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A Qualitative Exploration of Alternative Strategies for Building Community Health Partnerships: Collaboration- Versus Issue-Oriented Approaches

Allen Cheadle, Sandra Senter, Loel Solomon,
William L. Beery, and Pamela M. Schwartz

ABSTRACT *Broad-based community partnerships are seen as an effective way of addressing many community health issues, but the partnership approach has had relatively limited success in producing measurable improvements in long-term health outcomes. One potential reason, among many, for this lack of success is a mismatch between the goals of the partnership and its structure/membership. This article reports on an exploratory empirical analysis relating the structure of partnerships to the types of issues they address. A qualitative analysis of 34 "successful" community health partnerships, produced two relatively clear patterns relating partnership goals to structure/membership: (1) "collaboration-oriented" partnerships that included substantial resident involvement and focused on broader determinants of health with interventions aimed at producing immediate, concrete community improvements; and (2) "issue-oriented" partnerships that focused on a single, typically health-related issue with multilevel interventions that included a focus on higher-level systems and policy change. Issue-oriented partnerships tended to have larger organizations governing the partnership with resident input obtained in other ways. The implication of these results, if confirmed by further research, is that funders and organizers of community health partnerships may need to pay closer attention to the alignment between the membership/structure of a community partnership and its goals, particularly with respect to the involvement of community residents.*

KEYWORDS *Collaboration, Community health partnerships, Community-based health promotion, Resident involvement.*

INTRODUCTION

Broad-based community partnerships are seen as an effective way of addressing many community health issues. There is an extensive literature on community collaboration and community organizing that includes general arguments for collaborative approaches,[1–4] theoretical rationales,[5–7] specific strategies to promote community participation,[8–10] and case study examples of successful collaboration.[11–13]

Dr. Cheadle is with the Department of Health Services, University of Washington, Seattle, Washington; Ms. Senter and Mr. Beery are with the Group Health Community Foundation, Center for Community Health and Evaluation, Seattle, Washington; Dr. Solomon is with Kaiser Permanente, Community Benefit Program; and Ms. Schwartz is with Kaiser Health Plan and Hospitals, Center for Community Health and Evaluation, Oakland, California.

Correspondence: Allen Cheadle, PO Box 354804, University of Washington, Seattle, WA 98195. (E-mail: cheadle@u.washington.edu)

In addition, a growing movement toward community-based participatory research seeks to make academic and other institutions an integral part of the process of community collaboration.[14–16]

Lasker and Weiss provide a comprehensive summary of the partnership literature and develop their own model for a collaborative approach to community problem solving.[17] In developing their own model, they place particular emphasis on breadth of participation as a key factor in partnership success: "…the Community Health Governance model shows that broad engagement is more than an end in itself. It is needed to strengthen the capacity of the community to identify, understand, and solve complex problems and improve community health" (p. 26).[17] This emphasis on breadth of participation is echoed by others.[18–20]

At the same time, it is acknowledged that a partnership approach has had relatively limited success in producing measurable long-term outcomes, whether outcomes are defined as changes in community-level policies and systems or changes in health indicators. As Lasker and Weiss point out "…the experience with community participation initiatives over the last 40 years seems to have generated more frustration than results" (p. 15).[17] The few systematic reviews of the community partnership literature have been largely negative.[20,21] The lack of long-term results of many partnership-based initiatives have caused some to question of the value of this approach as a health improvement strategy.[22]

Some of this failure to demonstrate a measurable long-term impact may be the result of problems inherent in conducting experimental or quasi-experimental trials of community-based initiatives.[23,24] With community as the unit of analysis, only a small number of units can typically be included in an experimental or quasi-experimental design, and therefore, statistical power is limited. Because some form of health promotion activity is occurring in all communities, it is difficult to identify true controls. Also, it is difficult to achieve a measurable impact because intervention activities are typically small in relation to other factors that influence the chosen health outcomes. Collectively, these and other evaluation challenges may mean that community partnerships produce real benefits that go unmeasured.

