

Sustainability of Collaborative Capacity in Community Health Partnerships

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Sustainability is a key requirement for partnership success and a major challenge for such organizations. Despite the critical importance of sustainability to the success of community health partnerships and the many threats to sustainability, there is little evidence that would provide partnerships with clear guidance on long-term viability. This article attempts to (1) develop a conceptual model of sustainability in community health partnerships and (2) identify potential determinants of sustainability using comparative qualitative data from four partnerships from the Community Care Network (CCN) Demonstration Program. Based on a grounded theory examination of qualitative data from

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the CCN evaluation, the authors hypothesize that there are five primary attributes/activities of partnerships leading to consequential value and eventually to sustainability of collaborative capacity. They include outcomes-based advocacy, vision-focus balance, systems orientation, infrastructure development, and community linkages. The context in which the partnership operates provides the conditions for determining the appropriateness and relative impact of each of the factors related to creating consequential value in the partnership.

Keywords: *community health; partnerships; sustainability; collaboration*

While public health advocates have long argued that medical care delivery alone cannot effectively address the burden of disease and illness in a population, only recently has broader, cross-sector support emerged for the idea that medical and public health-based interventions will be required to significantly improve health at the community level (Rundall 1994; Stoto, Abel, and Dievler 1996). Accordingly, there has been a renewed interest in efforts to improve community health through the formation of partnerships that integrate public health and medical care delivery components of local health systems (Bazzoli et al. 1997; Bogue et al. 1997; Bolland and Wilson 1994; Gamm 1998; Kreuter, Lezin, and Young 2000; Weiner and Alexander 1998). However, to realize their rather ambitious goal of improving the overall health of the whole community, partnerships and their activities must be sustained over a significant period of time (Shortell et al. 2002; Lasker and Weiss 2003).

Sustainability is a key requirement for partnership success and a major challenge for such organizations. Community health partnerships take a comprehensive approach to improving community health status that focuses on education, prevention, early detection, and seamless delivery of health and human services. However, broad, systemic coordination of multisector services aimed at improving community health necessitates long-term effort, and an even longer period to actually see measurable results (Green 1997; Huxham 1996; Shortell et al. 2002; Lasker and Weiss 2003; Norris 2001). Besides not realizing systemic changes in community health, an insidious

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consequence of unsustainable partnerships is the reluctance of community organizations and providers to engage in similar efforts in the future. Unsustainable partnerships leave a legacy of mistrust and pessimism that erodes the foundation for future collaboration among community entities (Huxham and Vangen 2000; Weiner and Alexander 1998).

Community health partnerships face strong structural challenges to sustainability. Partnerships operate on the basis of voluntary collaboration rather than hierarchical control. Consequently, the partnership's authority to set agendas, allocate resources, and resolve conflict is tenuous, deriving more from consent than from equity ownership or contractual authority (Alexander et al. 2001; Huxham 1996). This suggests that members of the partnership are only loosely bound to the organization and can leave without serious consequences to themselves should the partnership take an unacceptable position. Lack of barriers to exit is an omnipresent threat to partnership sustainability (Alexander et al. 2001; Zuckerman, Kaluzny, and Ricketts 1995). Second, partnerships consist of a broad spectrum of public, nonprofit, investor-owned, and community-based organizations. Cultural differences that arise from differences in time horizons, risk orientations, and decision-making styles makes it difficult to design a partnership structure and set of operational rules that are acceptable to all parties (Alexander et al. 2001; Sink 1996; Weiner, Alexander, and Zuckerman 2000). Because the structural "glue" present in most formal organizations is lacking in most partnerships, considerable efforts by partnerships in the short term are focused on building trust and collaborative decision-making norms, rather than active movement toward the goals of the partnership (Gulati, Khanna, and Nohria 1994; Huxham 1996). In a similar vein, partnerships consist of members with varying levels of resource and effort commitment to the partnership and varying degrees of overlap between their own institutional goals and activities and those of a partnership (Okubo and Weidman 2000; Swain 2001). All partner organizations walk a fine line between commitment to the partnership and its goals, on one hand, and those of their home organizations, on the other hand (Gamm 1998; Huxham 1996; Sink 1996; Zuckerman, Kaluzny, and Ricketts 1995). This duality provides considerable stress on the ability of community health partnerships to sustain effort consistently over the long term.

NEW CONTRIBUTION

Despite the critical importance of sustainability to the success of community health partnerships and the many threats to sustainability, there are few evaluations that provide partnerships with clear guidance on long-term viability. Because extended funding for partnership evaluation is rarely

provided, the structural constraints on researchers interested in systematically examining questions of sustainability are significant. The 3- to 5-year horizon of most evaluations is usually adequate only for assessing the early stages of partnership development. As a result, the literature contains few empirical investigations on the topic (Butterfoss, Goodman, and Wandersman 1993, 1996; Green 1997; Kegler et al. 1998; Kreuter, Lezin, and Young 2000; Shortell et al. 2002). Adding to the lack of empirical study, the theoretical writings on sustainability are subject to considerable controversy, beginning with the definition of the concept. Scholars disagree most fundamentally on what it is that should be sustained—for example, the partnership as organization, its values, or its initiatives (Doz and Hamel 1998; Goodman et al. 1996). For example, is a partnership sustained if it disbands as an organization but one or more providers in the community adopt its functions? Finally, from a design perspective, sustainability is by definition a future-based concept and cannot be assessed directly (other than in retrospective fashion). Investigators are therefore forced to rely on an assessment of factors that serve as the precursors or foundations for potential sustainability.

Our article attempts to bridge some of these research gaps to provide practical guidelines for partnership sustainability by (1) developing a conceptual model of sustainability in community health partnerships and (2) identifying potential determinants of sustainability using comparative, qualitative data from four partnerships from the Community Care Network Demonstration Program. While acknowledging the definitional differences in the literature, we focus on the role of the partnership in sustaining the capacity to collaborate. As vehicles for interorganizational collaboration, partnerships can be mobilized and redirected toward a wide range of community health interventions. Whereas the organizational form under which such collaboration occurs may shift over time, the ability to engage in mutually productive collaboration remains a constant. Similarly, partnerships can serve as a catalyst for convening disparate community segments and provide neutral ground where participants can leave their institutional politics at the door and focus on community-wide issues. Such functional attributes are important to funding agencies, policy makers, and community leaders because, while specific community health interventions come and go, the ongoing ability to collaborate under different conditions represents a durable resource that enhances the social capital of the communities that partnerships serve.

THEORETICAL FRAMEWORK

From an evaluation/research perspective, sustainability is difficult to conceptualize and evaluate, primarily because it indicates a future state. Instead,

sustainability must be measured in proxy fashion on the basis of other observable qualities and characteristics. These characteristics are presumed to be precursors of sustainability. Following Cropper (1996), we suggest that sustainability is built on the value that collaborative capacity adds to the community and community health and on the collaborative processes through which this value is created. Value may be conceptualized on two dimensions. First, consequential value refers to the (asserted) efficiency, security, productivity, legitimacy, and adaptability of particular collaborative efforts, or even of collaboration in general, especially relative to noncollaborative efforts (Cropper 1996). These behavioral factors represent the bases of value for the partnership and its members and the standards against which the partnership and other forms of organizing are compared. They may or may not be amenable to manipulation by the partnership or its leaders. Simply stated, collaborative efforts are more likely to be sustained when these consequential bases of value are greater.

