefore, described as rudimentary/formative because relationships built during Community Voices work could potentially provide a foundation for a maintenance sub-system should an organizational partnership be established.
2.3.4 The Management Sub-system

The management sub-system involves an authority structure, coordination, and regulatory mechanisms. The original intent in the project proposal was to create a formal partnership structure as set out in the project proposal, “The partners in the Community Voices Project will create a management board” of the core partners and community organizations. 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 explained the lack of participation by one core partner the Department of Health and Human Services, Bureau for Public Health, “The partnership with public health may not have worked because it was not seen as a priority.” She continued, “There is no central or core partnership board. Resources are shared but this is written into the grant.” Present during one of the quarterly conference calls required by the funding agency, the researcher observed that, while collegial and non-directive, this call provided further evidence of the role played by the Kellogg Foundation, since discussion mainly involved reporting back to the project director and to the Kellogg Foundation program officer. Describing the various roles played by the Community Voices project 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 one where required, called on its own members to develop implementation strategies to achieve a stated goal.
Because there was no central management board and participating organizations were autonomous, financial controls and other regulatory mechanisms, such as financial controls, remained at the level of the participating organization, with the exception of reporting requirements established between the Community Voices office and each grant recipient. The project director was accountable to the Kellogg Foundation and not to a central management board. Participating organizations, therefore, did not need to make internal changes to accommodate the needs of a partnership, nor were additional incentives required for their staff to act as liaisons, given that they are “socially conscious and committed” individuals. Common processes were limited to meetings (no minutes were kept), frequent communications, and the annual retreat discussed previously. Formal bilateral agreements between each organization and the Community Voices project supported short-term activities. Participating organizations contributed to Community Voices plans through the annual retreats that served as “an opportunity to share information and to provide input for the next year’s activities.”

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.
2.3.5 The Production Sub-system

The production sub-system in the partnership model represents activities carried out to improve community health and to develop the partnership. The focus of this research, partnership development activities included development of the sub-systems discussed previously 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, as well development of communication processes and decision-making strategies, among others.

Although the focus of this discussion is on partnership development efforts, organizations of health improvement activities provides some understanding of the way Community Voices operated. The different coalitions pulled together by the project together to address changing, short-term goals accomplished most of the work, with the exception of reporting on progress and building relationships. Confirming this, a key informant suggested, “Each coalition is unique to the issue.”

Community Voices 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 projects, 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. As stated earlier, partnership development efforts concentrated on participating organizations in general but did not include attention to special needs of the management board. Contracted by the project office, a Marshall University consultant provided training, group facilitation, and problem solving inputs for all participants. A more recent contract with Marshall involved teaching partners how to measure outcomes. The project director arranged additional activities on an ad hoc basis to encourage participation, such as sending members to conferences. For example, faced with a recalcitrant church leader in the minority health coalition, a partnership coordinator/core partner “sent him to study partnership in Nepal. Upon his return, he was more interested in partnership, having found a common interest in infant mortality.”

Focusing on health improvement activities, the production sub-system included training and technical assistance for individual organizations and the coalitions that made up Community Voices. 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. 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.
Table 2 on the next page sets out a comparison of the transformation process element of the community health partnership model with the practice of Community Voices. The table demonstrates that needs assessments at the county level exist but their relationship to the annual budgets was not clear. Community Voices demonstrated few of the sub-systems that define a social system, with the exception of boundary spanning partner liaisons and a rudimentary/formative maintenance sub-system, given its potential to serve as the foundation for an organizational partnership.