Other reasons for a lack of demonstrated success may reflect real shortcomings in the partnership approach. One potential reason is a mismatch between the goals of the partnership and its structure/membership. As Kreuter et al. state, "The match of mission and membership is critical to a coalition's long-term survival" (p. 53).[21] Several authors have pointed to the need for choosing partnership members carefully to match the goals of the effort.[2,5,25,26] Partnerships are often complicated and difficult to manage, which is exacerbated in those with a larger and more diverse membership.[21]

As with many issues related to community partnerships, the relationship between goals and structure/membership has not been systematically examined. We are not aware of studies that have looked at a cross-section of partnerships and examined whether certain goals were more effectively addressed by certain forms of partnership structure/membership. This article reports on an exploratory empirical analysis relating the structure of partnerships to the types of issues they address. Specifically, results are presented showing two, relatively distinct approaches to building successful partnerships, which we label "collaboration-" and "issue-" oriented. Collaboration-oriented partnerships—those with the greatest amount of (nonprofessional) resident involvement—tended to focus on concrete projects in a number of different areas, often related to the broader determinants of health (e.g., education,

environment, employment). Issue-oriented partnerships—those that focused on a single issue (e.g., health system integration, asthma)—were less likely to involve residents and resident-driven organizations in a central role. Examples and summary characteristics for each type of partnership are presented.

METHODS

The results reported here grew out of a study sponsored by Kaiser Permanente (KP) to identify factors associated with successful community health partnerships. The KP study involved the development of a largely qualitative partnership database comprised of "successful" partnerships that was then used to search systematically for factors associated with their success. As the database analysis was being carried out, the particular pattern of goals/membership noted in the introduction was observed. This section defines several terms that require clarification and then describes both the construction of the database and the methods used in the qualitative analysis.

Definitions

Several terms that have been used frequently in a variety of contexts need to be clarified before describing the *Methods and Results*, including "community health partnerships," the distinction between "partnerships" and "initiatives," and our definition of partnership "success."

Community Health Partnerships Beginning with the North Karelia project[27] in Finland in the 1970s, there have been a growing number of community health improvement efforts that share several common features: a population-level focus on geographic communities, a collaborative approach involving partnerships between multiple organizations, comprehensive multilevel interventions, and a long-term perspective on health outcome improvement. For the purpose of this article, community-wide collaborative efforts sharing these characteristics will be labeled "community health partnerships" (CHPs or "partnerships").

CHPs include earlier community-based programs that focused on reducing specific diseases or health problems.[28–30] They also include more recent "comprehensive, community initiatives," (CCIs) such as the Healthy Cities and Communities movement.[31,32] CCIs view most dimensions of life in a community, including economic conditions, housing, and education, as either reflecting community health or serving as potential building blocks for community health improvement.

Initiatives Versus Partnerships The term "initiative" has been used to describe a variety of community-wide efforts at health promotion, whether in a single community or in multiple communities. However, for clarity in describing the community-level efforts in this article, we use the term "initiative" only for large-scale, multisite efforts involving more than one community. When a single community is involved, the effort will be referred to as a CHP or partnership.

Partnership success As described further below, the analyses reported here focused on a sample of "successful" partnerships. Because most initiatives have not measured and/or produced long-term health outcome changes,[21] "success" was defined as either sustainability of the partnership and its activities (including potential for sustainability for partnerships funded under current initiatives), or significant scope and scale of intermediate outcome achievement, including community

and system changes (e.g., changes in programs and policies). Both sustainability and intermediate outcomes were assessed qualitatively, relying on informants knowledgeable about multisite initiatives to identify more successful partnerships.