However, as Cropper (1996) points out, these qualities are often not objectively defined but viewed in the broader context of the life cycle of the collaboration or the institutional and environmental context in which the collaboration functions. These factors constitute the second dimension of value, constitutive bases of value. This may mean, for example, that a partnership that functions in a strongly market-driven environment may suffer far less from a loss of legitimacy than would a partnership whose operating context features important institutional actors, expectations, and norms. Thus, value attainment of collaborative efforts is constrained and mediated by prior attachments and accountabilities to reference groups, and larger environmental circumstances outside the immediate boundaries of the collaboration. Successful collaborations must be able to identify the importance of these contextual factors and to incorporate them in decisions regarding the value-generating activities of the partnership. The key element of this framework is the notion that activities and behaviors associated with value creation (and thus, sustainability) cannot be effectively isolated from each other or from the broader operating context in which the partnership functions. These interrelationships and the success with which the partnership recognizes and acts on them are likely to be the keys in value creation and sustainability.

The model for community health partnership sustainability is illustrated in Figure 1. Based on a systematic examination of qualitative data from the Community Care Network (CCN) evaluation (described under Method), we propose that there are five primary attributes/activities of partnerships leading to consequential value. They include the following: outcomes-based advocacy, vision-focus balance, systems orientation, infrastructure development,

and community linkages. Outcomes-based advocacy is the ability of the partnership to effectively identify and communicate specific short-term, sometimes symbolic, achievements of the partnership to internal and external stakeholders, while articulating the partnership's unique contribution to those achievements over and above those of individual partnering organizations. Vision-focus balance refers to the ability of the partnership to come to agreement on a broad, long-term vision of community health, and then to commit to a series of specific actions/initiatives designed to move the partnership toward that vision. Systems orientation is the ability of the partnership and its leadership to conceptualize community health problems as the result of multiple interacting forces and to envision the solutions to such problems in terms of a coordinated effort of different sectors and actors within and outside the community. Infrastructure development is the ability of the partnership to develop internal support systems that foster effective member participation, develop leadership, and avoid overburdening key members. Finally, community linkages refers to the ability of the partnership to establish strong, working relationships to institutions and individuals in the community and to be inclusive with regard to direct community input and participation in the partnership.

We conceptualize context in terms of four primary environmental dimensions: the historical/cultural, political, physical, and economic. The historical/cultural environment includes such things as, for example, prior experiences with collaboration between organizations or communities, whether positive or negative, or the level of ethnic or socioeconomic diversity in a community. The political environment includes the extent to which states or local governments exercise more control over local health policy and planning, and the degree to which community health (and other) issues are politically contentious. Physical environment refers primarily to geographic or other factors with which the partnership must contend, for example, wide dispersal of the locations of partners and partnership activities in a rural setting. Finally, important elements of the economic environment may include the health of the local or regional economy, the relative diversity of local employers, and the breadth of the local tax revenue base.

Elements of the framework described above operate in contingent fashion on value creation and ultimately sustainability. That is, the four dimensions of context described do not exercise direct effects on partnership sustainability but instead provide the conditions for determining the relative impact of each of the factors related to creating consequential value in the partnership. For example, a negative economic environment will not in and of itself impair the partnership's ability to create value. Nonetheless, high poverty rates, poor

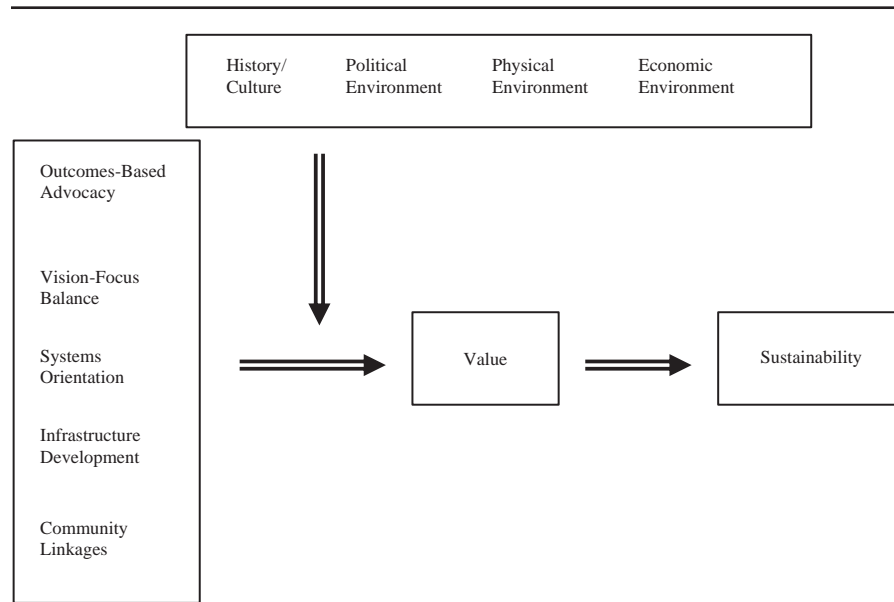


FIGURE 1 Sustainability Conceptual Model

business climate, or constrained health care budgets will probably raise the salience of efficiency and productiveness as the basis for judging consequential value of the partnership. This, in turn, might underscore the importance of engaging in outcomes-based marketing as a means for securing a steady and adequate flow of resources from resource-constrained institutional partners. Or, to take a second case, a cultural/historical context of deep-seated suspicion of health care providers among economically disenfranchised or culturally distinct community segments might raise the salience of legitimacy as a source of consequential value for the partnership. As such, community linkages might become a more critical sustainability factor for partnership operating in such contexts. Under such conditions, those partnerships that build strong community linkages—and thus demonstrate a better fit between environmental context demands and partnership structure and activities—may prove more sustainable than those partnerships that focus exclusively, say, on building connections within the health care provider community. Thus, the historical/cultural, political, physical, and economic environments provide an important set of interpretive and social constructions for determining the salience and direction in which value-generating activities by the partnerships are formulated and operationalized.

METHOD

STUDY SETTING

This study was part of a larger investigation on governing collaborative community health partnerships (Alexander, Comfort, and Weiner 1998; Alexander et al. 2001; Weiner and Alexander 1998; Weiner, Alexander, and Zuckerman 2000). The partnerships in our study participated in the National Demonstration of the CCN Vision (for details, see Bogue and Hall 1997). Study partnerships included a diverse array of service delivery organizations and community stakeholders, reflecting a systemic, population-based view of health status and its determinants. In addition to hospitals and health systems, partnerships included physician groups, insurers, business alliances, schools, churches, social service agencies, public health departments, local government agencies, and community interest groups. Partnership activities included measuring and tracking community health status, providing multi-faceted services to defined populations, developing community problem-solving capacity, and evaluating and communicating progress in improving community health and achieving systems change.

