Healthy New Orleans (HNO) is one of 41 local Turning Point partnerships sponsored by the WK Kellogg Foundation and supported by the local program office at the National Association of County and City Health Officials. A parallel effort in 21 states was sponsored by the RW Johnson Foundation and supported by the national program office at the University of Washington.

Turning Point was designed to strengthen the public health system for the 21st century through experimentation. Each Turning Point site worked to expand the definition of health and thus, the type and number of potential partners in working toward improved health. Partnership was seen as a means to build and improve the public health system, by bringing together various constituencies, including the community, to increase local relevance and commitment to sustaining public health activities.
Healthy New Orleans aimed “to improve the health status of New Orleans through a collaborative that develops and implements a Community Public Health System Improvement Plan focusing on individuals, families and community with children as a priority.” Healthy New Orleans comprises individuals who informally represent either their communities or the public and private organizations for which they work. The two co-chairs of Healthy New Orleans direct the New Orleans Health Department and Excelth, a membership organization for primary health care providers. Past efforts to improve the public health delivery system developed in response to specific needs, rather than by examining the system as a whole. Healthy New Orleans works with the state Louisiana Turning Point Partnership, ensuring that local needs are addressed at the state level, where relevant.

Starting with a public forum, 75 stakeholders from the community contributed to the proposal that was submitted to the Kellogg Foundation in 1997. A Community Public Health System Improvement Plan was developed during 1998 through a participatory process that involved five committees or teams and a series of community voices (public dialogue) meetings in churches and neighborhoods. Based on a shared vision and a conceptual framework of community wellness, the plan outlined underlying contradictions needing change or removal and outlined three strategic directions—empowering individuals, transforming health, and providing easy, accurate and accessible information. A conceptual framework with community wellness as the goal of a New Orleans public health system was developed.
1.2 Health Status of New Orleanians

The population of New Orleans was 484,674 according to the 2000 Census, of which over 67 percent are African American and 28 percent are white. The median household income for New Orleanians was $27,133, compared with $32,566 for Louisiana, and $42,994 for the nation. People living below the poverty line comprised 27.9 percent of the population compared to 26.3% for the state and 13.3% for the nation. Children living in poverty represented 40.3% of the population, compared with 27.9% for the state. People with less than a high school education made up 17.3% of the population, compared to 15.9% of the state.

The leading causes of death in Orleans Parish were heart disease, cancer, stroke, diabetes, and homicide. Table 1 on the next page sets out death rates for these diseases and important risk factors, compared to the state and to the U.S. These figures illustrate why in 1998, Louisiana ranked 49th in the nation for rates of general poverty and child poverty, 50th in terms of poor overall health indicators and access to primary health care, and 48th in terms of teen deaths due to accidents, homicide or suicide. In addition, Louisiana is a leader in U.S. production of hazardous waste and in the amount of chemicals released in the air, water, and soil. Of children screened in public health clinics, 30% had elevated blood lead levels.
Table 1 Selected Indicators for Orleans Parish

<table>
<thead>
<tr>
<th></th>
<th>Orleans Parish /100,000</th>
<th>Louisiana /100,000</th>
<th>US /100,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>282.5</td>
<td>272.1</td>
<td>202.7</td>
</tr>
<tr>
<td>Cancer</td>
<td>245.3</td>
<td>214.6</td>
<td>213.0</td>
</tr>
<tr>
<td>Stroke</td>
<td>69.6</td>
<td>58.0</td>
<td>63.1</td>
</tr>
<tr>
<td>Diabetes</td>
<td>58.8</td>
<td>38.7</td>
<td>22.7</td>
</tr>
<tr>
<td>Homicide</td>
<td>49.9</td>
<td>13.1</td>
<td>6.1</td>
</tr>
<tr>
<td>Infant Mortality</td>
<td>9.4</td>
<td>9.2</td>
<td>7.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>%</th>
<th>%</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inactivity</td>
<td>--</td>
<td>36.2%</td>
<td>29.7%</td>
</tr>
<tr>
<td>Obesity</td>
<td>--</td>
<td>23.6%</td>
<td>17.0%</td>
</tr>
<tr>
<td>Smoke</td>
<td>--</td>
<td>24.1%</td>
<td>23.0%</td>
</tr>
<tr>
<td>No Health Insurance</td>
<td>--</td>
<td>21.9%</td>
<td>16.9%</td>
</tr>
<tr>
<td>%&lt; Poverty</td>
<td>27.9%</td>
<td>19.6%</td>
<td>13.3%</td>
</tr>
<tr>
<td>children &lt;18 in poverty</td>
<td>40.3%</td>
<td>26.3%</td>
<td>17.0%</td>
</tr>
</tbody>
</table>

Source: Orleans Parish Health Profile 1999; Census 2000

1.3 The Informants

Site research involved eighteen interviews, a review of documentation, and a focus group. Due to a death in the family, one of the co-chairs and director of the New Orleans Health Department, unfortunately, was not available. As will be discussed more fully later, interviewees involved volunteers representing their communities rather than their organizations, if they were employed. They all participated as their other responsibilities allowed, leading to a high level of turnover in participants and to varied knowledge about Healthy New Orleans among interviewees. A focus group, organized to supplement and clarify information gained in the individual interviews, included nine people, two of whom had not participated in the individual interviews.
This unexpected lack of organizational partners did not mean, however, that the model could not apply to Healthy New Orleans. Originally designed to focus on single organizations and their relationship with their environments, open systems and institutional theories were extended in the model to study partnership as an organization made up of multiple organizations. The researcher, therefore, focused on Healthy New Orleans as a single organization, with individual volunteers acting as ‘staff,’ and on the relationship between Healthy New Orleans and its environment. The lack of organizational partners, however, meant that terminology used to identify the types of interviewees (partnership coordinator, partner liaisons, and executive directors) set out in the methodology chapter no longer applied. Interviewees at the Healthy New Orleans site were, therefore, classified as an Healthy New Orleans co-chair, members of the executive committee (two), or community volunteers (twelve). Interviewees suggested key informants (three) who had provided support to Healthy New Orleans, including the Healthy New Orleans training contractor and representatives from The Louisiana Public Health Institute (the state Turning Point project) and Tulane University.