Part of the analysis of the interviews involved identifying key concepts or activities that had not received adequate attention in the community health partnership model. The research proposal stated that existing research on the ‘how to’ or the wisdom literature of partnership functioning and on community participation could complement the community health partnership model. Interviewees repeatedly confirmed this, pointing to one component, relationship building, as an important component of the production sub-system. Community Voices brought together organizations active in health issues with those who had not worked in health previously (for example, Lifebridge). Most participating organizations were already active in trying to improve community welfare. Commenting on this, a partner liaison stated “Community Voices provided an opportunity to network.” Another stated, “It’s more about collaboration than funding” and still another underlined the importance of “building relations among members.”
<table>
<thead>
<tr>
<th>Model – Partnership Sub-systems</th>
<th>Community Voices Sub-systems</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Partners</strong></td>
<td><strong>Short-term participation for specific goals, linked state and local efforts. Awareness of determinants of health increasing, but not reflected in participating organizations.</strong></td>
</tr>
<tr>
<td>Multiple sectors</td>
<td><strong>Kellogg funds ($2.8m) complemented participating organizations’ resources, including money, staff, expertise. Social legitimacy brought to CV by participating organizations and contributed to successful proposal.</strong></td>
</tr>
<tr>
<td>Multiple levels</td>
<td><strong>Rudimentary</strong></td>
</tr>
<tr>
<td><strong>Resources - Money</strong></td>
<td><strong>Formative</strong></td>
</tr>
<tr>
<td>Personnel</td>
<td>Regular partner liaisons identified. Project director serves as link to outside world</td>
</tr>
<tr>
<td>Equipment/supplies</td>
<td><strong>Rudimentary/Formative</strong></td>
</tr>
<tr>
<td>Knowledge/Technology</td>
<td>No common culture, autonomous organizations have similar cultures. Yearly retreat and regular meetings help build trust</td>
</tr>
<tr>
<td>Social Legitimacy</td>
<td><strong>Rudimentary</strong></td>
</tr>
<tr>
<td><strong>Adaptive</strong></td>
<td>No active central CV management board. Project director coordinates, but accountable to Kellogg, not partnership. Required regular reporting to donor.</td>
</tr>
<tr>
<td>(mechanism to adjust to changing environmental demands)</td>
<td><strong>Rudimentary</strong></td>
</tr>
<tr>
<td>Plan – set out common activities, resources, responsibilities, and timeline</td>
<td>Some partnership development activities for participating orgs in general, see sub-systems above. Numerous health improvement activities</td>
</tr>
<tr>
<td><strong>Need/Environmental Assessment</strong></td>
<td><strong>Rudimentary</strong></td>
</tr>
<tr>
<td>– basis of plan, setting out needs of community and assess issues that may influence partnership development</td>
<td></td>
</tr>
<tr>
<td><strong>Boundary spanner</strong></td>
<td></td>
</tr>
<tr>
<td>(Link between partners and to outside world)</td>
<td></td>
</tr>
<tr>
<td><strong>Maintenance</strong></td>
<td></td>
</tr>
<tr>
<td>(organizational culture)</td>
<td></td>
</tr>
<tr>
<td><strong>Management</strong></td>
<td></td>
</tr>
<tr>
<td>(central structure, coordination, regulatory mechanisms)</td>
<td></td>
</tr>
<tr>
<td><strong>Production</strong></td>
<td></td>
</tr>
<tr>
<td>(Activities to accomplish goals)</td>
<td></td>
</tr>
</tbody>
</table>
The annual retreat provided an opportunity “to get to know each other.” Respondents underlined the need to build trust between participants, including the community. Community Voices built trust because it welcomed diversity, viewing it as an asset to achieve increased power and access to additional resources, such as expert knowledge. A partner liaison summarized respondents views, “Many partners have similar agenda;” but we “deal with differences by talking and listening.”

Finally, informants almost universally mentioned leadership as a key factor in the success of Community Voices. Highlighting this, a partnership coordinator/core partner asserted, “A successful partnership depends on the personality of the leader. Without a strong leader, a coalition risks degenerating into turf issues.” Several respondents pointed to the project director as a source for Community Voices’ success. An evaluation of Community Voices pointed out that the two directors were free to act on their own judgment but that “this structure does mean that the success of the project rests largely on the director’s shoulders.” The flexibility of the project allowed the directors to recognize and take advantage of opportunities as they arose. In addition to individual leaders, the Kellogg Foundation provided opportunities to develop other project leaders by providing resources to attend national Community Voices meetings focusing on understanding systems and bridge building, for example. Two reviews of the existing literature on partnerships confirm the importance of relationship building and leadership development activities (Kreuter and Lezin 1998; Roussos and Fawcett 2000).
III. The Influence of the Macro and Institutional Environments

Institutional theory served in the model to show that organizations adapt to demands in their environments by developing structures, processes, and procedures that meet those demands. 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. Building on this, this research argued that some of these adaptations may impede or facilitate the ability of individual organizations desiring to participate in partnerships. This section provides an analysis of information from project 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 environment of the partnership.