Constructing a Database of Successful Partnerships

The KP study involved identifying a sample of successful partnerships and creating a database to capture critical elements of those partnerships that could help us identify factors that made them successful. Database fields were generated from factors associated with partnership success found in the literature and other hypotheses about why partnerships succeed or fail. This list was reviewed by outside experts in the field of community-based health improvement. Fields captured descriptive information about the community (size, social and economic characteristics); partnership characteristics (history, structure, membership, governance, community involvement, staffing, resources); and partnership goals, interventions, and intermediate and long-term outcomes to date.

We used a purposeful approach to identifying successful community health partnerships for inclusion in the KP study database. For convenience in generating the greatest number of partnerships and for data availability, the focus was on larger-scale, multisite initiatives funded by private foundations and government agencies. These larger scale initiatives were identified through a combination of review articles and the personal knowledge of the study investigators about important and influential community-based initiatives. The principal criteria applied in selecting initiatives for inclusion in the KP study was to identify a representative cross-section of initiative types, including some of the narrower disease-focused ones and the more recent healthy communities initiatives. In addition to these multisite initiatives, we included several high-profile partnerships found in literature reviews. Eighteen multisite initiatives and 45 individual partnerships were included. Five of the 18 multisite initiatives were treated as a single "partnership" because they were research studies with a single, fairly well-defined partnership model, being implemented in a relatively small number of communities.

Contacts with initiative sponsors and evaluators were used to identify partnerships that had been particularly successful. As noted above, success was defined as either sustainability of the partnership and its activities (including potential for sustainability for partnerships funded under current initiatives), or significant scope and scale of intermediate outcome achievement, including community and system changes (e.g., changes in programs and policies). Approximately half of the partnerships were still being funded under their original initiative at the time of the study.

Database cells were filled using published data where possible and interviews with partnership key informants where published information was not available. In a few instances, informants could not be identified and only published information was used. The telephone data gathering focused on a few key fields: the degree to which the partnerships and/or its activities had been sustained, changes in the partnership structure over time, intermediate and long-term outcomes, challenges they faced and how they were overcome, and self-identified reasons for partnership success. The information was entered into the database and reviewed independently by two researchers to identify factors associated with partnership success and other themes. The final list of themes included only those identified as important by both reviewers.

Categorizing Partnerships as "Collaboration-" Versus "Issue-Oriented"

As noted earlier, the results presented here on collaboration- versus issue-oriented partnerships grew out of patterns observed as the investigators searched for factors

associated with successful partnerships. The successful partnerships that had the greatest amount of resident involvement tended to focus on broader determinants of health (e.g., education, environment, employment) with a wide array of projects yielding immediate, concrete benefits to the community. By contrast, partnerships that focused on a single health-related issue (e.g., health system integration, asthma) were less likely to involve residents or resident-driven organizations in a leading role.

To formalize the distinction, we created the terms "collaboration-oriented" and "issue-oriented" to describe the two types of partnerships observed in our sample. Two basic criteria were used: (1) extent of collaboration—was there a broad-based partnership that included community residents and/or resident-driven community-based organizations in a central decision-making role; and (2) issue focus—was there a focus on a single issue versus multiple diverse issues? These two criteria created a potential two by two table: broad-based collaboration (yes/no) and single/multiple issues being addressed. It should be noted that the terms "collaboration-" and "issue-oriented" suggest a clearer distinction than what may be actually present. Issue-oriented partnerships still involve a substantial amount of collaboration and collaboration-oriented partnerships still address important issues related to community health. The terms should be viewed more as a shorthand way of describing a subtle, but real distinction that was observed between partnership membership/structure and goals/activities.

Two raters reviewed 34 partnerships in the database where information was adequate to determine both the extent of collaboration/resident involvement and the major focus of activities. Raters classified the partnerships as either primarily collaboration oriented, primarily issue-oriented, or both (for example, a single issue-oriented partnership that has a high degree of resident involvement in decision-making). A level of confidence (high, medium, low) was assigned by each rater to their assessment. In addition to the classification of partnerships into collaboration- and issue-oriented categories, a qualitative analysis was carried out independently by two researchers to identify common characteristics associated with each partnership type. The final list of characteristics included only those identified as important by both reviewers.