STUDY DESIGN

To examine factors related to partnership sustainability, we adopted a multiple holistic case study design (Yin 1994). We used theoretical rather than statistical criteria to generalize study findings to the body of knowledge relevant to these kinds of interorganizational arrangements. Specifically, we selected cases through a two-stage process. First, we screened the pool of 25 CCN partnerships using the following criteria: partnerships had to have a relatively balanced mix of public and private sector organizations. Second, partnerships had to exhibit a relatively balanced profile of activities on the four dimensions of the overarching CCN vision (see Hasnain-Wynia 2003 [this issue]).

We then selected four partnerships from the remaining pool based on maximizing variation on potential for sustainability, defined as developmental progress in realizing the objectives of the partnership, the capacity to collaborate, and a stable financial base. Determination of a partnership's position on these criteria was made on the basis of expert opinion. Specifically, members of the evaluation team and the demonstration project team reviewed the site visit reports on the four sites as well as ongoing progress reports from the partnerships. There was unanimous agreement among the raters that two of the sites ranked high on the potential sustainability criteria and were in thriving, robust condition. Similar consensus was reached on the other two sites, which

were essentially moribund at the time of the assessment. These partnerships were designated low-potential sustainability sites. This approach of selecting two sets of very different partnerships for study conforms to a replication logic whereby generalization to theory is the goal and cases are selected to achieve contrasting results (Yin 1994). These tentative classifications provided the basis for more in-depth qualitative comparisons of the factors that differentiate high-potential and low-potential partnerships and the influence of partnership context on the specific approaches taken to create value by partnerships. Descriptions of the four partnerships and their activities are summarized in Table 1.

DATA

We conducted semistructured, face-to-face interviews at the four case study sites in 1997, 1998, and 1999, typically with 10 to 14 key informants. These informants represented a broad cross-section of each partnership and included governing body representatives as well as individuals not directly involved in partnership governance. Informants were deliberately chosen to maximize sector representation, organizational affiliations, and formal role in the partnership (e.g., executive director, individual member). We modified the interview guide annually to explore in greater detail the themes of collaborative governance and sustainability uncovered through prior interviews and research (available from authors). Each interview lasted approximately 1 hour and was recorded in full by the investigators. A total of 115 individual interviews were transcribed word-for-word and prepared for computerized text search using QSR NUD*IST 4.0 software (Nonnumerical, Unstructured, Data, Indexing, Synthesizing, and Theorizing).

ANALYSIS PLAN

The 115 hour-long interviews produced more than 4 million bytes of data, translating into approximately 2,500 double-spaced pages of transcripts. QSR NUD*IST 4.0 was employed as a research tool to help us to manage this quantity of data and examine the meanings and methods of sustainability from the perspective of the interview participants. Analysis proceeded in four steps. In the first step, we used an iterative sorting process to develop a conceptual map of the construct of partnership sustainability. In the second step, we used the resulting groups of sustainability-related terms to conduct text searches with NUD*IST on all 115 interview transcripts simultaneously. The text searches employed a Boolean "OR" logic, such that any references to a search term by any interview participant would be captured and collated into a report. Team

TABLE 1 Sample Partnership Characteristics

	<i>Partnership</i>			
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Location	Mixed urban-rural county near large metro area on West Coast; 45,000 uninsured, 42,000 dependent on Medicaid	Urban partnership encompassing three communities in large East Coast city; large working class with high minority representation; 11% of population lives below poverty line	Operates in ethnically diverse, nine-county area in southeast; regional population of 780,000	Partnership focused on one county in upper Midwest; county consists of 16 rural communities, with a combined population of 41,500; primarily Caucasian with 1,087 Native Americans
Problems/ issues	Health care access for uninsured, health disparities among Latino and African American groups; lack of prenatal care, high teenage pregnancy rates, incomplete immunization for children	High rates of substance abuse, teenage pregnancy, infant mortality, TB, and hepatitis B; access issues specific to Portuguese, Brazilian, Haitian, and Latino communities	Highest incidence of chronic disease in state; low levels of education; lack of primary care facilities and physicians, poor coordination of health services, absence of child health services	High rates of heart disease, cancer, violence, and trauma-related deaths; inadequate care in sparsely populated areas exacerbated by declines in economy and aging of population

(continued)

TABLE 1 (continued)

	<i>Partnership</i>			
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Initiatives	(1) County-organized managed care plan for Medicaid; (2) one-stop outreach to enroll children in appropriate health care insurance; (3) multicultural health improvement initiative to reduce health disparities	(1) Ensuring access to culturally appropriate preventive and primary care; (2) reducing substance abuse by increasing primary prevention; (3) expanding managed care to elderly population	(1) Needs assessment of high-risk populations; (2) support educational opportunities for health care providers; (3) develop regional health promotion programs for children	(1) Partnering with large health care system; (2) development of a Center Without Walls; (3) self-care project to enhance partnership between health care providers and consumers
Special emphasis	Teams created in each community to address specific needs; top-down and bottom-up approach to governance; emphasis on diversity and local community concerns	Long history of community activism and collaboration; full integration of community-based collaboration into local health care system	Vision of creating a coordinated, regional system of health care, including prevention, treatment, and rehabilitation; diverse steering committee membership	Community Visioning process involving providers, business and union representatives, government officials, and consumers; ties to local medical center and local foundation

members reviewed these reports independently to examine what informants said about sustainability, with one team member formally coding the results. This process yielded a consolidated scheme of emergent categories that could be organized as five factors related to partnership sustainability (Lofland and Lofland 1995). In the third step, the team used the consolidated five-factor scheme in a further round of coding and generated a subsequent set of reports that linked all coded text associated with a given factor. Each team member then examined these reports, identified key themes for each sustainability factor, and wrote a short memo that more fully described these themes (Lofland and Lofland 1995). Team members discussed the memos, expanded or consolidated themes, and repeated the process for each sustainability factor. In the fourth and final step, we used the memos to compare and contrast high- and low-potential partnerships based on the five emergent sustainability factors and the partnership context information. The aims of these comparisons were to identify differences in sustainability factors between high- and low-potential sustainability sites and to explore how partnership context influences the specific approaches taken by partnerships to create value.

RESULTS

Table 2 presents a highly condensed summary of our analysis of the textual data generated from individual interviews, data reports, and conceptual memos. The five sustainability factors described above emerged from our analysis and represent an important study finding in their own right. These factors supported several subsidiary themes that, in turn, structured our comparisons across the four partnerships examined in the study. Overall, these results indicate that the two high-potential partnerships achieved greater development on the five sustainability factors than did the two low-potential sites. However, it is important to note that the specific approaches to developing partnership value differed between the two high-potential sites (and between the low-potential sites). Furthermore, these sites were not uniformly successful or unsuccessful in meeting all the challenges posed in the process of value creation. Indeed, even the successful partnerships continue to struggle with issues such as community linkages. In some cases, there was little distinction between high-potential and low-potential partnerships. For example, all partnerships appeared to struggle with the infrastructure development issue of partnership staffing. In the discussion below, we employ these themes to summarize the key findings and describe how the high-potential and low-potential partnerships in our study approached the five sustainability factors.