II. The Community Health Partnership Model – the Transformation Process

This case study is organized around the elements proposed in the community health partnership model; that is the transformation process, the institutional and macro environments, effectiveness characteristics, and contribution to improved community health. For each element, the following is presented
• A short description of each element of the model and source(s) of information
• A description of each element within Healthy New Orleans with supporting quotations and
• A conclusion regarding the state of the element under discussion

The partnership model argues that for partnership to be an effective strategy in improving community health, attention must not only be paid to health improvement activities but also to the development of the partnership. Information on the transformation process was gathered through interviews with the Healthy New Orleans co-chair and participants. Questions were asked about partners, resources, planning, environmental and needs assessments, partnership structure, sub-systems, processes (decision-making, communication, other), incentives and procedures, and any monitoring or feedback mechanism that led to change and improvements.

2.1 Participants 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. During the interviews, the co-chair and Healthy New Orleans participants were asked to name the partner organizations, the sector to which they belong, and their role in and contribution to Healthy
New Orleans. Documents, including the strategic plan and reports to the National Association of County and City Health Officials also provided information.

The Community Public Health Improvement Plan provided evidence that Healthy New Orleans’ membership comprised individuals, rather than organizations, “Interest in the partnership that emerged as Healthy New Orleans was inspired by a common desire and vision among individuals for a healthier New Orleans and an improved public health system.” Over 75 stakeholders attended a forum convened to develop a response to a call for interest from the W. K. Kellogg and the Robert Wood Johnson Foundations Turning Point project. Membership in Healthy New Orleans drew from these stakeholders, as well as others who joined during the strategic planning process and later. Describing the nature of this participation, a co-chair/member of the executive committee pointed out, “There is no formal partner list. Some participate more than others.” Although this presented problems in constantly needing to provide education to bring people up to date, participants viewed this flexibility as a benefit. Confirming this, a volunteer suggested, “We can always go back after dropping out for a while.” While all interviewees agreed that “partners represent the community and not so much their organization,” some ambiguity remained as evidenced by one volunteer. Referring to her employer during the focus group discussion, she suggested “So while [participation of my organization] hasn’t been formalized, I think we can say it is involved.”
Volunteers in Healthy New Orleans self-selected from approximately 200 people from various organizations who participated in a one-day strategic planning process. Individuals from community-based social services, academia, religious groups, government (both state and local), and individuals representing their communities came together. These volunteers worked for organizations such as the New Orleans Health Department, Excelth, Inc., Tulane Center for Applied Environmental Public Health, the Medical Center of Louisiana at New Orleans, Agenda for Children, Daughters of Charity Services, Mental Health Association of New Orleans, and Infinity Network (a substance abuse program), as well as residents of several neighborhoods of New Orleans. Healthy New Orleans welcomed any organization to adopt parts of the Community Public Health System Improvement Plan and carry out activities to fulfill that part of the plan. During the focus group, one participant pointed out the complementary nature of efforts to improve health in New Orleans. “Where others take on Healthy New Orleans efforts, Healthy New Orleans welcomes them as complementary to their own.” Two organizations participated more regularly as a result of the two directors serving as co-chairs of Healthy New Orleans. One co-chair asserted, “Healthy New Orleans doesn’t exist formally but organizations come together. Excelth, Inc. donates financial staff,” given his position as director. Similarly, the New Orleans Department of Health participated informally, based on the director’s ability to assign resources to Healthy New Orleans such as a ½ FTE for administrative support. This participation was put in doubt upon the departure of the director, and will be discussed later under the local health department discussion within the environmental analysis.
Community Health Networks (CHNs) represented the empowerment strategy adopted by Healthy New Orleans and an important link between neighborhoods and Healthy New Orleans at the city level. These CHNs involved residents who worked together to identify small changes in neighborhoods to which they could contribute. A focus group discussant observed, “The [empowerment] process is so powerful because each person is as important as, say, a CEO. Empowerment is not political power but rather the power of first the individual.” Thus, Healthy New Orleans defined early on exactly what was meant by community participation, an important step in establishing Healthy New Orleans.

Although Healthy New Orleans established important links with city neighborhoods, few links were found to exist vertically to state and national programs and organizations, with the exception of the Turning Point project. The Community Public Health System Improvement Plan described involvement in the State Turning Point project, where both co-chairs served on the State Steering Committee. General members of Healthy New Orleans participated in training sessions organized by the Louisiana Public Health Institute (LPHI, the state Turning Point project), in conjunction with the Louisiana Office of Public Health (OPH). A key informant pointed out that this involved “sessions to understand what health is broadly and assessment tools” during the development phase. OPH scaled down its participation after political changes at the state level. At the national level, Healthy New Orleans participated in a number of Turning Point working groups, including one on Community Health Governance.
The driving forces behind Healthy New Orleans were the two co-chairs, as evidenced by several community volunteers’ agreement that what worked was “the enthusiasm of Andry and Webb, who both were influential and who brought their own political clout.” As directors of their organizations, they are able to bring organizational resources to Healthy New Orleans, while their organizations had no formal agreement to participate.

The community health partnership model is premised on the participation of organizations from multiple sectors that have an impact on health to work together to improve the influences on healthy people and healthy communities. All interviewees were aware of the determinants of health and of the need to broaden the approach to improving health status. The strategic plan stated “The Partnership affirms the World Health Organization definition of health and is influenced by this expanded concept of health that has many determinants.” A participatory planning process was used to develop the Community Public Health System Improvement Plan, given “that health is the responsibility of every person in the community” and that it “encompasses broader quality of life issues: clean environments, healthy lifestyles and behaviors, respect for each individual so that the basic emotional, physical and spiritual needs of each person in the community are fulfilled.” Because there are no organizational partners, it was not possible to assess the influence of the determinants of influence on partner selection.

A key strategy involved participation of neighborhood residents of New Orleans. Early on, organizations were invited to send representatives to the above-mentioned forum, who were then requested to represent their own neighborhoods. A community volunteer pointed out
that “partners represent the community and not so much their organization.” A report to NACCHO confirmed that “the process is an open one that is welcoming to all that come to the table.” Community involvement contributed to increased trust and social cohesion, as well as commitment to and relevance of neighborhood efforts. “Working to develop the community voice,” a community volunteer stressed that Healthy New Orleans worked through person-to-person contacts to expand the network of participants into local communities. Referred to as “community voices,” this approach was considered by the co-chair as “another one of the accomplishments of the partnership. It is in neighborhoods, at churches and in other community settings that the partnership has connected with the community around health issues that can unite us all.” During the focus group, one participant described how Healthy New Orleans volunteers apply the “Miss Yvonne test” to work within Healthy New Orleans. The test states that “it has to be real to the typical person (Miss Yvonne) in a neighborhood – what would she say or think?”