3.1 The Macro Environment

The macro environment includes those influences that affect the way society organizes its economic, political, and cultural institutions. This section presents information that an adaptive sub-system might provide, pointing to both facilitators and constraints experienced by West Virginia Community Voices that can be traced back to the economy, changes in the political party in power, and the culture.

Informants viewed the declining economy as a both a facilitator and impediment to the work of Community Voices. A few partner liaisons felt that Community Voices had
insufficient resources to meet growing needs, due, in part perhaps to changes in the economy of West Virginia. When the grant proposal was written, the West Virginia legislature had made an additional $35 million available for children and public health initiatives. Since that time, however, the state experienced budgetary problems that led to cuts in social service programs. While creating obvious problems for social services providers, this crisis facilitated individual organizations joining together as they looked outwardly for increased resources. “Skyrocketing costs of medical malpractice insurance” and “bankruptcy of mental health providers” acted as facilitators, as several partner liaisons mentioned, to the bringing organizations together in Community Voices. Another problem pointed out by a partner liaison involved “difficulty in bringing in new and younger partners,” due in part perhaps to the declining economy that prompted 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. A partner liaison suggested that the events of 9/11 led to diversion of federal funds for emergency preparedness and consequent cuts in funds for social programs, adding to the state cuts discussed above. Laws reflect social norms and the prevailing political environment. The innovative Governor’s Cabinet on Children and Families, created in the early 1990s by the West Virginia legislature, was to work across agency lines, reducing competition and duplication between agencies with interests in children and families. A partnership coordinator/core partner, however, pointed out, “The Cabinet
was never allowed to exert this authority. This authority of the Cabinet was removed by the legislature during the 2002 legislative session.” Political changes also influenced the readiness of the Department of Health and Human Resources to participate in Community Voices, when administrators familiar with Community Voices were replaced after the 2000 elections.

The culture in West Virginia provided both facilitators and impediments for partnership development. The community of social services providers and advocates was small and closely knit in West Virginia. When asked about facilitators, respondents answered almost universally “everyone knows everyone.” Given this small community, a partnership coordinator/core partner pointed out, “When I leave this position, I will still be involved in health care in West Virginia,” creating continuity for social efforts. These long-standing relationships between key players eased access to officials and ensured that some degree of trust was present early on in the project. Summarizing the view of most partner liaisons and key informants, as well as project 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.” A reluctance to interact with the outside world on the part of people who live in rural Appalachia may also be explained by a norm to accept the existing situation. A key informant explained that within Community Voices’ work in the area of oral health,
for example, people do not seek help because “the Appalachian people see tooth loss as a natural part of life. Childhood teeth are not important.”

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

3.2 The Institutional Environment

Evidence from Community Voices informants pointed to facilitators and impediments stemming from the institutional environment that funding agencies, interest groups, the professions, and government agencies created through coercive, normative, and mimetic pressures.

At the national level, pressures to copy recommendations made by influential bodies may have prompted the W. K. Kellogg Foundation to adopt partnership as a strategy to improve health. One respondent pointed out that there is “an informal agreement at the national level that national foundations follow the recommendations of the Institute of Medicine and the Centers for Disease Control and Prevention,” which both promote partnership. These foundations, in turn, make partnership development a requirement for grants, as was the case in Community Voices.
Accountable to their constituencies for specific issues or groups, many Community Voices participating organizations were small advocacy groups (American Friends Service Committee, West Virginia Center for Civic Life, Partnership of African American Churches, the Welfare Reform Coalition, West Virginia Healthy Kids Coalition, Coalition for West Virginia Children). Often staffed by one to two people, these organizations were characterized by a great deal of flexibility, having few requirements to develop complicated bureaucracies. In response to a question about constraints from the institutional environment on their ability to participate, one partner liaison participating in the focus group replied, “You are asking the wrong people this question because we don’t have these constraints and therefore are here at the table.” Providing further evidence, a representative of one of these organizations stated, “We are not a provider organization and receive no public funds so we can be more independent and take more risks. We may also be viewed therefore as pesky and have less legitimacy.”