(text continues on p. 146S)

TABLE 2 Cross-Case Comparison of Sustainability Factors

<i>Sustainability Factor</i>	<i>Partnership</i>			
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
<i>Outcomes-based advocacy</i>				
Documentation of value created and value added	Strong recognition of importance of measuring value created and value added; still exploring how to do that	Emphasis on getting results on short-term goals that stakeholders care about; creating and showing value	Little value created or value added; partnership never clicked	Value created and value added, but convener role limits ability to measure unique contribution
Generation of momentum from initial successes	Strategically built on initial successes	Built on initial successes and generated excitement	Not applicable since little value created or value added	Failed to build on initial successes and generate momentum
Communication of value added (business case made)	Use of advocacy groups to communicate broadly; partners strongly believe in business case	Hired media consultant; some partners believe in business case, others are not so sure	Not applicable since little value created or value added	Communication limited to health care providers; no business case after initial success
<i>Vision/focus balance</i>				
Consensus on vision and long-term goals	Consensus on vision, small set of clear long-term goals or foci	Consensus on vision, long-term goals (or foci) still fluid	Consensus at abstract level, not much gut-level commitment	Consensus on vision, short-term goal; no long-term goals

Task-oriented focus	Strong activity orientation, focus on accomplishing targeted goals	Strong activity orientation, focus on accomplishing goals	Preoccupied with process, start-up issues; only a few collaborative activities initiated	Loss of focus and little activity after initial success
Willingness to let structure follow strategy	Structure seen as highly adaptable, process seen as central	Structure seen as adaptable, values seen as central	Politics drive structure, proposed changes viewed with suspicion	Structure seen as adaptable, values seen as central
<i>Systems orientation</i>				
Focus on population health and broader determinants	Focus on population health and broader determinants	Focus on population health and broader determinants	Focus on medical model and health care delivery system	Focus on medical model and health care delivery system
Community seen as complex system	Effort made to articulate linkages among multiple facets of community system; recognition of multiple communities within system	Effort made to articulate linkages among multiple facets of community system	Inhibited due to institutional competition and local politics, highly parochial	Good grasp of health care system but not other facets of broader community system
Activities linked to each other and to broader goals	Effort made to articulate linkages among activities within focal areas and pursue goals systematically	Effort made to articulate linkages among activities and pursue goals systematically	Activities disconnected and not cumulative	Activities disconnected, not linked to a defined long-term goal

(continued)

TABLE 2 (continued)

<i>Sustainability Factor</i>	<i>Partnership</i>			
	<i>A</i>	<i>B</i>	<i>C</i>	<i>D</i>
Leadership depth, distribution, and continuity	Conscious effort to develop depth and breadth of leadership; concern about burnout	Conscious effort to develop depth and distribute leadership; concern about burnout	Partner turnover created leadership gap, high dependence on staff, loss of momentum	Little emphasis; burnout of small leadership cadre resulted in turnover and loss of momentum
Attention to long-term direction of partnership	Engaged in strategic planning, community capacity building; stable, long-term funding sources obtained	Engaged in strategic planning, community capacity building, and development of stable, long-term, diverse funding sources	Short-term focus crowds out focus on long-term needs; sustainability not a priority; partnership never emerged from start-up phase	Burnout, loss of leadership; drift after initial success; ambivalence about sustainability; little diversity of funding
<i>Community linkages</i>				
Integration into local ecology of health and human service organizations	Well integrated; saw role as accountability assurance mechanism; identity blurred vis-à-vis health system	Well integrated; viewed as convener/facilitator; identity/autonomy clear	Poorly integrated; partnership role ill defined; not visible with stakeholders	Well integrated; viewed as convener/facilitator; role ill defined after initial success

Institutional "ownership" of partnership	Long-term commitment of partnering organizations backed up with funding, staff	Long-term commitment of partners; participation of partner leadership institutionalized	Poor due to institutional competition and local politics	Long-term commitment of one partner; others unsure
Broad-based participation within community	Actively cultivated voice and participation, especially disenfranchised communities	Worked actively to cultivate voice and participation	Seen as important, but little effort/ success in cultivation; no core issue to rally broad interest	Seen as important, but little effort/success in cultivation; focused on provider community

OUTCOMES-BASED ADVOCACY

Participants in high-potential and low-potential partnerships recognized the need to document and communicate the value their partnerships were creating. Partnerships A and B, however, were more successful in their ability to articulate that “value-added” element of their activity, particularly in terms of dollars and cents. After its initial success, Partnership D had difficulty measuring its unique contribution and making the case that its efforts were worthwhile in business terms, while Partnership C struggled to even demonstrate a significant value contribution. The high-potential partnerships were also better able to leverage their initial successes in creating value to generate credibility, enthusiasm, and additional resources for subsequent efforts.

In both of the high-potential partnerships, interviewees articulated a felt need for their partnership to “sell” itself to external (and sometimes internal) stakeholders. Partnership A, needing to ensure the continued interest of reluctant partners, resource holders, and community members, strategically prioritized short-term goals to produce relatively quick successes (e.g., improvement of health care access for Medicaid patients). These generated momentum and, when communicated to external stakeholders, additional funding. Rapid achievement of short-term goals reassured partners whose priorities were not initially selected that their interests would be addressed in a reasonable time frame. More important, perhaps, these successes generated visibility and legitimacy for the partnership in the community. Indeed, the partnership’s first success was viewed by many in “David versus Goliath” terms, a victory of “just us ordinary folks.” It carried enormous symbolic value for the partners and boosted their confidence that future goals were attainable.

Partnership B, on the other hand, saw the need to make the case that a population health agenda was an “effective component of the business plan” of the local integrated health system. Partnership leaders recognized that quantifiable measures were important “for long-term sustainability of these outreach and community-based programs, to show that they actually improve the health of the people, [and therefore are worth] paying for out of your capitated rate.” They therefore enlisted the help of the local integrated health system’s information unit to develop explicit measures of effectiveness. Partnership members argued and, to the extent possible, supplied evidence that community-based programming was not only the “right thing to do” but also good business because, over time, it would contribute to an overall savings in total health expenditures.

In contrast, Partnerships C and D were far less effective in promoting themselves and their accomplishments, even though they recognized the

importance of doing so. Partnership C, for example, produced a newsletter on a regular basis; however, its distribution list consisted almost entirely of health care professionals. Financial considerations played a part, but the newsletter's limited distribution also reflected the partnership's inward focus on medical care delivery and the narrow role envisioned for nonhealth professionals. Even among health professionals, the partnership's outcome-based advocacy suffered from the partnership's ambiguous position and uncertain future in an evolving health care market.