RESULTS

Results are presented showing the distribution of partnerships as collaboration-oriented or issue-oriented, and the characteristics associated with each type of partnership.

Distribution of Partnerships Between Collaboration- and Issue-Oriented

Of the 34 partnerships reviewed, the two raters agreed on the classification of all but four of them (88% agreement). After reviewing the information and discussing the cases, these four partnerships were classified as either both collaboration- and issue-oriented (n = 2) or issue-oriented (n = 2). After reconciling the interrater disagreements, 15 partnerships were classified as issue-oriented (44%) and 16 as collaboration-oriented (47%). Only three partnerships (9%) were classified as both collaboration- and issue-oriented. Thus, it was rare to have partnerships that included community residents, or resident-driven organizations in a prominent role working on a single health-related issue. None of the partnerships occupied the fourth cell of addressing multiple issues with limited community involvement.

Table 1 gives examples of partnerships in each of the two categories. The collaboration-oriented example is an urban partnership in a relatively small geographic

TABLE 1. Examples of collaboration- and issue-orientated partnerships

Characteristics	Collaboration-oriented	Issue-oriented
Community size, partnership dates/status	Urban, population: 23,000. Partnership founded in 1993, still active.	County-level, mixed urban/rural, population: _ 470,000. Partnership founded in 1993, still active.
Partnership structure/governance	Three partners: Health department, community health council, and community consortium representing 20 community-based organizations. Governed by Steering Committee that includes five resident members.	Volunteer board includes members from local government, federally qualified health centers, and health providers.
Goals/activities	• Increase capacity of residents. • Work in a variety of community improvement activities, including health promotion and solid waste. • Respond to social and environmental issues related to local airport: lay-offs due to September 11th, a Good Neighbor Policy, and noise pollution.	• Work to provide more integrated health services in the county.
Outcomes	• Established "neighborhood colleges"—community resident leadership trainings. • Helped improve solid waste disposal system. • Improved lighting in neighborhood.	• Implementing single point of entry system designed to provide better-coordinated services, allowing patients to go to the right place for services.
Factors associated with success	• Community resident training. Strong, collaborative community agency leaders. • Strong community group with a track record and emphasis on building capacity. • Addressing multiple issues, allowing for broader community engagement in the work of the partnership.	Having a clear and specific focus. Investment in and disproportionate weight given to relationships. Creating an objective and safe environment to advance our work. Not being afraid to stretch. • Using established management principles to balance process and outcomes.

area (population 23,000). Partnership members include the health department and an array of community-based organizations of all sizes. Residents are integral to partnership governance: there are five regular resident members of the governing board. The partnership goals include increasing the capacity of residents as well as working on a variety of community improvement activities. Outcomes include improvements to neighborhood lighting and the solid waste disposal system. Factors associated with success included having provided resident training, having a strong community group as a partner, and a focus on multiple issues, which gave more people a reason to be involved.

The issue-oriented example summarized in Table 1 is a countywide partnership established with the goal of achieving a more integrated health services delivery system. Partnership members include health providers, federally qualified health centers, and local government. The main outcome is implementing a single point of entry to the delivery system to allow for better coordinated services. Reported factors associated with success included a clear and specific focus, emphasis on relationship building, and using established management practices to balance process and outcomes.

Characteristics of Collaboration- Versus Issue-Oriented Partnerships

The qualitative analysis of the different types of partnerships revealed some clear themes (summarized in Table 2). Examples illustrating the themes for collaboration- and issue-oriented partnerships drawn from the database are shown in italics.

Primary Objective Not surprisingly, those partnerships that were identified as collaboration-oriented tended to have the creation of a broad-based partnership as an explicit goal at the beginning of the initiative; for example:

The mission of the partnership is to promote collaborative programming among community organizations and to encourage the integration of community services to effectively and efficiently improve the quality of life and health of county residents.