The strategic plan conceptual framework set out community wellness as the Healthy New Orleans’ goal, confirming that Healthy New Orleans interpreted the Turning Point goal of public health system improvement as community health improvement. This is an important distinction as it led Healthy New Orleans to concentrate, at least initially, on small improvements that individuals can make in their neighborhoods, rather than looking to reform the public health system. These small, isolated neighborhood efforts may be the basis for what one co-chair called “a quiet revolution,” when and if they are connected.
With a goal as broad as that for Healthy New Orleans and with no formal organizational partners, it is difficult to determine key players who should be involved but who are not. However, according to a Healthy New Orleans report prepared for a Governance Working Group comprised of local sites participating in the national Turning Point project, missing participants included business, environmental health agencies, law enforcement, youth, and school administrators and teachers. The Community Public Health System Improvement Plan also mentioned managed health care providers, and politicians. Other Healthy New Orleans reports mentioned the need to seek new partners from non-traditional health sectors, such as the Chamber of Commerce, architects, postal employees, truck drivers, and youth.

While Healthy New Orleans is linked to the neighborhood level, few links exist to the state and national levels. The lack of formal organizational partners and the self-selection of individual volunteers made it impossible to assess whether partners represented the multiple sectors influencing health, as suggested by the community health partnership model.

In line with the addition of the community as a participant from the West Virginia Community Voices research, Healthy New Orleans revealed the need not only to include the community as a partner but also to define its role so that strategies could be included to support that role. For example, Healthy New Orleans sought participation of the community as a full participant and in pursuit of this, concluded that empowerment and capacity building strategies were required to realize their slogan of “the power is within you to make a difference.”
2.2 Healthy New Orleans Resources

The community health partnership model states that partner organizations contribute money, personnel, equipment and supplies, knowledge/technology, and social legitimacy to support project goals. The co-chair and Healthy New Orleans participants were asked about the contribution of their organizations to Healthy New Orleans.

The WK Kellogg Foundation provided a $60,000 grant over three years for developing a plan to build and improve the public health system. Part of the grant was used to pay a consultant to plan and implement an ongoing train-the-trainer facilitative training program. Healthy New Orleans won further Kellogg grants to support development of a Center for Empowered Decision-Making ($170,000) and of community health networks ($100,000). As discussed in the section on participants, initial training was provided within the national Turning Point project through the state level project and technical assistance.

Healthy New Orleans’ manpower comprised individual volunteers who informed their organizations about Healthy New Orleans and gained permission to participate, as long as their normal duties were performed. A co-chair/member of the executive committee pointed out that “there was so much volunteer support that Healthy New Orleans had some of the original $60,000 remaining” at the end of the project. Community residents provided the manpower for the work of the Community Health Networks.
The two co-chairs made resources available from their own organizations. For example, the director of the New Orleans Health Department contributed a ½ FTE for approximately two years to provide administrative support, in addition to in-kind resources, such as meeting space. Unfortunately, this administrative support was lost once the director left the department. The Healthy New Orleans fiduciary is the Greater New Orleans Foundation and staff of Excelth Inc. provided financial services for Healthy New Orleans.

Social legitimacy; that is, credibility and acceptance by the community, is considered a resource that contributes to partnership development. Both the director of the Department of Health and of Excelth, Inc. brought their own legitimacy to Healthy New Orleans, making it easier to attract participants and others into efforts to improve health. A co-chair/member of the executive committee argued that the convener role of the health department “has been one of the stronger attributes of the Department [under the Director]. It was the credibility of the Department that was able to attract both traditional and non-traditional participants to the table because the relationships had already been formed through this convener role.”

Healthy New Orleans accomplished much with its limited resources. However, a key informant pointed out that “Kellogg needs to be careful regarding the difficulties in forming partnerships. Perhaps they were over ambitious for it takes a lot more resources to entirely rearrange a public health system. The sum provided was peanuts and led to an impoverished intervention. Foundations will have to think longer term and within a larger context. Little guidance was provided in the allowed short time frame.”
Although Healthy New Orleans accomplished several tasks set out in its community wellness framework, limited resources and dependency on volunteer and ad hoc contributions reduced the potential for work at the systems level. All volunteers mentioned lack of time as a constraint, with most also mentioning limited resources. One volunteer stated, “The consensus decision-making process is time consuming and people are not always comfortable with this.”

2.3 Development of Organizational Sub-systems

The five sub-systems required for organizational survival include the adaptive, boundary spanning, maintenance, managerial, and production sub-systems. 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 work 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

An adaptive sub-system recognizes that organizations are open systems that affect and are affected by their environments. It provides an organization the ability to track its environment to identify the need for organizational changes in plans and activities for survival.

In line with this, participants in Healthy New Orleans developed a strategic plan, based on a process that started with a day-long summit attended by over 200 people as discussed previously. The process included a number of teams that carried out an analysis of existing health data, a community survey, and a series of community meetings and an action planning retreat, attended by over 200 participants. The resulting Community Public Health System Improvement Plan set out a vision for a Healthy New Orleans that transformed its reputation from the “City that Care Forgot” to the “City That Cares.” Comprehensive in terms of time frame, people consulted and involved, and analysis of obstacles to changing the public health system, the plan, however, did not assign roles and responsibilities to accomplish activities, nor did it encompass a feasibility analysis to understand the influences in the environment to guide the decision regarding the type of affiliation that Healthy New Orleans adopted.

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

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

2.3.2 Boundary Spanning Sub-system

A boundary spanning support structure ensures that an organization has access to resources in its environment and that it maintains good relations with the external world. In an organizational partnership, this also requires staff from each participating organization to act as liaison between their organizations and the partnership. However, because there were no partner organizations in Healthy New Orleans, one would not expect to find partner liaisons to fulfill this function.

Members of the executive committee carried out the external boundary spanning function. A co-chair/member of the executive committee stated “My role is to act as spokesperson for
Healthy New Orleans.” He, along with other members, ensured that successful grant requests were submitted for additional funds.

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

2.3.3 The Maintenance Sub-system

The maintenance sub-system involves ensuring that variation within the social structure (the partnership) is kept to a minimum by developing a common culture of shared values and norms. Relationships and trust are built and a process for accommodating diversity exists.