Should the partnership define its purpose as holding local hospitals accountable and make performance monitoring and reporting its core activities? Alternatively, should the partnership define its purpose as promoting collaboration among health care providers and make duplication reduction and quality improvement its core activities? Indecision and uncertainty made it difficult for the partnership to communicate a consistent message to potential partners and resource holders in the health sector, much less a compelling one that would have enticed representatives from other sectors—or even individual citizens—to contribute and participate.

Partnership D also suffered from a lack of consensus, which hobbled its efforts to promote itself and its accomplishments. Respondents from Partnership D recognized that sustainability depended on showing partner organizations and external stakeholders “how we are providing what they are looking for, and [how] their dollars are well spent.” Interviewees even spoke about hiring a professional marketer who could more effectively communicate the partnership's mission, message, activities, and successes to external and internal audiences alike. However, marketing never achieved much priority. Moreover, participants disagreed over whether the marketing should focus on increasing name recognition of the partnership (“brand identity”) or communicating the results achieved by the partnership.

VISION-FOCUS BALANCE

Respondents from high-potential and low-potential partnerships saw the importance of having a broadly shared vision for their partnerships and consensus among partners on long-term goals. They also seemed cognizant of the challenges that staying focused and on track toward these goals would present, particularly given the need to raise funds to support partnership activities. The high-potential partnerships, though, were better able not only to articulate these challenges but, more important, to respond to them. They showed the discipline to commit to a long-term strategy and let it dictate the partnership's focus and structure, rather than letting short-term tasks or enticing funding opportunities distract and take them off in tangential directions.

Participants in Partnership A shared a “big picture perspective” that served as a touchstone, reminding participants why collaboration was important and why continued participation was vital. As the partnership evolved, the partnership’s board routinely revisited the vision, allowing the collective agenda to reflect the interests of both continuing and new partners. This shared vision provided partnership participants big enough problems to solve—or as one interviewee phrased it, “new mountains” to climb—to keep them engaged over the long term. However, interviewees saw that an imbalance could result if vision became divorced from implementation, and therefore emphasis on the big picture was carefully regulated to avoid endless cycles of planning and process without taking action. On the other hand, though Partnership A showed a strong action orientation, interviewees did recognize that too much focus on specific tasks could excessively narrow or even misdirect the partnership’s perspective. Interviewees were keenly aware of the potential pitfalls of relying on categorical funding sources, and exercised caution to ensure that the partnership was not “letting the funding stuff take us off into places we don’t want to go.”

Partnership B adopted a similar philosophy of vision-focus balance, although it took a somewhat different approach. Partnership leaders repeatedly stressed that sustained funding depended on demonstrated success, which, in turn, required focused effort. Indeed, as they saw it, a critical advantage of the partnership was the “luxury” of focusing on a limited number of health issues, rather than having to cover all areas as the public health department or publicly funded hospital was required to do. At the same time, however, interviewees recognized the dangers of doing only that which they knew would be successful. Taking the “safe course” would duplicate the efforts of other organizations and produce little value for the community as a whole. They acknowledged that maintaining task focus and clear vision represented significant challenges in a rapidly changing environment. As the local public health and health care systems consolidated into a single integrated system in the late 1990s, Partnership B grappled with the issue of what exactly needed to be sustained. The partnership concluded that capacity to collaborate was the key, not the partnership entity itself. “Even though Partnership B is still an office with a staff, it is more honestly, the way the organization does business [that matters].”

As in the case of Partnership B, interviewees at Partnership C sought to sustain the collaborative values of the partnership and showed less concern with maintaining a particular organizational structure. As such, the partnership’s waning might even be viewed as a success if it meant that the willingness and ability to collaborate to improve local health care delivery had become institutionalized. However, this was not the case. The partnership’s loss of

momentum was primarily due to the fact that it had no shared vision of the future nor any widely accepted long-term goal that could serve as a compelling reason for continued collective effort. A cadre of partnership leaders and staff members viewed the partnership as an instrument for building an integrated health care delivery system. However, the general membership did not share that vision. Many of these general members had joined the partnership when a crisis erupted in the local health care system. The crisis had given new life to the partnership, bringing it a much-needed focus and a unique role to play in the ensuing drama. But while the partnership had achieved a short-term goal that created significant value for the community, it could not retain momentum after its initial success. Lack of shared vision, coupled with burnout, resulted in a loss of task focus and a drop-off in participation.

Interviewees from Partnership D, on the other hand, did share an image of what their partnership aspired to become, create, and achieve. However, the vision was not concrete enough to guide and discipline partnership activity, nor did participants have a gut-level commitment to follow the vision even if it meant forgoing financially attractive but potentially distracting opportunities. As a result, collective attention became focused on a disparate set of health improvement projects initiated primarily because funding became available to do them.

SYSTEMS ORIENTATION

The two high-potential partnerships showed a strong systems orientation in that Partnerships A and B focused on population health and broader determinants, sought to articulate linkages among multiple facets of the community system, and engaged in strategic planning to clarify linkages between short-term activities with long-term goals. By comparison, the two low-potential partnerships emphasized the medical model, focused primarily on the health care delivery system, and engaged in short-term activities that seemed disconnected to each other and to long-term goals.

Even for high-potential partnerships, building a systems orientation did not prove easy. In Partnership A, for example, some partners seemed to “get” the population-based view of health more so than others did. In particular, representatives from health services organizations, health maintenance organizations, and physician groups did not always see how resources devoted to addressing community-level risk factors also benefited current and future health system clients. Although this did not seem as problematic for Partnership B, participants there nonetheless struggled to articulate the partnership’s role in the larger health and human service delivery system and, particularly, its relationship with the local integrated health system. Some favored an

arms-length relationship. Others valued a close relationship so that the partnership would function as “part of the whole system and not a kind of ghetto where we can find places for our ethnic people to be dealt with and understood.” In both cases, the organizational, cultural, and demographic diversity of partnership membership seemed to foster a deeper understanding of the population health perspective and encourage thinking in more systemic terms about community-level determinants of health status. Partnership A participants generally understood that community health improvement also involves community capacity building and multifaceted strategies. Likewise, despite differences in perspectives, Partnership B participants agreed that the partnership was uniquely positioned to act as a catalyst for collaboration among health care organizations, social service agencies, advocacy groups, and economically disadvantaged and culturally distinct neighborhoods.

Partnerships C and D possessed a systems orientation in the sense that participants had a solid grasp of the structure, problems, and opportunities of the local health care delivery system. Yet neither partnership included many participants from the human service, education, or public health sectors of the community system. Not surprisingly, both partnerships emphasized the medical model of health and focused on reforming the local health care delivery system. Even within this narrower sphere of activity, however, Partnership D found it difficult to take a systemic approach to community health issues due to ownership changes and leadership turnover among the three hospitals in the county. For Partnership C, health care provider competition, local politics, and parochial attitudes outweighed the compelling logic of taking a systemic, multicounty approach to common community health issues.