Professional norms acted as a barrier in several of the coalitions. A partner liaison suggested that the Mental Health Association encountered a different culture in its work with juvenile offenders and the juvenile justice system that “cannot overcome traditional ways of working and bureaucracy.”

Turf issues also arose between dental hygienists and dentists working as part of the West Virginia Oral Health Task Force. In West Virginia, as elsewhere, the increasing cost of taking on staff who meet professional licensure requirements is leading to creation of a
new cadres of paraprofessionals whose services may cost less. A dispute about Medicaid reimbursement rates involved dental hygienists who were seeking to expand their scope of work to include tasks reimbursed by Medicaid at rates that dentists were unwilling to accept. Dentists, on the other hand, “don’t want an expanded scope for hygienists, they want to increase Medicaid rates.” Another partner liaison suggested that in other areas such as education, medical care, and social services, professionals “may have problems dealing with paraprofessionals.”

In addition to influences from their main profession medicine, for-profit health care providers were also influenced by regulations and laws to which they must adhere and by economic concerns to realize profit. A partnership coordinator/core partner suggested that Partners in Health and the Charleston Area Medical Center (CAMC), looking to their bottom lines, were slow to join Community Voices. Participating 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.” A key informant pointed out that “partnership is not natural to the health care industry, which is based on competition and adversarial relationships.” Explaining the absence of business in Community Voices, a partner liaison stated that business “wants to continue to work alone, maintaining control over their own resources.” Another pointed to yet another professional norm that “the way organizations are viewed by others” affects their ability to join relationships, adding that “local health department staff are not accepted by hospital administrators.”
The complicated bureaucracy of the Department of Health and Human Resources reflected requirements of specialized federal departments and regulatory agencies. A key informant pointed to the “numerous specialized executive agencies at the national level that require a high degree of specialization within state government,” as an explanation for a hierarchy that is slow to react to changing needs. This degree of specialization “leaves government open to turf wars which result from role confusion and mission misalignment.” Listed as a core partner, the Department of Health and Human Services no longer filled this role at the time of this research and was represented by a lower level staff with no decision-making authority. Commenting on this, one key informant stated “people with time and commitment for partnership are not high enough in the hierarchy to make policy statements…so delays occur.” Commenting about a possible home for Community Voices once Kellogg funds expire, a partnership coordinator/core partner summed up this view of government, stating, “It [Community Voices] cannot be in a state agency where there is no room for experimentation or creativity.” Another partner liaison pointed out that where government is involved, “it often seeks control,” rejecting a major tenet of partnership that decision-making and power are shared. The location of the Community Voices office in the West Virginia Higher Education Policy Commission with financial resources passed through the West Virginia University Foundation attests to the desire of proposal writers to benefit from the efficiency found outside government bureaucracy.

Two key informants involved in government pointed to restrictions placed on federal categorical grants as a limit on their ability to partner. One asserted that “categorical
grants are promoted by interest groups, mandated by Congress, and regulated by the various executive departments.” Both mentioned the need for creative financing to stay within legal limits while ensuring that local needs were met. One termed this “accountability accommodation” and the other “work arounds.” A partner liaison expressed frustration in his coalition work where “the coalition didn’t want state money because it feared too much oversight and government would take back the money” if all was not spent by the end of the project.

In summary, informants pointed to numerous influences from the institutional environment on organizations participating in Community Voices. Exhibiting a desire to follow national trends, the Kellogg Foundation 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. This analysis suggests that organizations with fewer sources of influence such as community-based advocacy groups may face fewer impediments (Powell and DiMaggio 1991).

Confronted with these problems, participating organizations looked for ways around them, rather than trying to change the situation, perhaps in line with West Virginia’s culture of accepting the status quo, as suggested by a key informant. 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. One partner liaison explained, “If you can’t go directly at a problem, you need to find an alternative. In some arenas and social policies, you can’t hit the issue directly so you skirt around it. Have to have a win-win situation.” This may also explain the incremental approach to change, rather than large systems change as set out in the project proposal. 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. This may have contributed to a shift away from large systems change as set out in the project proposal to a short-term incremental approach. Institutional theory may provide 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).