Issue-oriented partnerships had goals related to a single problem or issue, whether a focus on a specific disease (e.g., asthma) or a specific sector of the community (e.g., health system change):

The partnership mission is to create a sustainable model of asthma care…that will reduce hospitalizations, emergency department visits, and school absences and improve quality of life for children who have asthma and their families.

Reason Formed Both types of partnerships were formed frequently in response to a specific Request for Proposal (RFP) and occasionally in response to a community crisis or event. If not formed in response to an RFP, collaboration-oriented partnerships tended to grow out of a need for greater networking and collaboration among community-based organizations.

The partnership was created in 1994 by a number of local nonprofits to avoid unnecessary competition around projects and resources and to better coordinate events. Over time, community groups began to share information and work collaboratively on a number of projects.

By contrast, issue-oriented partnerships not responding to RFPs tended to grow out of specific issues identified as important by community stakeholders:

The group was brought together by the hospital a year before (the formal initiative started) due to concern about the number of repeat admissions for newborns with health problems—most were babies of teen moms. It involved the schools, service providers, and health care agencies. Focus shifted toward pregnancy prevention.

TABLE 2. Partnership characteristics: collaboration- versus issue-orientation

Characteristics	Collaboration-oriented	Issue-oriented
Primary objective	• Build a broad-based community partnership to address a number issues affecting health.	• Develop a comprehensive community-based approach to addressing a specific health issue
Reason formed	• Recognized need for cooperation among key stakeholders.. • Response to RFP calling for community partnerhips	• Response to community crisis/widely recognized problem. • Response to RFP for specific health issue.
Role of community residents/ grass roots organizations	• Resident participation extensive. • Residents an important part of governance process.	• Resident representation in governance limited. • Resident input sought in other ways (focus groups, community meetings).
Programs/activities	• Multiple areas addressed. • Focus on broader determinants of health (e.g., education, public safety). • Concrete immediate benefits.	• Multilevel approach to single issue, including policy and systems change. • Focus more likely to be narrower health issue.
Intermediate outcomes/community changes	• Sustained partnership producing multiple projects. • New programs and services.	• New programs and services. • Systems and policy changes.
Factors associated with success	• The ability to mobilize the community. • Leadership development training for residents.	• Strong leadership.

RFP, Request for proposal.
Based on review of data from 34 successful partnerships (see text).

Role of Community Residents/Grass roots Organizations By definition, collaboration-oriented partnerships had extensive resident involvement, including involvement in decision-making. The following is an example of how one partnership involved residents:

The primary modes of resident participation within the partnership include participation in the Team Leaders' meeting and within the Teams, especially the Highway Safety Team. With time, participation, and communication, residents and other participants (i.e., sheriff department staff) have come to be seen as valued and trusted team members with unique resources and a sincere interest in and commitment to the work of the group.

Issue-oriented partnerships also emphasized resident involvement but the involvement tended to be more input than control; for example, participation at a community meeting to give input on partnership objectives and strategies:

Although (the partnership) struggled with recruiting residents to be collaborative members, resident input was obtained through community meetings and other more informal methods.

Programs/Activities Collaboration-oriented program activities tended to focus on the broader determinants of health and involve multiple issue areas.

Efforts included "cops and shops" forums to promote public safety and facilitate communication with merchants, community meetings to develop standards for alcohol sales, distribution of condoms, treatment of adults with drug and mental health problems, and a community newsletter. The health department convened multiple groups to improve nutrition of low-income residents. Designed food security program to increase resident access to fresh produce.

Issue-oriented partnerships (by definition) focused on a single issue, usually addressed with a comprehensive, multilevel approach that included both individual-level interventions and systems and policy changes.