INFRASTRUCTURE DEVELOPMENT

Participants in the two high-potential partnerships devoted considerable time and energy to planning for and addressing the short-term and long-term infrastructure needs in the areas of staffing, leadership, and funding. Partnerships A and B explicitly sought to find a balance of partnership staff and partner organization responsibilities that would prove effective, efficient, and sustainable. Although both partnerships benefited from committed senior-level leadership from partner organizations, participants expressed concern about the potential problems of burnout or turnover and therefore sought to develop depth and breadth of leadership. Both also secured long-term funding, which, in turn, supported the partnerships’ staffing and operational infrastructure. By comparison, participants in the low-potential partnerships gave less attention to long-term infrastructure needs. Partnerships C and D seemed less concerned about partnership sustainability due to short-term crises (e.g., staff

turnover), malaise resulting from burnout, or simply ambivalence about future involvement. Consequently, neither partnership succeeded in building a viable infrastructure in terms of staffing, leadership, or funding.

Some differences emerged between the two high-potential partnerships with respect to balancing partnership staff and partner organization roles. In Partnership A, debate centered on whether to use dedicated staff in addition to the volunteer partners. Participants experienced tension between the desire to ensure sustained leadership and follow-through, which dedicated staff would provide, and the desire to maintain feelings of ownership and commitment among volunteer partners. Some interviewees questioned whether adding dedicated staff might lessen the civic spirit, ownership, and commitment of partnership members by “professionalizing” the partnership. Others noted, however, that in addition to managing the finances and operations of the partnerships, dedicated staff members could broaden the partnership’s leadership by developing leadership capacity in the community.

In Partnership B, by contrast, participants showed little disagreement about the contribution of dedicated staff to partnership effectiveness and sustainability. Participants recognized a need for support staff as well as an overall coordinator of partnership projects. However, disagreement existed about whether staff members should be employed by the partnership and supported by grant funding or whether they should be employed by particular partner organizations and supported largely by the financial contributions of those organizations.

Interestingly, all four partnerships struggled with the issue of leadership breadth and depth. As is often the case in voluntary partnerships, all four study partnerships relied on a small cadre of people to scan the environment, formulate goals, seek funding, manage relationships, develop projects, monitor activities, and recruit members. Partnerships A and B seemed keenly aware of the partnership’s dependence on these individuals. As one interviewee observed, “It’s an organization that depends to a very large extent on . . . a very small number of people, who then energize a large number of people. . . . I think that the organization would be very vulnerable to a change of leadership.” Although participants at both partnerships recognized the implications of such leadership fragility on partnership sustainability, they acknowledged that efforts to cultivate a broader leadership base and groom junior members to take over critical tasks had only recently begun. Partnerships A and B were fortunate that leadership burnout and turnover had not yet occurred. Partnerships C and D were not so lucky. In both cases, the departure of a few key individuals created a leadership vacuum that paralyzed the partnership for months, resulting in a loss of momentum, gaps in task coordination, and a weakened sense of partnership cohesion.

COMMUNITY LINKAGES

Three subthemes emerged under the construct of community linkages: integration into the local ecology of health and human services organizations, institutional ownership of the partnership, and broad-based participation in the partnership within the community. Three of the four partnerships were well integrated in their community context and served important roles either as community conveners or by providing accountability assurance. Partnership C, however, was not well integrated because its role was ill-defined and its community visibility was poor. The two high-potential sites exhibited strong long-term commitment to the values and strategy of partnering by partner organizations. In Partnership A, this was backed up by participating organizations providing funding and staff to the partnership; and in Partnership B, by institutionalizing the partnership leadership among high-ranking members of partner organizations. In contrast, the two low-potential sites exhibited no or limited institutional ownership of the partnership. Finally, all four sites recognized the importance to sustainability of broad community participation. However, only the two high-potential sites worked actively to achieve greater inclusion and voice from disenfranchised groups in the community.

The partnerships employed several strategies to foster community linkages and generate broad-based participation. To increase partnership visibility among external stakeholders, Partnership A hired a media consultant to get the partnership's name and activities out in print and video. Partnership members also made presentations and networked with service clubs, schools, and local public officials to market the vision and goals of the partnership. The personal connections of partnership staff and board members proved instrumental in this regard. Finally, this partnership facilitated and supported collaborative efforts led by other organizations as a means of increasing community capacity and heightening partnership visibility. However, even the high-potential partnerships struggled with the challenge of how to ensure ongoing community voice and community accountability in the midst of consolidation in the local health and human service system. Partnership B recognized that "authentic community voice" depended on building trust between the health system and the community. At the same time, however, the desire for real community "ownership" of the partnership and its activities was balanced with a concern that too much emphasis on community participation and lack of institutional (i.e., health system) sponsorship might put partnership sustainability at risk.

The two low-potential sites similarly struggled with broad-based community participation in the partnership. For example, although some Partnership

C interviewees agreed in principle that broad-based community participation was valuable, action toward this stated value was not forthcoming. Indeed, some interviewees suggested ambivalence about the importance and value of broad-based community participation. Some noted, for example, that for ordinary citizens possessing little knowledge of health care delivery, "there's a level of education and understanding that is time consuming" in terms of bringing them up to speed about the partnership so that they could participate effectively. Consequently, leaders of Partnership C made the implicit choice to forgo bringing community members into the "inner circle" of the partnership because they perceived that doing so would slow or even halt the partnership's progress. Rather than build a broad base of support, they felt that the partnership could survive on the basis of its reputation, its unique role, and its institutional sponsorship by the largest hospital in the county.

Partnership D experienced even more fundamental problems in establishing community linkages. The partnership was little known among health care professionals and enjoyed no tangible institutional "ownership" due to intense rivalry and distrust among local health care organizations. Integration into the local ecology of education and human service organizations also met resistance due to divisive county politics across the nine-county region of the partnership's service area. Partnership leaders simply could not find a core issue to rally broad interest across so large a region. Moreover, initiatives focused on individual counties sparked little interest (and some resistance) among participants from other counties. As time passed, Partnership D could point to little accomplishment, and grassroots support waned.

CONTEXT AND SUSTAINABILITY

Three conclusions emerge from our examination of the environmental context in which the study partnerships operated. First, environmental context does not appear to exercise direct effects on partnership sustainability. No one dimension of environmental context differentiated high-potential partnerships from low-potential partnerships, nor did any particular combination of dimensions do so. For example, Partnership B (a high-potential site) and Partnership D (a low-potential site) both operated in a challenging historical and cultural context in the sense that both confronted long-standing rivalries among cities within the partnership's geographic catchment area, contested domains among multiple organizations and agencies working on similar health issues, and deep-seated distrust and suspicion of local medical care providers, particularly among economically disadvantaged and culturally distinct community segments. Yet as discussed above, Partnership B exhibited higher potential for sustainability than did Partnership D. Rather than