3.3 Local Health Departments and Community Voices

Special attention was paid to local health departments in this research because it is at the local level that health is created and this entity was given the role of convening the
community for health improvement efforts in the Institute of Medicine’s review of public health in 1988 and confirmed in a subsequent report in 2002. The interviews with West Virginia Community Voices participating organizations revealed that local health departments were only peripherally involved, if at all. Understanding why these organizations were not involved might provide useful insights. Key informants from two local health departments, the state health department, and Marshall University were interviewed, in addition to devoting time in the focus group interview to this issue.

During the mid-1990s, public health officials in West Virginia set about transforming the public health system in line with Institute of Medicine recommendations to focus on the core public health functions. A proposal was set out to regionalize health departments. In pursuit of the Robert Wood Johnson Foundation state level Turning Point grant, the state established a transitions team that set out a pyramid of basic health services to be provided consistently in all counties and adequately funded by the legislature. At that time, the state had set aside $4 million to transition local health departments from a service delivery to a core public health functions role. Building on this, local health departments were seen as key to the Community Voices strategy in the qualification statement for the Kellogg grant. The proposal envisaged integrating the service delivery role of public health departments with the private provider network. However, during the 1995 legislative session, local health departments were successful in defeating the proposal mentioned earlier, as they feared that local communities, especially rural ones, would suffer if clinical services were remove.
In West Virginia local health departments serve as staff for local boards of health, which have most budgetary control over them. The state health department has some oversight because federal funds are passed on to the local level through the state. Many local health departments are small, with 50 percent having fewer than five staff, usually public health nurses. Most provide personal health care services, in response to the rural nature of much of West Virginia and lack of alternatives. During the crisis in medical malpractice insurance when many practitioners were forced to leave the state, local health departments were the only health care providers in a few counties.

The two local health departments involved in the interviews did not participate directly in Community Voices efforts. They were aware only peripherally of Community Voices through work with the Healthy Kids coalition outreach efforts to bring in more children to CHIP and Medicaid and the Kanawha Coalition for Community Health Improvement needs assessment. 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. Community Voices may not have actively sought local health department participation for reasons similar to the problems experienced by the state health department and discussed in the sections on participating organizations and environmental influences. One key informant representative described the health department as a series of “fragmented CDC services [that provide] disincentives to work together because the department cannot be reimbursed for other needed services when a client comes in for a reimbursable service. The client must be sent to multiple services, with the risk of losing the client.” This respondent added that his local health department
also finds itself fighting with the state health department, which does not see the need for service integration. Health department staff have accepted this narrow role. As with the state health department, local health departments use “accountability accommodation” to ensure that resources are available for program needs not financed under categorical grants. Hospitals were not eager to integrate services with local health departments, viewed as unequal and as competitors.

Short staffed, with limited resources and a medical focus, and ensconced in a traditional way of working, local health departments were not perceived as ideal partners by focus group participants. Some Community Voices participating organizations carried out activities that form part of the nationally recommended Essential Public Health Services (EPHS), but which are not traditional strengths of local health departments. These included needs assessment work (Essential Public Health Service #1 – monitor health status to identify community problems) carried out by regional Family Resource Networks assessment work and the community dialogues organized by the West Virginia Center for Civic Life and the convener/facilitator role (EPHS #5 – mobilize community partnerships to identify and solve health problems) performed by Lifebridge. Local health departments are funded for their provider role and are reimbursed for health care services that do not include convener or assessment roles. Given the lack of a funding mechanism, support for retraining existing staff for these new roles is limited. One partner liaison who participated in the focus group 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. Another partner liaison
participant pointed out that leadership for change at the local health department level has been lacking as many directors feel comfortable with their existing niche. Where funds are available for free training with such organizations as the Public Health Leadership Institute, no one from Kanawha County local health department and only one public health staff member from Boone County had participated.

IV. The Effectiveness Characteristics and Community Voices

Criteria available to characterize the effectiveness of partnership or the value added by collaborating include formalization, intensity, reciprocity, and standardization in addition to whether the partnership is institutionalized. Each characteristic will be described in the following discussion according to its strength along an effectiveness continuum, with weak and strong at the two extremes. The partnership coordinator, partner liaisons, and key informants provided information for this discussion, in addition to a review of documentation.