Healthy New Orleans was successfully developing a culture built on an appreciation of diversity and community participation. Actively encouraged by the Healthy New Orleans co-chairs who hired a contractor to provide training for all involved in facilitative consensus decision-making, this culture involved a participatory culture, where all inputs were appreciated. The training included developing a core group of volunteers who could replicate the training in the Community Health Networks. One Healthy New Orleans volunteer affiliated with an organization pointed out that “the partnership has established a culture of acceptance and respect…” Another confirmed this by stating “Healthy New
Orleans functions by finding common ground for action rather than differences. The Healthy New Orleans partnership meets in consensus building mode.” Universally, interviewees expressed a recognition and appreciation for this participatory culture. This culture may, however, cause problems in the future should Healthy New Orleans decide to pursue organizational partners as one community volunteer pointed out that few business people, for example, participated in Healthy New Orleans because they viewed “this process as time consuming and those who do not return do not like the culture.”

This consensus decision-making process helped prevent potential problems, which one community volunteer felt “is the most important thing about Healthy New Orleans.” Another stressed, “the facilitative training [in consensus decision making] is what made Healthy New Orleans gel.” This training allowed individuals to build meaningful relationships and trust, an important foundation for partnership development. However, a co-chair/member of the executive committee felt that this was somewhat limited by the fact that “a lot of new people with fewer who were involved in the beginning meant that education of new people” was continually required and by extension, new relationships and trust had to be continually established.

Healthy New Orleans was well on its way to developing a common culture and relationships built on trust, a sound basis to use as a springboard to bring in organizational partners. Although participation was inconsistent, attention to developing a common culture meant that the maintenance sub-system was in the formative stage.
2.3.4 The Management Sub-system

The management sub-system involves an integrative mechanism, along with regulatory and common processes to facilitate multiple organizations working together. Although Healthy New Orleans was a fluid group of individuals who moved in and out as their work responsibilities allowed, an executive committee with two consistent co-chairs coordinated the work of Healthy New Orleans. Confirming this, a co-chair/member of the executive committee stated “the executive committee has a flexible membership with two regular co-chairs. People attend according to their time and commitment.” A variety of task forces, dealing with public relations, fundraising, the Center for Empowered Decision-Making, evaluation, data collection, a website, and leadership, supported the executive committee, along with a ½ FTE person who carried out administrative duties. This structure is, however, informal because members of the executive committee were self-selected and not elected.

Looking to the future sustainability of Healthy New Orleans, a co-chair stated “there is no formal agreement [between organizations] but we are looking into a memorandum of agreement…We want to get the traditional partners to sign on now because people are changing.” This refers to the recent political shake up in the health department after city elections, opening the likelihood that the department no longer participates because Healthy New Orleans was seen as a priority and there was no organizational agreement.
Common processes to help a partnership function more smoothly may include decision-making, communications, and monitoring and evaluation, among others. The two co-chairs provided strong leadership and ensured that the participatory approach was sustained. One community volunteer who participated in the focus group stressed, “The other thing that’s important is that […] as director of the health department and as co-chair, brought a vision because she is so committed to the collaborative approach.” Decisions were by consensus and were often formulated in committee or task forces for agreement by the full membership. Communication was both formal and informal, through e-mail meeting announcements, minutes and word of mouth. A forthcoming Healthy New Orleans website will provide a more formal means of presenting Healthy New Orleans externally. Although Healthy New Orleans participants, resident in the participating neighborhoods, facilitated Community Health Network meetings and provided facilitative training to develop local leaders to maintain continuity between Healthy New Orleans and the Community Health Networks, one community volunteer suggested that Healthy New Orleans should have closer ties with the CHNs to ensure a more consistent approach, stating “the relationship between the two was peripheral.” Another suggested that “people in the Community Health Networks struggle to understand Healthy New Orleans.” Monitoring and evaluation, other potential common processes and discussed earlier under the adaptive sub-system section, were carried out informally within Healthy New Orleans, where ‘leadership oversight” by the co-chairs served to prod volunteers to fulfill commitments.

Rather than describing processes employed between organizational partners to facilitate their work, analysis of the management sub-system described Healthy New Orleans as a single
organization. The existence of an informal structure leads to the conclusion that the
management sub-system was in the formative stage.

2.3.5 The Production Sub-system

The production sub-system in the partnership model transforms resources from the
environment into activities to improve community health and to develop the partnership.
Community health improvement activities within the community wellness framework in
Healthy New Orleans focused both on building capacity at the city and at the neighborhood
levels through the Center for Empowered Decision-Making at the city level and Community
Health Networks in neighborhoods.

A co-chair/member of the executive committee suggested that the Center for Empowered
Decision-Making, currently being established as a 501(c)3 nonprofit organization, with
Healthy New Orleans participants as board members, will ensure that Healthy New Orleans
is sustained by serving as its support arm and to carry out community research, collaborative
planning, data collection, policy making, and leadership development. Three Community
Health Networks were established in New Orleans neighborhoods. Community volunteers
and trained facilitators in each neighborhood used $3,000 planning grants to identify needs
and develop solutions that can be implemented by the community. One neighborhood
Carollton United is the furthest along in these efforts, where one interviewee, who is a
volunteer in this neighborhood, pointed out that “residents build on existing programs and
define health in terms of structure, such as clean streets and safe neighborhoods.”
Partnership development activities included development of the four sub-systems discussed previously, all described as in the formative stage. Healthy New Orleans worked to expand participation and to develop a core group of facilitative trainers. Building community awareness and empowerment were seen by one community volunteer as a way to “transform the public health system by building community awareness of what they can do to make the health system work for them.” Facilitative training for consensus decision making contributed to a Healthy New Orleans goal to build on community assets and resources and reduce the current sense of powerlessness. This training was considered ‘the glue that keeps Healthy New Orleans together.” Some interviewees, however, held different views, ranging from “Healthy New Orleans is built on a grand design and good intentions to take care of the poor” to “Healthy New Orleans is a quiet revolution,” building capacity among the powerless to demand accountability from the political elite.

Training provided by the national Turning Point project concentrated on improving the planning process, rather than on providing training to the executive committee to enable members to perform their management functions better. Individual participants received training in facilitative skills.

Regular Healthy New Orleans meetings and communications contributed to the building of relationships and trust among individual volunteers. Healthy New Orleans reduced regular monthly meetings to bi-monthly when products were no longer required by the Turning Point project. Support from the national project included training and technical assistance, discussed under the partner section. However, no one mentioned, when asked, any training,
such as board or leadership development, to enable members of the executive committee to perform their management functions better.