Education and support for asthma education are being provided in the home by two Community Health Workers. The partnership is also providing asthma control support to schools through "Team Asthma Goes to School (TAGS)." Systems-level interventions include improving coordination across levels (e.g., development of a common asthma action plan for use by schools, clinics, community health workers and childcare sites) and promoting asthma control policies (e.g., promoting coordination of care and services through creating access to common client-specific asthma-related health data).

Intermediate Outcomes/Community Changes Collaboration-oriented outcomes typically included more immediate, concrete, visible community benefits (e.g., improved lighting, neighborhood safety, community gardens).

Assault arrests decreased by 36%, violent crime arrests decreased by 47%. Social services were provided to 1000 homeless families, 1100 hours of treatment for drug/mental health patients through outreach, 5000 contacts by mobile crisis team, 20,000 students/residents provided safe sex education. Food security project provided free gardening supplies and information to 3000 community gardeners, raised $25,000 to open new farmer's market, supported school gardens, trained youth in gardening and business skills, increased access to fresh food for 3000 residents.

Issue-oriented outcomes focused more on high-level systems changes and sustainable programs.

The community-health worker program was established and is continuing. There have been changes in clinical practice from the "learning collaborative" intervention. Childcare provider training shows an increase in knowledge. Two referral

systems are in place and functioning—one that links community members to appropriate services and information; and one that links clinicians to community services.

Factors Associated with Success There were a number of success factors identified that were common to both types of partnerships, including a history of collaboration, mutual respect and trust, open and frequent communication, a shared vision, attainable goals, paid staff, and skilled leadership. In addition, there were a few factors specific to either collaboration- or issue-oriented partnerships. Most of the collaboration-oriented partnerships implemented some form of leadership training to help residents take an active role in partnership decision-making:

Community resident training was an important factor. Partnership members and neighborhood residents increased their leadership capacity through trainings offered in Tiers 1 and 2 of the neighborhood college.

In addition, the successful collaboration-oriented partnerships had a history of mobilizing residents and grass roots groups.

It is a strong community group with years of community organizing experience.

The most commonly mentioned reason for success in the issue-oriented partnerships was strong leadership.

We have a strong, active (80% attendance) board made up of key leaders from health care, schools, and business.

DISCUSSION

A qualitative analysis of 34 "successful" community health partnerships produced two relatively clear patterns relating partnership goals to structure/membership: (1) "collaboration-oriented" partnerships that included substantial resident involvement and often focused on broader determinants of health with interventions producing immediate, concrete community benefits; and (2) "issue-oriented" partnerships that focused on a single, usually health-related issue with interventions aimed at a variety of levels, including systems and policy change. Issue-oriented partnerships tended to have larger organizations governing the partnership with resident input obtained in other ways.

The figure provides another way of viewing the results and offers a simple format for speculating about the dynamics that might lie behind the observed pattern. The figure shows the four potential partnership types, categorized by whether the goals/activities are focused in one or multiple areas and whether resident involvement is limited or substantial. Almost all of the successful partnerships in our sample were on the diagonal from lower left to upper right: either with a single goal and limited resident involvement or multiple goal areas and more substantial resident involvement. A key question is whether this pattern was simply an artifact of our sampling strategy or whether there is some underlying dynamic that causes successful partnerships to fall into these two categories. In particular, are there forces at work that make the "off-diagonal" partnerships unstable/unsustainable and likely to evolve into either being issue-or collaboration-oriented partnerships? The following is based on our experiences from major initiatives we have evaluated in the past.