4.1 Formalization

Formalization is described by the level of social legitimacy, the ability to raise funds, the existence of a plan and agreements, and support from partner organizations.

Evidence for Community Voices’ own social legitimacy was mixed, including on the one hand, improved access to the top levels of state government with the recent appointment
of the previous project director to head the Governor’s Cabinet on Children and Families, as well as increased ease in getting the media’s attention and in obtaining additional resources from foundations such as the Benedum Foundation. On the other hand, several respondents 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.”

Agreements existed between grant recipients and the Kellogg project office but no central agreement connecting all participating organizations existed. A partner liaison added “There is a formal agreement between Kellogg and each organization but no central agreement.” Lack of a central agreement may have contributed to the demise of the core partner management mechanism that was established initially. 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 project consultant] technical assistance work, the partners had difficulty in figuring out how to knit the pieces together.”

Organizational support for the partnership can be in terms of well-specified roles and responsibilities of each organization, as well as the ability of liaison staff to commit resources and make decisions for their organizations. Within informal coalitions pulled together by the project director, of the twelve partner liaisons interviewed, four were executive directors, reflecting in part the small size of participating organizations and perhaps the importance placed on Community Voices. These liaison staff had the
authority to commit organizational resources, with the exception of one, who was three layers down in a government bureaucracy. However, this was not the case at the level of Community Voices itself.

Mixed results, including an ability to raise additional funds and some social legitimacy that were countered by limited recognition of Community Voices itself and little formal support from participating organizations other than funding agreement requirements, led to a weak formalization characteristic within Community Voices, falling between none and a quarter on an effectiveness continuum.

4.2 Intensity

Intensity is measured by the frequency/regularity of interactions, internal organizational support for the partnership, and the match between the complexity of the goal and the timeframe, partners, and resources.

Previous discussions demonstrated the regularity of meetings and communications and that participating organizations did not need to make any internal changes to accommodate the needs of Community Voices. Job descriptions of participating individuals all 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 CV but building relationships is. My position is located in top
management, which is committed to Community Voices.” As stated earlier, many participating organizations were small with few bureaucratic constraints, allowing them to participate flexibly in Community Voices.

Partnership calls for change from the status quo, requiring organizations to relinquish some autonomy in the interest of shared decision-making and of common processes and procedures to facilitate partners working together. These organizational changes could be in the form of organizational restructuring or of new policies, processes, procedures, or incentives. Internal change made by participating organizations was limited to designating a staff member to act as liaison to Community Voices and/or introducing health issues to other existing efforts. Once again, these changes were made as a result of grant conditions.

The extent that partners and resources reflect the complexity of the goal addressed contributes to its degree of intensity. The stated goal of systems change 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. Participating organizations, drawn mainly from health-related non-profit or other organizations, offered new ways to reach the public with health care messages (for example, Lifebridge), in line with the stated goal to expand access to health care. The core partners and then the project director identified and recruited organizations for their
ability to work to expand the state health insurance program for children and to increase services for dental care, mental health, women’s health, and minority health.

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 participant section, did reflect the importance of involving different levels.Confirming this, a key informant suggested, “For change to take place and be sustainable, one needs to convince the existing system of the legitimacy of that change. Community projects have to know how to work the political process.” Organizations participating in Community Voices developed relations with decision makers to create facilitating laws or changes in regulations to bring about mental health parity in insurance and raising the eligibility levels for Medicaid and CHIP, for example.

With regard to the adequacy of resources, partner liaisons pointed to shortages of time and staff, perhaps reflecting the size of their own organizations compared to the tasks to be accomplished. All partner liaisons confirmed that participation in Community Voices Resources was in addition to their normal duties within their own organizations. Resources for sustaining Community Voices also contribute to its intensity characteristic; at the time of the research, there were no funds available past the Kellogg grant, as discussed under the section on resources. Respondents had different views on the subject
of sustainability when the Kellogg funds run out in approximately one year. Small budgets may have limited participating organizations’ ability to provide any funds to sustain Community Voices beyond this point. A partnership coordinator/core partner stated, “While many are demanding partnerships, no one wants to pay for the glue person to hold the partnership together. Kellogg provided opportunities for this and when its funds are exhausted, the glue will go with it.” A key informant added that it is “essential to have some body to aggregate interests, which was the goal of Community Voices. Community Voices will be sustained if it fulfills its market niche; that is, balance between the community, government, and academia.” Others felt that it was not important for Community Voices to continue, having successfully created new relationships around common issues. This was evidenced in comments such as “the partnership won’t continue per se but the partnerships fostered by Community Voices will, as well as the idea of partnership building.”