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

Evidence from Healthy New Orleans confirmed the importance of relationship building and leadership development as part of the transformation process found in the West Virginia Community Voices research. Underlining this, one volunteer suggested, “Healthy New Orleans is an invisible entity that allowed {Community Health Networks] to do their own thing. You make more progress by developing indigenous leadership than by doing it yourself.” Another pointed to lack of adequate attention to leadership development, “A problem in my Community Health Network was that we pushed individuals to leadership positions too quickly and didn’t follow through.” An additional focus revealed in the Healthy New Orleans analysis involved training within the transformation process in the model. As discussed earlier, training provided the strategy for creating a common culture holding Healthy New Orleans together. Because this research stresses development of the partnership itself, training should not only be available for individual members, as in Healthy New Orleans, but also for developing a strong management board.
Table 2 summarizes the transformation process within Healthy New Orleans. Individual volunteers, providing manpower for Healthy New Orleans expressed a broad awareness of the determinants of health, although there was little evidence that they influenced participant selection. Financial resources were inadequate for the system-level goal; other resources were provided either by individual volunteers (manpower, social legitimacy, expertise) or on an ad hoc basis by organizations (meeting space). Healthy New Orleanans developed a comprehensive plan that however lacked assignment of responsibilities and a feasibility analysis for an Healthy New Orleans partnership. The boundary spanning, maintenance and management sub-systems received the most attention; they, however, support Healthy New Orleans as a single organization, rather than as a partnership of organizations.
<table>
<thead>
<tr>
<th><strong>Partnership Model Element</strong></th>
<th><strong>Evidence from Healthy New Orleans</strong></th>
</tr>
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<tbody>
<tr>
<td>Partners from multiple sectors representing risk factors/influences on health</td>
<td>Individual volunteers mainly represent their communities. Broad awareness of social determinants of health but not translated into org. participation.</td>
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<table>
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<tr>
<th><strong>Resources</strong></th>
<th><strong>Evidence from Healthy New Orleans</strong></th>
</tr>
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<tbody>
<tr>
<td>Money</td>
<td>Inadequate for stated goals.</td>
</tr>
<tr>
<td>Personnel</td>
<td>Individuals volunteer time on top of regular duties.</td>
</tr>
<tr>
<td>Equipment/supplies</td>
<td>Provided in-kind on ad hoc basis.</td>
</tr>
<tr>
<td>Knowledge/ TecHealthy New Orleanslogy</td>
<td>Individual expertise; some support provided by national and state TP projects.</td>
</tr>
<tr>
<td>Social Legitimacy</td>
<td>Individual participants bring their personal credibility.</td>
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<table>
<thead>
<tr>
<th><strong>Transformation Process</strong></th>
<th><strong>Evidence from Healthy New Orleans</strong></th>
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<tbody>
<tr>
<td>Adaptive:</td>
<td>Formative</td>
</tr>
<tr>
<td></td>
<td>-A long-term Community Public Health System Improvement Plan is in place, but no implementation responsibilities assigned.</td>
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<tr>
<td></td>
<td>-No formal feedback system.</td>
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<td></td>
<td>-No feasibility analysis for partnership development; community dialogues and survey combined with data analysis for health priorities.</td>
</tr>
<tr>
<td>Boundary Spanner</td>
<td>Formative stage</td>
</tr>
<tr>
<td></td>
<td>-No partner liaisons given no formal org. participation; exec. comm. fulfills external liaison function.</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Formative stage</td>
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<tr>
<td></td>
<td>-HEALTHY NEW ORLEANS developing own culture of inclusion and participation supported by consistent facilitative training.</td>
</tr>
<tr>
<td>Management</td>
<td>Formative stage</td>
</tr>
<tr>
<td></td>
<td>-Executive Committee with task force structure for individual members; informal/informal communication; consensus decision making; no common processes required for participating orgs.</td>
</tr>
<tr>
<td>Production</td>
<td>Formative</td>
</tr>
<tr>
<td></td>
<td>-No support to partnership board development, rather to new participants for facilitative training. Health improvement activities included CHNs and CEDM.</td>
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III. The Influence of the Macro and Institutional Environments

Institutional theory was used in the model to show that organizations adapt to demands in their environments by developing structures, processes, and procedures that meet those demands. 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 analyzes information from annual reports and evaluations, as well as results of interviews and focus group discussions, to identify both facilitators and impediments experienced by Healthy New Orleans that might be traced back to its environment.

Problems faced by Healthy New Orleans can be classified as personal, structural, and environmental problems. Personal problems mentioned by interviewees were related to self-interest, conflicting goals, inconsistent participation, waning interest, and operating in isolation. Structural problems included limited resources, the need to continually educate new members, and unclear specifications for Community Health Network proposals.

Environmental problems will be discussed below under the macro and institutional environments. Because Healthy New Orleans had no organizational partners, the analysis was based more on the influences suggested by interviewees on Healthy New Orleans itself and on the facilitators and impediments that might influence potential organizational partners’ ability to participate.
3.1 The Macro Environment

The macro environment (the culture, political system, and economy) exerted a significant influence on Healthy New Orleans. The inclusive empowerment process adopted by Healthy New Orleans was grounded in the history and culture of the city, which led to a feeling of “powerlessness of disenfranchised segments of the city’s population,” as pointed out in a report on governance. Founded as a port at the mouth of the Mississippi River, New Orleans is influenced heavily by its European origins. Although the area surrounding New Orleans was based on a plantation economy with slave labor, slaves were allowed to purchase their freedom and become free people of color during the 18th and part of the 19th centuries, a rare right on the American continent at that time. After New Orleans became part of the United States, these rights and others of people of color were removed. As the ‘Americans’ moved in to New Orleans, a clash of cultures occurred, leading to a separation of the Creole descendants of the French and the Americans, who settled west of Canal Street. The French Quarter was shunned by these newly arriving Americans as the seat of a hospitality industry for a transient population that led to the characterization of New Orleans as “the city that care forgot.” To this day, Creoles view themselves as a sophisticated aristocracy, compared to their frontier American neighbors. Although neighborhoods were settled along racial lines, they appear “amorphous between the rich and poor,” as one volunteer described, with whites settling along the wide boulevards and tradesmen and servants living on the smaller back streets of the same neighborhoods. One Healthy New Orleans volunteer suggested that a divide also exists between New Orleans and the rest of the state because “New Orleans is resented as an economic driver for the state.” The state is also divided in terms of religion,
where “above Route I90, people are Baptist, below, Catholic.” A community volunteer pointed out that “decreased community cohesion has made it difficult to pull people together around issues…” and ‘problems working with disconnected communities continue, making it hard to have an influence at the systems level.” A report of a workshop on the social determinants of health sponsored in conjunction with NACCHO concluded with recognizing the need for increasing awareness of the consequences of institutionalized racism, among other things. This background may explain why Healthy New Orleans adopted consensus decision-making training and concentrated much of its efforts in neighborhood Community Health Networks.