exercise direct effects, environmental context instead boosted the salience and relative impact of particular sustainability factors on the creation of consequential value (both positively and negatively). For example, challenging historical, cultural, and economic conditions contributed to the high salience and relative importance of outcomes-based advocacy in Partnership B. Specifically, many health and human service organizations made competing domain claims, and widespread, deep-seated suspicion of health care providers was prevalent among the large immigrant populations in its service area. Partnership B leaders and staff knew that documenting and communicating the value created by the partnership would be a critical success factor to keeping a broad array of community advocacy groups and community-based health and human service organizations at the table and demonstrating that the partnership had an identity distinct from that of the local integrated health system. Given high poverty rates, poor business climate, and constrained health care budgets, Partnership B leaders and staff also knew that securing resource contributions from multiple institutional partners and keeping community health improvement on the agenda of the local integrated health system also depended in large part on documenting and communicating value created by the partnership. Likewise, challenging political and physical conditions contributed to the relative importance of vision-focus balance in Partnership D. The nine counties comprising the partnerships' service area had considerable power over the delivery of local health and human services and prized their autonomy in exercising that power. Little history or culture existed to support regional planning approaches. Perceived interdependence was low despite the fact that the counties shared common health problems that they could not solve single-handedly. The physical distances separating major cities and towns and the poorly developed transportation infrastructure that linked them further contributed to the sense of isolation and disconnectedness. Not surprisingly, Partnership D leaders and staff struggled to find common ground among partners to forge a shared long-term vision of community health that would not only commit partners to collective action but also create a sense of shared destiny.

Finally, comparisons across the four sites indicate that partnerships exhibiting high potential for sustainability responded more creatively and adaptively than did their low-potential counterparts to the opportunities and challenges present in the environmental context in which they operated. For example, like Partnership D, Partnerships A and B operated in a cultural context characterized by substantial ethnic diversity and high levels of distrust and suspicion of health care providers among economically disadvantaged and politically disenfranchised community segments (e.g., immigrants). Yet in contrast to Partnership D, Partnerships A and B more successfully built

community linkages by relying on advocacy groups, churches, and tenants associations rather than depending on at-large representation by individual community members. Partnership A also held “town-hall” meetings in churches, schools, and clinics where underserved community residents lived as a means of cultivating broad-based participation and support in the absence of high levels of social capital. Ironically, Partnership C had the greatest potential of all four partnerships to build community linkages through leveraging existing social capital. Partnership C operated in a more demographically homogeneous context with a marked culture of progressive values and civic involvement. Yet Partnership C did not capitalize on this advantageous aspect of its operating context in large part because the systems orientation of Partnership C did not include a population health perspective that emphasized the broader social, economic, and environmental determinants of health. In a similar vein, although both Partnerships B and D operated in difficult political contexts, Partnership B more successfully overcame the challenges of collaborating across geopolitical boundaries by cultivating state-level legislative support for its initiatives and providing needed services to communities whose municipal governments could not otherwise afford them.

DISCUSSION

Five hypothesized sustainability-enhancing factors inherent to partnerships and their actions emerged from our examination of four community-care network partnerships: outcome-based advocacy, vision-focus balance, systems orientation, infrastructure development, and community linkages. These factors appear to also effectively differentiate between two partnerships showing high potential for sustainability from two that displayed low potential for sustainability. The context within which the partnership operates provides more or less salience to each of these factors as they affect value creation and a foundation for long-term sustainability. It would be misleading, however, to suggest that if partnerships simply focused on developing capacity in these five areas they would increase the likelihood of sustainability over the long term. First, neither of the two high-potential partnerships exhibited consistent strength across all five factors related to sustainability. What differentiated these partnerships from the low-potential organizations was a conscious attention to these issues and overall positive development across the five dimensions. By contrast, the low-potential partnerships showed problems in multiple factors and either did not recognize these problems or could not mount a serious effort to address them. Second, partnership context proved to be a key catalyst affecting the relative importance of the five sustainability

factors, as well as shaping or constraining the approaches taken to enhance value. For example, the political and historical context in which a partnership functions may give rise to a culture of collaboration on one hand, or a fierce desire for independence and autonomy on the part of local institutions on the other hand. Such differences are likely to express themselves in success or lack of success that partnerships experience in developing their sustainability factors. Third, although the heuristic value of the five sustainability factors is enhanced by separate presentation, in practice, these factors are likely to be highly interdependent. Problems in one area may create problems in another or conversely, strength in one area provides a foundation for developing another. For example, poor community linkages as expressed in little institutional ownership of the partnership may contribute to infrastructure problems such as lack of stable funding. Similarly, a strong systems orientation as expressed in the development of mutually reinforcing activities may contribute to the ability of partnership to mount a successful outcomes-based marketing campaign. The caveats cited above should be further explored in future research on partnership sustainability.

At least two challenges were common to all the study sites. First, all the partnerships studied seemed to struggle with achieving and maintaining an effective staff-partner balance. That is, all sites experienced conflict as to whether they should professionalize their partnerships by adding paid staff members to coordinate partnership activities, engage in a liaison and development with the local community, and provide continuity across initiatives. These advantages contrast with the perceived disadvantage of losing "ownership" of the partnership by volunteer members and/or the risk of disengaging this group by ceding certain activities to paid, professional staff. Partnerships engaged in this issue should reflect on whether they are interested in sustaining the partnership as an organization, on one hand, or sustaining the capacity to collaborate, on the other hand. Answering this question may provide direction for the partnership and its activities to take in the future.

A second issue faced by all partnerships in their quest to create value was balancing the dependence of the partnership on a lead organization versus establishing the partnership as an independent entity. For example, staffs of the partnerships are often employees of the lead agency of the partnership (e.g., hospital or health care system). Partnerships constantly struggle with the need for ongoing support from members with deep pockets, while at the same time recognizing that resource obligations need to be more widely diffused if ownership of the partnership and its activities is to be truly achieved. The resolution of such issues will likely be shaped by lifecycle considerations that would identify the stage of development of the partnership and its funding needs, as well as by a serious consideration of the implications for

independence versus dependence on the question of added value. If, for example, the capacity to collaborate can be more effectively developed under the sponsorship of a single organization, such as a health care system, then the quest for independence may not assume as great importance. On the other hand, if equal participation and contribution by all partners to the fiscal health of the partnership is viewed as a direct contributor to the capacity to collaborate, then the answer may be different.

Sustainability will continue to be an elusive concept from a research and practical perspective. This article has cited the dilemmas of deciding what should be sustained, how partnerships should approach the development of added value, and the importance of context and life cycle in shaping such approaches. From a practical standpoint, sustainability is essential because the length of the collaborative relationship is likely to be associated with positive performance, particularly with partnerships that must contend with complex issues requiring a long period of time to address (e.g., improvement in community health). However, sustainability should not be construed as performance. This is tautological and not only confounds two related concepts but leads to the logical trap of performance driving longevity, rather than vice versa. For example, the efficacy of selected interventions, mix of partners, and soundness of operational management may all directly affect performance while contributing to sustainability only indirectly. Sustainability, on the other hand, may at times have little to do with performance. A partnership may perform quite well in pursuit of its stated objectives but fail to survive because it prioritized the wrong goals (a case of doing things right but neglecting to do the right things). Partnerships must think seriously about what would create requisite value in their communities and how such value can be systematically developed by the partnership through collaborative activity. The identification of the five sustainability factors in this article may point partnerships in the right direction. However, it will be incumbent on partnerships themselves to develop a theory of action and periodically reassess the partnership and its activities to ensure that it is directed toward creating lasting value for the community.