The combination of regular meetings, 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 means that the intensity characteristic was weak, falling between none and a quarter on an intensity continuum.
4.3 Reciprocity

The degree to which resources are exchanged, risks and power are shared between partners, and the ability to deal with differences and conflict and build trust form the basis for the reciprocity characteristic.

As discussed earlier, the Kellogg Foundation provided financial incentives for organizations to participate. At the Community Voices level, this did not represent sharing of resources, although within the coalitions, organizations did share resources to accomplish short-term goals. Nor was decision-making shared for priority setting or financial resource allocation, where the Kellogg Foundation acted as central 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 focus on reporting back on activities evidenced during a quarterly conference call attended by the researcher confirmed this relationship. A partnership coordinator/core partner stated, “Originally we did not intend such a broad participation but Kellogg kept broadening the scope.” Once the project director identified new organizations to fulfill goals suggested by Kellogg, bilateral negotiations then took place. This decision-making process was best summarized by one
partner liaison, who said, “Decisions about funding are made between individual partners and the Community Voices director, who then presents them to the Kellogg Foundation for approval.”

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. Regular meetings allowed participating organizations to develop relationships and trust, while the project director dealt with differences at the Community Voices level. Multiple 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.”

Although the reciprocity characteristic within the coalitions making up Community Voices would be described as strong, lack of a common culture and centralized resource allocation contributed to a weak reciprocity characteristic for the Community Voices itself.

4.4 Standardization

Standardization is measured by the existence of linking procedures between participating organizations and of common rules, and regulations. Few linking procedures or common regulations existed to connect the short-term coalitions working toward different
goals other than those imposed by the Kellogg Foundation, as discussed earlier under the management sub-system section. On a standardization continuum, this characteristic would, therefore, fall close to the no standardization extreme.

These effectiveness characteristics describe the extent to which member organizations were able to share resources and efforts to improve their individual efforts to achieve a specific goal. These characteristics point to weak collaboration at the Community Voices level, although organizations working together within Community Voices demonstrated strong reciprocity. Results of this analysis increased understanding of the contribution of Community Voices to improving community health, discussed in the next section. Figure 1 presents a visual presentation of this analysis for Community Voices, placing each effectiveness characteristic on an effectiveness continuum.

**Figure 1. Effectiveness Characteristics for Community Voices**

Weak | | | | Strong
---|---|---|---|---
Formalization
Intensity
Reciprocity
Standardization
4.5 Form of Affiliation, Institutionalization, and Contribution to Health Goal

The community health partnership model posited that attention to the partnership process would ensure that an effectively implemented strategy of partnership could contribute to a health improvement goal. The following analysis, therefore, combines previous analyses of the transformation process and the effectiveness characteristics for an understanding of the form of affiliation practiced by Community Voices and of its contribution to improving health.

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. At one end of an organizational affiliation continuum, partnership was defined for this research 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. The partnership agreement may be formal and in writing or verbal.”

Comparisons between the partnership model and Community Voices practice in terms of definition, sub-systems, and effectiveness characteristics demonstrated that Community Voices did not meet this definition nor did it possess many of the elements and sub-systems of the model. Although initial efforts to develop a partnership relationship were
dropped due to political changes and busy executives, Community Voices afforded its numerous participating organizations an opportunity to become familiar with each other, developing relationships and trust, necessary for building a partnership.

Discussion of the transformation process revealed that Community Voices paid limited, if any, attention to partnership development. The determinants of health framework played little role in the selection of participating organizations, with the concentration of organizations in Community Voices from the health care sector or with outreach capacity. Social legitimacy represented an important resource sought from participating organizations to increase the likelihood of funding, as well as success in implementation. Organizations used Kellogg grants to complement their own within the coalitions but each ceased to participate when its Kellogg grant was completed. Resources were not available to sustain Community Voices past the Kellogg grant. Analysis of development of sub-systems pointed to lack of attention to their development, with the exception of the boundary spanning sub-system reflecting funding agency requirements and a potential maintenance sub-system, based on the relationships and trust established. Results of the effectiveness characteristics analysis pointed to weak collaboration at the Community Voices level, with organizations working together in coalitions within Community Voices demonstrating strong reciprocity.