The official and unofficial political system provided further impetus for the community-based approach. Although African Americans run the majority African American city, one community volunteer pointed out that “the Boston Club, a private social club, is where political decisions are made behind closed doors.” Another pointed out that “the business and economic community is mostly white…Vested interests parallel race that hold influence in spite of a black political structure.” One problem pointed out by a community volunteer involved getting whites involved in Healthy New Orleans because ‘they are already empowered.” Corruption among politicians and the police may have also contributed to Healthy New Orleans avoidance of the power structure. While a report to a Turning Point governance work group identified lack of engagement by the political structure as a problem for Healthy New Orleans, this may be a purposeful strategy. Most interviewees were well aware of the “quiet revolution” being pursued by Healthy New Orleans to “undo racism and change the status quo.”
The strategic plan pointed to influences that combined to give New Orleans some of the worst health statistics in the U.S. “The city of New Orleans is steeped in Old World charm, rich in history and culture. As one of America’s oldest southern cities, New Orleans lures visitors with nostalgic ambience… The city is known internationally for its fine cuisine, hospitality, laid back culture and reputation as a party capital… The citizens of New Orleans are challenged with behavioral practices that are entrenched as a way of life. This entrenchment coupled with many environmental, social, and economic factors contributes to the ranking of New Orleans and the State of Louisiana at the top of the charts of poor health outcomes.” Other factors offered by interviewees involved a lack of priority for health issues and the view of health as a medical concern and an individual responsibility.

The city’s economy is built on its status as a major U.S. port of entry, tourism, and more recently petrochemical plants. Tourism makes up an increasing share of employment in New Orleans. Healthy New Orleans felt the influence of recent state budgetary problems that led to funding cuts that “drastically impacted the state Office of Public Health, resulting in a major exodus of key personnel.” Although there is a large amount of wealth in New Orleans, the poverty rate measures 30 percent and one in four people are either un- or underinsured. Perhaps a reflection of cultural priorities, one resident questioned, “Recent cuts [that] have been made in social program funding, while at the same time making funding available to attract a baseball team to New Orleans.”
The sub-tropical climate and pollution from the oil and gas industry contribute to the health status of residents of New Orleans. The river between New Orleans and Baton Rouge is “considered a chemical corridor, full of contaminants,” where one community volunteer thought that there was evidence of “environmental racism, where chemical plants are built near poor areas.”

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

3.2 The Institutional Environment

The institutional environment exerts more direct influences on organizations than does the macro environment through organizational/professional culture or norms, government requirements, and funding mandates in Healthy New Orleans, as suggested by community volunteers.

Several community volunteers pointed to the difficulty of bringing business into Healthy New Orleans because of differences in organizational culture. “We tried to bring in the Chamber of Commerce but their bottom line is not tied into the community process. Meetings are not part of their culture unless they are tied to a product.” A Healthy New
Orleans report revealed a similar problem, “It is difficult to legitimize the community-based approach in the eyes of traditional health professionals. Ultimately, a common language about community health needs to be developed that everyone will be able to understand.” Hierarchical organizations that depend on their own expertise and competition may find it difficult to adopt the participatory approach employed by Healthy New Orleans.

With reference to the ability of government to participate in Healthy New Orleans, a co-chair/member of the executive committee suggested that “categorical grants place restrictions on recipients’ ability to participate.” A key informant went on, “The State has so many rules and regulations. The task is to follow rules rather than accomplish tasks. The State can’t collaborate within its own agencies… They hire traditional people… and believe that their leaders have the knowledge and expertise so they don’t want to partner.” Confirming bureaucratic difficulties in working with government, another key informant who formerly worked for state government stated “it is too difficult to do things in government, where managers think in terms of categorical programs and lack the big picture.”

The influence of the funding source was acknowledged by several community volunteers, “Kellogg mandated partnership within the grant.” This represented a coercive influence, although Kellogg’s influence did not extend to the management of Healthy New Orleans as it did in West Virginia Community Voices.

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

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

One constraint in the Healthy New Orleans research involved the lack of availability of the director of the New Orleans Health Department due to a death in the family. Efforts to overcome this constraint involved identifying knowledgeable key informants and relevant documents. The discussion that follows will therefore describe the role of the New Orleans Health Department in Healthy New Orleans and general problems in the city public health system, which might influence its ability to participate formally in the future.

The previous director of the New Orleans Health Department was one of two co-chairs of Healthy New Orleans. She “provides a strong influence with a vision for Healthy New Orleans,” a co-chair/member of the executive committee asserted. While the Department was not officially affiliated with Healthy New Orleans, the director was able to make resources available to Healthy New Orleans, as discussed under the section on participants. One key informant reported that the director’s “participation was outside her government job” and that “her level allowed her to approve the administrative support.” Recognizing that this support might be temporary, a report to the governance task force asked whether this support was shared by others in the department. Another indication of support for Healthy New Orleans by the Health Department was the fact that the only person offered for interview for this research from the Health Department was the administrative person who departed along with the director. According to minutes of one meeting, with regard to the relationship between Healthy New Orleans and the new director of the health department, “Dr. Stevens [the new director] is very busy…but he plans to be supportive. Healthy New
Orleans might not be the top priority on his list. The group decided that a small delegation of Healthy New Orleans partners needed to make an appointment with Dr. Stevens…” The continued participation in Healthy New Orleans by the New Orleans Health Department was therefore uncertain at the time of this research.

Because participation of the New Orleans Health Department in Healthy New Orleans was limited to the director and an administrative person, who both participated in their individual capacity, it is not possible to comment on the Department’s ability to participate. The following discussion of the public health system may offer insights.