Several large-scale initiatives that we have been involved in started in the lower right hand corner of the figure—focused on a single health or systems objective and asking partnerships to involve a broad range of community stakeholders, including community residents. In many cases, the resident members of the partnership lost interest during the extended planning sessions required to develop a comprehensive,

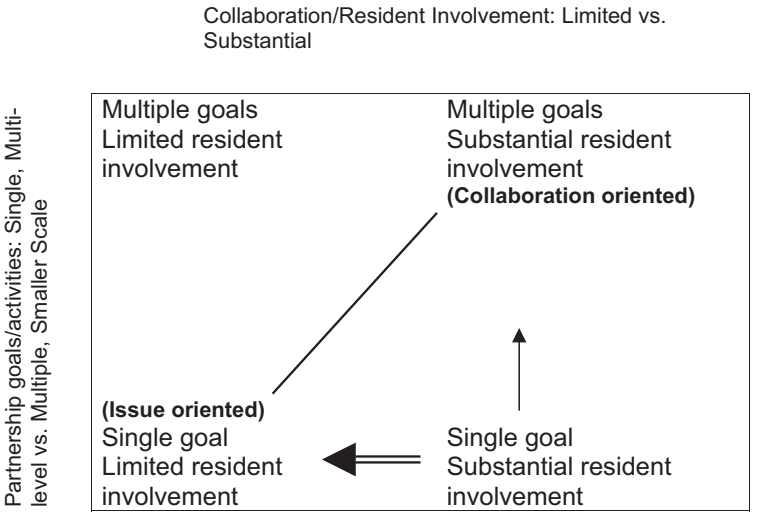

FIGURE. Evolution of community health partnerships into issue- and collaboration-oriented types.

multilevel strategy for addressing the issue. In addition, there were frequently language, cultural, and class barriers between residents and professional members that made the residents reluctant or unable to participate actively (a problem noted by others[33]). In our experience, there are three primary ways this situation was resolved. First, the residents left the partnership, or at least stopped attending meetings. The partnership evolved into an issue-oriented model, with limited nonprofessional involvement. This has been the most common outcome in the initiatives we have evaluated and is illustrated by the thicker arrow in the figure. A second outcome is that the partnership adapted to meet the needs of residents: created roles suited to residents interests and skills and/or pursued activities more in line with their interests—including the concrete activities focused on broader determinants of collaboration-oriented partnerships. This has occurred less frequently in our experience (illustrated by the thinner arrow in the figure). The third outcome is that the partnership continued to struggle to maintain both resident involvement and a higher or multilevel focus and was unable to make much progress beyond the planning phase, that is, was unsuccessful (and therefore would not have appeared in this sample).

The other potential partnership type in this classification scheme—pursuing multiple goals with limited resident involvement—did not appear at all in our sample of 34 partnerships. This may be an artifact of our sampling strategy; in particular, the multisite initiatives in our sample either emphasized a single area of focus (specific health condition or health system change) or attempted to promote broad-based community collaboration, with the issues largely unspecified. Therefore none of the initiatives in our sample started with multiple goals and did not ask partnerships to involve residents. Some more recent initiatives are attempting to address a number of health conditions in a more integrated way with a partnership-based approach (e.g., STEPS to a Healthier US addressing obesity, diabetes, and asthma).[34] These initiatives may provide an opportunity to assess whether multiple issues can be addressed effectively with a higher level approach and limited resident involvement.

As noted in the *Introduction*, there is a relatively sparse literature that we are aware of empirically addressing the match between partnership goals and membership.

The results suggesting that residents become more actively involved when the issues addressed are concrete and related to broader determinants of health are consistent with the existing literature on community mobilization. Authors focusing on community organizing and mobilization have repeatedly emphasized the importance of "starting where the people are"—that is identifying issues that are of immediate concern to community residents.[36,37] The issues that motivate residents tend to be more focused on the broader determinants—economic issues, environment—than on more directly health-related issues (e.g., asthma, diabetes, access to health care). Reports from both the Partnership for the Public's Health initiative and the Casey Foundation note the challenges of involving residents and outline a number of strategies that include engaging residents around issues related to basic needs.[10,37]

Not surprisingly, there is even less literature arguing for narrower partnerships with less resident involvement, but as noted earlier, several authors have mentioned the importance of matching membership to objectives.[21,25] This was confirmed by comments from some issue-oriented partnership informants who reported having the high-level "key players" is crucial to partnership success.