This analysis pointed to less developed forms of organizational affiliation of networking and coalition. Networking offered Community Voices participating organizations opportunities for dialogue for common understanding with loose links between members.
Described by one partner liaison as a “coalition of coalitions,” Community Voices brought together organizations with common interests to link resources for changing common goals, although no links between coalitions existed. Coalitions are short term and do not require surrendering autonomy over shared resources and as such, are less threatening. Given the long-term nature of Community Voices’ original goal to bring about systems change, partnership, also long term, would have been a more appropriate form of organizational affiliation. At the central level, the relationship between the Community Voices project office/Kellogg Foundation and participating organizations can be described 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/core partner stated, “Community Voices will disappear but individual partnerships are sustainable, others not.” However, a 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.”

The networking and coalition strategies adopted by Community Voices increased the contribution to the health improvement goal over that of any single organization. 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, as well as a fairly strong reciprocity characteristic within the coalitions supported by Community Voices. Within these relationships, the commingling of financial resources, expertise, and social legitimacy contributed to the short-term achievements (both in terms of policy that expanded access to health care services through creation of an oral health and women’ health office and raising CHIP eligibility and in terms of community interventions to bring in more children to the CHIP program). As mentioned earlier, a strong motivation for organizations to join together was to improve chances of success in the various advocacy efforts of the project.

V. Conclusion

Once it became clear that Community Voices did not provide an example of partnership as defined by this research, the researcher sought to determine whether the model could be useful in identifying and describing other forms of affiliation. This decision was based upon the fact that partnership exists at one of a continuum of organizational affiliation, where the characteristics of each form of affiliation build on the preceding
Analyses of the transformation process and the effectiveness characteristics contributed to an understanding of the types of affiliation represented by Community Voices, the stage of development, and the added value of working together. This research revealed that Community Voices represented a donor/recipient relationship between individual organizations that then worked together in short-term coalitions, where members of specific coalitions networked with members of other coalitions.

It became clear early in the research that use of the term ‘partnership’ by the Kellogg Foundation and by West Virginia Community Voices was different from that used in this research. Following the lead of prominent, national organizations promoting partnership for health improvement, the Kellogg Foundation provided no definition or model and as such, the term ‘partnership’ encompassed any form of organizational affiliation. However, this lack of clarity may cause confusion in matching the time frames for the type of affiliation and the health improvement goal. Once Community Voices shifted to the pursuit of short-term goals, it became appropriate for it to adopt a coalition strategy. Furthermore, this lack of clarity will make it impossible to determine the contribution of a partnership strategy to improved community health. Where efforts fail, evaluators will be unable to establish whether the wrong strategy was used or whether the strategy was implemented ineffectively.

Open systems theory provided a framework within the model to understand the systems nature of partnership and the five sub-systems required of a social system, while institutional theory helped to understand the impact of the environment on partnership.
The environmental analysis suggested influences both at the macro and institutional levels that created problems for organizations to work with other organizations. Within the study of Community Voices, this analysis suggested that organizations with fewer sources of influence such as community-based advocacy groups may face fewer impediments. Evidence examined regarding the ability of local health departments to work with other organizations supported problems presented in the literature, mainly stemming from their status as government entities and professional cultures.

An important part of this research was to improve the proposed community health partnership model, based on partnerships in practice. Within the participant component, responses provided by informants indicated the need to add the community within local level participants. Within the transformation process, informants highlighted the importance of relationship building and leadership development. These components contribute to a more comprehensive model and reflect much of the existing literature on partnership, providing further support for adding these elements to the community health partnership model.

This case study presented findings from the analysis of West Virginia Community Voices. This analysis showed that the community health partnership model can be used, with some modifications, to identify and describe the form of organizational affiliation in Community Voices. A revised model, based on suggested adaptations from this case study, will serve as the basis for the research in the Healthy New Orleans site.