Sources of information on the status of the public health system included the Healthy New Orleans Community Public Health System Improvement Plan and a task force report organized to review the state of public health prior to the recent city elections. The New Orleans Department of Health (NODH)differs from other local health departments in Louisiana, which are part of the State health department. Operated by the city of New Orleans, almost all income for NODH is generated locally through general funds, grants, and income earned from selected services, with state support through pass-through funds only. The director serves as a member of the mayor’s cabinet. Based on history and on the needs of its inner city population, the Department provides mainly direct services. The State Office of Public Health provides contracts for federal pass-through fund programs dealing with chronic disease, MCH, Family Planning, and WIC, in addition to public health surveillance. The Department supports three community health centers, in cooperation with Excelth, Inc. Other providers of health care services to the underserved that function as part of the city
Community discussions during the Healthy New Orleans planning process pointed to a public health system that was narrowly focused, confusing to the public, under resourced (finances and expertise), fragmented, and uncoordinated. These discussions stressed the lack of community input into prioritizing and acting on perceived health problems. The existing system “emphasizes treatment, not prevention, and traditional medicine prevails…” A Report of the Public Health Task Force (prepared for the incoming newly elected mayor and the director of the health department) stressed that the “Department of Health is heavily involved in the provision of clinical services… however, there remain many large gaps…and there is not a well coordinated city-wide plan for primary and preventive health care services. Because of its restrictions as a government entity, the Department of Health is often not able to receive full reimbursement for services provided or to pay staff adequate salaries to provide optimal services… State law was changed in 1973 to assign many public health functions, including some potential revenue generating functions, to the State Office of Public Health.”

A key informant related problems within the public health system to city difficulties, “First and foremost was the fact that health has not been a priority for politicians. In addition, low pay led to limited skills and poor quality staff.” The department remains fragmented, narrowly focused, and characterized by problems associated with a
governmental body, which may pose constraints on the ability of the NODH to participate in partnership without the full support of the director to work around these constraints.

IV. The Collaboration Effectiveness Characteristics

In addition to examining whether sub-systems required for Healthy New Orleans to be considered an organization are in place, criteria are available to characterize the effectiveness of partnership in terms of the value added by joining organizational efforts. These criteria, formalization, intensity, reciprocity, and standardization, describe the level of collaboration and whether results are greater than if member organizations had acted on their own.

4.1 Formalization

Formalization can be ascertained by examining the level of social legitimacy, the ability to raise funds, the existence of a plan and agreements, and support from partner organizations. The co-chair, Healthy New Orleans volunteers, and key informants provided information on these items.

Healthy New Orleans developed limited social legitimacy of its own. To increase its visibility, Healthy New Orleans developed a website and letterhead with its logo. However, when asked if ‘the man on the street’ or the mayor would be able to explain Healthy New Orleans, almost all people said probably not. A co-chair/member of the executive committee stressed, “Healthy New Orleans has more influence outside the State of Louisiana…” One
community volunteer considered Healthy New Orleans as “an invisible entity that has allowed them to do their own thing. We make more progress by developing indigenous leadership rather than doing for them.” Another explained that Healthy New Orleans “is a well kept secret.” Because Community Health Networks are closer to where people live, they should be more likely to be recognized; however, respondents pointed out that the CHNs build on existing community efforts and as such, may not be well known either.

In terms of ability to attract funding, Healthy New Orleans attracted $100,000 for the Community Health Networks and $170,000 to establish the Center for Empowered Decision-Making, both from the Kellogg Foundation. Alternative sources of funding are required to ensure that Healthy New Orleans survives. A co-chair pointed out that “connecting with state and local government has served to further the legitimacy of the partnership and its efforts, and these early efforts may result in future funding.” Another indication of legitimacy was offered by a co-chair/member of the executive committee, who suggested that “the Institute of Medicine chose Healthy New Orleans as a site in their study on public health in the 21st century based on results.”

As discussed earlier, there is a comprehensive plan but no formal support or recognition by participating organizations for Healthy New Orleans in the form of agreements, setting out specific responsibilities for each partner. This, in conjunction with little social legitimacy of its own and an ability to raise funds only from existing funders leads to the conclusion that the formalization characteristic is weak, falling near the no formalization extreme on a continuum. The possible introduction of memoranda of understanding and the establishment
of “the Center for Empowered Decision-Making [which] will become the working arm of Healthy New Orleans” may lead to more formalization.

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. However, participation by individuals, and not organizations, in both Healthy New Orleans and Community Health Networks was inconsistent, requiring constantly updating participants and creating discontinuity in Healthy New Orleans. “Built on people power,” Healthy New Orleans and CHN volunteers affiliated with organizations did not have the authority (with the exception of the two co-chairs) to commit organizational resources. The ad hoc nature of organizational participation did not require any internal changes to accommodate the needs of a partnership. One focus group participant asserted “We are planting the seeds. We are changing our institutions by what we take back, by what we use, by the people we influence.”

A community volunteer offered an example of internal organizational change being implemented to accommodate working with other organizations. The Medical Center of Louisiana at New Orleans, the Daughters of Charity System of New Orleans, and community
health centers represented by Excelth, Inc. entered into an agreement to share patients, through an electronic information system, allowing access to patient records for referrals from medical providers in the community health centers to the medical center. In the near future, the reverse process will allow medical center providers to refer patients to the community health centers for outpatient follow-up and care. Stressing the need for this level of recognition within participating organizations, the volunteer asserted, “You need an institutionalized partnership to ensure that relationships are maintained. It lends legal credibility.”

The match between the complexity of the goal and the appropriateness of the timeframe, participants, and resources was weak. All interviewees spoke to the plan goal to broaden the view of health among residents of New Orleans to focus on the social determinants and to improve the public health system. The strategic plan reflected, in part, the needs of this broad vision by incorporating a fifty-year timeframe. All interviewees pointed to insufficient resources, with one key informant arguing, “It takes a lot more resources to entirely rearrange a system.”

The combination of regular meetings attended inconsistently by individuals, resources for implementation but not for sustainability, no internal changes by participating organizations, and the weak match between the complexity of the goal and the participants and resources brought to bear on its realization leads to the conclusion 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 participants, and the ability to deal with differences and conflict and build trust form the basis for examining Healthy New Orleans in terms of the reciprocity characteristic.