Finally, it should be noted that one of our high-potential partnerships completely abandoned the original organizational structure of a partnership. In this case, the partnership became absorbed as an integral part of a larger health care system. The capacity to continue to form collaborative relations with community-based organizations and linkages with other providers remains, and in fact became institutionalized as a way of doing business in the health care system. This illustrates how the definition of sustainability may be critically important to its evaluation and assessment. Had we defined sustainability simply as the long-term perpetuation of the partnership qua-

partnership, the partnership in question probably would have been deemed a failure. This is not only an important research/conceptual issue but also a very practical issue for practicing partnerships. They must decide not only what they are trying to achieve but how best to position the partnership in the long term to achieve value in the quest of those goals. This could well mean that the partnership needs to sustain a mature and smoothly running infrastructure. However, this is not always the case. Ultimately, what the partnership brings to the community in terms of added value should determine the answer to "What should be sustained?"

REFERENCES

- Alexander, J. A., M. E. Comfort, and B. J. Weiner. 1998. Governance in public-private community health partnerships: A survey of the community care network demonstration sites. *Nonprofit Management and Leadership* 8 (4): 311-32.
- Alexander, J. A., M. E. Comfort, B. J. Weiner, and R. J. Bogue. 2001. Leadership in collaborative community health partnerships. *Nonprofit Management and Leadership* 12 (2): 159-75.
- Bazzoli, G. J., R. Stein, J. A. Alexander, D. A. Conrad, S. Sofaer, and S. M. Shortell. 1997. Public-private collaboration in health and human service delivery: Evidence from community partnerships. *Milbank Quarterly* 75 (4): 533-61.
- Bogue, R. C., and C. Hall, eds. 1997. *Health network innovations: How 20 communities are improving their systems through collaboration*. Chicago: American Hospital Publishing.
- Bogue, R. J., M. Antia, R. Harmata, and C. H. Hall, Jr. 1997. Community experiments in action: Developing community-defined models for reconfiguring health care delivery. *Journal of Health Politics, Policy and Law* 22 (4): 1051-76.
- Bolland, J., and J. Wilson. 1994. Three faces of integrative coordination: A model of interorganizational relations in community-based health and human services. *Health Services Research* 29 (3): 341-66.
- Butterfoss, F. D., R. M. Goodman, and A. Wandersman. 1993. Community coalitions for prevention and health promotion. *Health Education Research* 8 (3): 315-30.
- . 1996. Community coalitions for prevention and health promotion: Factors predicting satisfaction, participation, and planning. *Health Education Quarterly* 23 (1): 65-79.
- Cropper, S. 1996. Collaborative working and the issue of sustainability. In *Creating collaborative advantage*, edited by C. Huxham, 80-100. London: Sage.
- Doz, Y. L., and G. Hamel. 1998. *Alliance advantage: The art of creating value through partnering*. Boston: Harvard Business School Press.
- Gamm, L. D. 1998. Advancing community health through community health partnerships. *Journal of Healthcare Management* 43 (1): 51-67.
- Goodman, R. M., A. Wandersman, M. Chinman, P. Imm, and E. Morrissey. 1996. An ecological assessment of community-based interventions for prevention and health

- promotion: Approaches to measuring community coalitions. *American Journal of Community Psychology* 24 (1): 33-61.
- Green, L. 1997. Community health promotion: Applying the science of evaluation to the initial sprint of a marathon. *American Journal of Preventive Medicine* 13 (4): 225-43.
- Gulati, R., T. Khanna, and N. Nohria. 1994. Unilateral commitments and the importance of process in alliances. *Sloan Management Review* 35 (spring): 61-69.
- Hasnain-Wynia, R. 2003. Overview of the Community Care Network Demonstration Program and its evaluation. *Medical Care Research and Review* 60 (4 Suppl.): 5S-16S.
- Huxham, C. 1996. Collaboration and collaborative advantage. In *Creating collaborative advantage*, edited by C. Huxham, 1-18. London: Sage.
- Huxham, C., and S. Vangen. 2000. Ambiguity, complexity and dynamics in the membership of collaboration. *Human Relations* 53 (6): 771-806.
- Kegler, M. C., A. Steckler, K. McLeroy, and S. H. Malek. 1998. Factors that contribute to effective community health promotion coalitions: A study of 10 project ASSIST coalitions in North Carolina. *Health Education and Behavior* 25 (3): 338-53.
- Kreuter, M. W., N. A. Lezin, and L. A. Young. 2000. Evaluating community-based collaborative mechanisms: Implications for practitioners. *Health Promotion Practice* 1 (1): 49-63.
- Lasker, R., and E. S. Weiss. 2003. Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health* 80 (1): 14-47.
- Lofland, J., and L. H. Lofland. 1995. *Analyzing social settings: A guide to qualitative observation*. 3rd ed. Belmont, CA: Wadsworth.
- Norris, T. 2001. America's Communities Movement: Investing in the civic landscape. *American Journal of Community Psychology* 29 (2): 301-8.
- Okubo, D., and K. Weidman. 2000. Engaging the community core in public health functions. *National Civic Review* 89:309-25.
- Rundall, T. 1994. The integration of public health and medicine. *Frontiers of Health Services Management* 10 (4): 3-24.
- Shortell, S. M., A. P. Zukoski, J. A. Alexander, G. J. Bazzoli, D. Conrad, R. Hasnain-Wynia, S. Sofaer, B. Chan, B. Casey, and F. Margolin. 2002. Evaluating partnerships for community health improvement: Tracking the footprints. *Journal of Health Politics, Policy and Law* 27 (1): 49-91.
- Sink, D. 1996. Five obstacles to community-based collaboration and some thoughts on overcoming them. In *Creating collaborative advantage*, edited by C. Huxham, 101-9. London: Sage.
- Stoto, M. A., C. Abel, and A. Dievler. 1996. Sharing responsibility for the public's health: A new perspective from the Institute of Medicine. *Journal of Public Health Management and Practice* 3 (5): 22-34.
- Swain, D. 2001. Linking civic engagement and community improvement: A practitioner perspective on the communities movement. *National Civic Review* 90:319-34.
- Weiner, B. J., and J. A. Alexander. 1998. The challenges of governing public-private community health partnerships. *Health Care Management Review* 23 (2): 39-55.

- Weiner, B. J., J. A. Alexander, and H. Zuckerman. 2000. Strategies for effective management participation in community health partnerships. *Health Care Management Review* 25 (3): 48-66.
- Yin, R. K. 1994. *Case study research: Design and methods*. 2nd ed. Thousand Oaks, CA: Sage.
- Zuckerman, H. S., A. D. Kaluzny, and T. C. Ricketts, III. 1995. Alliances in health care: What we know, what we think we know, and what we should know. *Health Care Management Review* 20 (winter): 54-64.