IMPLICATIONS

The strongest implication of these results, if confirmed by other research, is that funders and organizers may need to pay greater attention to the alignment between the structure/members of a community partnership and its goals than is generally recognized. In particular, if the goal is to produce systems and policy change targeting specific health issues, it may be unrealistic to include residents in a central role. Conversely, if initiatives seek to build community and increase social capital by strengthening resident involvement, they may need to forego a narrow focus on specific health topics and address broader issues of community concern.

The health outcomes that are reasonable to expect from the two different partnership types also may differ. In particular, it may be unrealistic to expect resident-driven, collaboration-oriented initiatives to produce measurable health-outcome changes over the 5-year time horizon often given issue-oriented partnerships. The effects of greater resident involvement on health status measures will likely take longer, whether they occur through the accumulation of many small activities focusing on broader determinants of health or through the direct health benefits that residents obtain from their participation in partnership activities (see Berkman et al.[38] for a summary of the relationship between participation in social networks and health).

The three partnerships in the sample that were classified as both collaboration- and issue-oriented offer some lessons as to how to creatively involve residents and still focus on a single issue. Two involve a single issue with multilevel interventions, focused in one case on teen pregnancy and in the other on substance abuse. Both have a flexible committee structure with action-oriented committees that involve residents in planning and implementing interventions, although neither have residents in a central governing role for the overall partnership. One of the two partnerships is in the process of widening its focus somewhat to include public safety and other issues, similar to a collaboration-oriented partnership, although its core area remains substance use. The third partnership is working to create a community wellness center. They used an initial community summit to create connections among a wide range of stakeholders, including consumers/residents, and have maintained the connections with six geographically based community health committees.

LIMITATIONS

A number of study limitations should be noted. Most obviously, the observation that there are two broad patterns of partnership goals and structure/membership was generated from a qualitative exploration of a single nonrandom sample of 34 partnerships. This should in no way be viewed as confirming a pre-existing hypothesis. Nonetheless, the sample is relatively large, and an effort was made to get a broad representation of partnership sizes, goals, and structures. Standard qualitative techniques were used in identifying the pattern and the investigators had no preconceived ideas in favor of finding this pattern.

A second limitation is that the study focused only on successful partnerships, so that the observed pattern of collaboration/issue focus was not confirmed in less-successful ones. We focused on successful partnerships largely for practical reasons related to the short time frame available for data gathering and analysis. Unsuccessful partnerships often no longer exist, making it difficult to find informants to describe partnership characteristics or the reasons why they failed. The investigators felt that more could be learned from an in-depth analysis of successful partnerships with relatively rich data available, rather than combining it with sparse, and more unreliable information gathered from unsuccessful partnerships. If the arguments advanced in the discussion of the figure above are correct, a sample of unsuccessful partnerships might include examples of single-issue focus with high resident involvement that were (for example) unable to move beyond the planning phase.

Another limitation is related to the quality of information included in the database. For three of the 18 multisite initiatives, some of the authors of this study were closely involved in the overall initiative evaluation and therefore very familiar with the partnerships. For other initiatives, the authors had to rely on a single informant and document review for the information. Some of the critical constructs, including the degree and nature of resident involvement may not be candidly and accurately reported to an unknown outsider. In particular, resident involvement may, in some cases, be more "token" than is described in funder progress reports or stated to outside interviewers.

CONCLUSION

This exploratory qualitative analysis suggests that funders and organizers of community health partnerships may need to pay close attention to the alignment between the membership/structure of a community partnership and its goals, particularly with respect to the involvement of community residents. Also, those wishing to involve residents in single-issue efforts may need to work harder and be more creative and strategic when the overall focus is on higher level systems and policy change. Further research is required with better data and a more diverse and representative sample of partnerships to confirm the findings. If nothing else, this study demonstrates the potential value in systematically building an evidence base of community health partnerships.

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