Because organizational involvement in Healthy New Orleans was ad hoc, they were not required to assume risks by committing resources on a regular, long-term basis. Adoption by Healthy New Orleans of a facilitative, consensus-building approach helped to establish a view of diversity as complementary and an asset to be accommodated with little conflict. One volunteer suggested, “Everyone is accepted as a worthwhile participant with something important to say. The challenge is to discover each person’s talents because everyone has a stake in the outcome.” Individual motivations for participation commonly involved “the faith-based foundation,…and the spiritual context and self sacrifice” that enabled Healthy New Orleans to concentrate on building relationships and trust. Diversity was seen as an asset to be accommodated without conflict. Several resident interviewees stressed “Healthy New Orleans provides a safe place to feel comfortable voicing their opinion…”

A co-chair/member of the executive committee summarized participants’ views of decision-making by describing the process, “The executive body brings issues to the partnership that then works through a facilitative process to reach consensus,” mainly on the implementation of the proposal. One community volunteer added that there is “mostly consensus decision making but someone has to be in charge.”
The involvement of the community and the ability to build trusting relationships based on common motivations led to a high degree of reciprocity between individual volunteers. Because they did not commit resources other than their own time and thus assume risk, this characteristic would fall in the middle of a reciprocity continuum.

4.4 Standardization

Standardization is measured by the existence of linking procedures between participating organizations and of common rules and regulations. Because organizations did not participate officially, linking procedures, rules and regulations were not required. Analysis, therefore, examined evidence of established procedures used by Healthy New Orleans. Several respondents pointed out that the common facilitative training represented an effort to standardize the work of Healthy New Orleans, as do the periodic retreats. On a standardization continuum, this characteristic would fall close to the no standardization extreme.

These effectiveness characteristics describe the extent to which Healthy New Orleans had established itself, as well as the value added by individual volunteers working together. Results of this analysis increase understanding of the contribution of Healthy New Orleans to improving community health, discussed in the next section. Figure 1 presents this analysis for Healthy New Orleans, placing each effectiveness characteristic on an effectiveness continuum.
4.5 Summary – Contribution to Health Improvement Goal

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

“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.”
As discussed earlier, Healthy New Orleans comprised individual volunteers who established an informal structure, including an executive committee, task forces, and general individual membership and a participatory approach.

Analysis of the transformation process indicated that a membership of individual volunteers, committed to building a voice for the powerless, ensured that Healthy New Orleans survived past the end of Kellogg funding. Attention to developing all sub-systems to the formative stage at the time of this research including putting in place not only an informal structure, but also a common culture. Individual volunteers and ad hoc organizational inputs contributed to weak effectiveness characteristics, with the exception of reciprocity based on a participatory consensus approach.

Using the typology identified for the West Virginia Community Voices research, Healthy New Orleans combined networking with formative elements of partnership, where consensus decisions among individual members led to a shared vision. As with Community Voices, networking offered opportunities for dialogue for common understanding with loose links between members. A co-chair/member of the executive committee confirmed this stating, “Partners represent the community more than their organizations. They come and go and are not too visible because Healthy New Orleans is informal.” A co-chair/member of the executive committee recognized that this form of affiliation may have reached its limits when the director of the New Orleans Health Department (NOHD) departed. After the director’s departure, it became clear that NOHD was not necessarily committed to Healthy New Orleans participation and that a new relationship with the incoming director would have to be
developed. This prompted a co-chair/member of the executive committee to consider formalization of organizational membership, using existing individual relationships as the basis to build organizational relationships. He stated, “We are considering memoranda of understanding to commit organizations [associated with individual volunteers] to sign on now because people are changing in organizations.”

Given formative sub-systems, weak effectiveness characteristics, with the exception of reciprocity, and an intention of Healthy New Orleans to formalize ad hoc organizational support, Healthy New Orleans can be described as being in the formative stage of organizational partnership, where existing individual relationships could serve as the basis to build organizational relationships and develop systems.

While several community volunteers expressed concern about the financial sustainability of Healthy New Orleans, the enthusiasm and commitment of individual leaders ensured that Healthy New Orleans was sustained beyond the initial Kellogg funding. Participation in Healthy New Orleans was less motivated by access to increased financial resources than by a common motivation among volunteers to create a higher level of social justice for an important unempowered segment of the population of New Orleans. Healthy New Orleans achievements were possible because of additional funds supplied by the Kellogg Foundation and a sharing of volunteer expertise and social legitimacy, along with in-kind contributions of organizations associated with Healthy New Orleans, especially the New Orleans Health Department and Excelth Inc. In terms of achieving a greater impact than had organizations and individuals worked alone, this has been limited, given the young age of Healthy New
Orleans and the focus on individual empowerment. Work in the Community Health Networks was undertaken to demonstrate to residents “the small things they could achieve on their own.” The facilitative training contributed to individuals’ ability to reach consensus decisions. Summing up the combined effort of Healthy New Orleans, a key informant argued that “New Orleans has a history of disorganization and Healthy New Orleans has increased the ability to plan and organize to meet needs.” Another pointed to the “synergistic communication in networking mini-grants that are used to bring people together.”

VI Conclusion

Analyses of the transformation process and the effectiveness characteristics contributed to an understanding of the types of affiliation represented by Healthy New Orleans, the stage of development, and of the added value of working together. Although designed to assess partnership, the model was useful in identifying and describing networking and an informal organization of individual volunteers represented by Healthy New Orleans because partnership exists on a continuum of affiliation, where each level of affiliation builds on the characteristics of the previous level.

The environmental analysis suggested influences both at the macro and institutional levels that created problems for Healthy New Orleans or for potential partners. Evidence of the ability of local health departments to work with other organizations confirmed problems presented in the literature, mainly stemming from their status as government entities and professional cultures. Had this environmental analysis been carried out as a feasibility
analysis, problems encountered during implementation might have been avoided by developing appropriate strategies. A feasibility analysis would have also contributed to an understanding of an appropriate form of affiliation for Healthy New Orleans. The long-term systems level change goal calls for a long-term form of affiliation, a fact recognized by one of a co-chair/member of the executive committees upon the departure of the other co-chair from her position as director of the city health department.

Healthy New Orleans provided evidence to support the argument in the community health partnership model that the strategy of partnership had to be effectively implemented before it could contribute to improve health. Although still in the formative stage, Healthy New Orleans built an informal organization with sub-systems to the formative stage that provided networking opportunities for dedicated individuals to contribute to improving community health. Current plans to formalize Healthy New Orleans and recruit organizational partners may improve its ability to contribute to this goal.