Local Public Health System Partnerships: A Mixed Methods Multi-State Study

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The purpose of this three-paper dissertation was to conduct a mixed methods multi-state examination of specific partnership-related activities among local public health systems (LPHSs) as well as to explore perceptions of LPHS practitioners regarding partnership practices.

In the first paper, secondary data analysis of questions from the National Public Health Performance Standards Program (NPHPSP, $n = 110$) was used to determine the frequency that partnership activities were conducted optimally ($\geq 75\%$ of the time) and whether any associations existed between three different partnership capacities. Activities were matched with relational, organizational, and programmatic capacities from the Collaborative Capacity Framework. Overall, 86\% of LPHSs reported non-optimal performance in all three capacities. The capacity that was most often conducted optimally was relational (15\% of LPHSs). The least frequent activity was review of partnership effectiveness (organizational capacity, 4\% conducted optimally). LPHSs that performed optimally in one capacity were statistically more likely to do so in the other two capacities.

The second and third papers explored perceptions of local health department (LHD) practitioners and their partners about characteristics contributing to LPHS
partnership mobilization and success. Semi-structured interviews were conducted and key findings were interpreted using metaphoric analysis. Public health practitioners described leading and administrating activities; however, some practitioners were interested in taking a support role more frequently. Practitioners reported using national assessment models and general community building principles as well as formally- and informally-structured partnerships. Practitioners, however, preferred to formalize partnerships by using contracts, memoranda of understanding, and subcommittees. Partners described working together more often in rural areas due to limited resources, but also reported greater concern of burnout. Partners’ reported multiple roles in the partnerships, but did not express a desire to play more of a leadership role. Motivations to participate ranged from personal to organizational among these partners.

In general, LPHSs conducted partnership activities at non-optimal levels across all three capacities, particularly in reviewing effectiveness. LHDs’ desire to take less of a leadership role was not echoed in the interviews with their partners. LHDs will need to consider specific partners’ motivations and expectations of their roles in order to optimize their partnerships.
In memory of Dr. Charles Blair –

a servant leader who worked tirelessly to build community partnerships in order to eliminate health disparities
ACKNOWLEDGMENTS

Thank you God for guiding me through every step of this marathon and for teaching me that crossing the finish line is not based on speed alone. Finishing the race is largely measured by having the courage to run in the first place, persevering through the challenging parts of the course, keeping a steady pace, and most importantly, finishing strong. Thank you, God for blessing me with so many people who invested their time and resources to ensure that I completed this race successfully.

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With the support received from God and others, I ran and finished this leg of the race! Now, the Olympic trials begin . . .

Priscilla A. Barnes
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CHAPTER I

INTRODUCTION

The purpose of this dissertation was to conduct a multi-state examination of specific activities related to partnership mobilization and to explore perceptions of local health department (LHD) practitioners and their partners. The dissertation is presented as five chapters including an introduction (Chapter I), three separate research studies (Chapters II, III, and IV), and a conclusion (Chapter V). Chapter I outlines the importance of partnership as an approach in improving the function of the public health system. Additional factors influencing the initiation and operation of partnerships as well as a framework for the three studies are also presented. Chapter II is a quantitative study, in which a theoretical framework is used to provide a national examination of specific partnership activities reported in the second version of the National Public Health Performance Standards Program (NPHPSP) by local public health systems (LPHSs). Chapter III is a qualitative interview study, in which a metaphor of theatre is used to analyze key characteristics in mobilizing partnerships as perceived by public health practitioners representing LHDs. Chapter IV is also a qualitative interview study, in which thematic analysis is used to explore characteristics contributing to successful partnership practices as identified by LHD partners. In Chapter V, key findings of the three studies are summarized and implications for practice are presented, in addition to recommendations for future studies and concluding remarks.
Significance of Using Partnerships in Public Health

Since the release of the 2002 Institute of Medicine’s *The Future of the Public’s Health* report, increased attention has been given to multi-sector partnerships involving public, private, and voluntary organizations and individuals within the public health system.\(^1\)\(^-\)\(^3\) The formation of these partnerships has resulted in organizations and individuals responding to natural and man-made disasters more cooperatively, addressing diminished financial and human resources, and meeting challenges of educational and service delivery in an effort to improve the public’s health.\(^3\)\(^-\)\(^6\)

In general, partnerships allow organizations and individuals achieve a common goal, as well as address issues that are larger and more complex than a single organization’s mission. It is widely postulated that partnerships increase the effectiveness and productivity of community initiatives by empowering stakeholders to collectively address health issues, thus building trust and accountability, and reducing duplication of resources.\(^2\)\(^,\)\(^5\)\(^,\)\(^7\)\(^,\)\(^8\) Although the literature highlights the importance of partnerships and their impact on community health, limited research has examined specific partnership activities conducted by public, private, and voluntary organizations from a national perspective. In addition, elements contributing to successful mobilization and operation of partnerships among public health practitioners representing LHDs and their partners have not been explored. It is important to identify current level of activities and beliefs of practitioners and their partners in order to better align resources and enhance the organizational infrastructure of the public health system.
Defining Local Public Health Systems

The term *LPHSs* is used to describe an organizational network comprising LHDs, public, private, and voluntary organizations, as well as individual volunteers, working together to improve the quality of public health practice and performance in counties, cities, regions, and districts in the U.S.\(^1\) All of these entities have an integral role in improving the public’s health through providing and coordinating direct services, leading and facilitating partnership activities, and influencing community level policy.\(^1\),\(^10\)-\(^12\) As a result, individuals within LPHSs work collaboratively to use human, material, and organizational resources to maximize opportunities to improve overall population health.

LHDs are considered one of the major “actors” in the LPHS.\(^1\) As “units of governments” in most communities, LHDs are responsible, primarily through mandates, to protect the public’s health by ensuring healthy conditions for the people they serve.\(^13\)-\(^14\) Historically, governmental public health agencies have worked independently to protect the public from epidemics and diseases, prevent injury, promote healthy lifestyle practices, ensure environmental conditions, and assure quality and accessible services.\(^13\) In order to protect the public’s health, LHDs’ work is rooted in three core functions: assessment, policy development, and assurance. Assessment relates to responsibilities related to the systematic collection, analysis, and distribution of public health data; policy development ensures comprehensive plans, legislature, and policies are guided by scientific knowledge; and assurance pertains to the provision and regulation of service that align with public health goals.\(^1\),\(^13\) Although the core functions provide a general idea of LHDs’ roles, they lack specificity in how public health practitioners are to carry out its
responsibility and do not show how other organizations and individuals in local communities play an integral role in impacting population health. As a result, the ten essential public health services were developed to provide governmental public health agencies, organizations, and individual volunteers with a framework so they might be more intentional in their efforts to improve coordination and population health (Table 1.1).

Table 1.1. Three Public Health Core Functions and Ten Essential Public Health Services (ES), U.S.

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<th>Core function: Assessment</th>
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<td>ES#1: Monitor health status to identify community health problems</td>
<td>ES #6: Enforce laws and regulations that protect health and ensure safety</td>
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<td>ES#2: Diagnose and investigate health problems and health hazards in the community</td>
<td>ES #7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable</td>
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<td>Core function: Policy development</td>
<td>ES #8: Assure a competent public health and personal health care workforce</td>
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<td>ES #3: Inform, educate, and empower people about health issues</td>
<td>ES #9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services</td>
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<td>ES #4: Mobilize community partnerships to identify and solve health problems</td>
<td>ES #10: Research for new insights and innovative solutions to health problems</td>
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<td>ES #5 Develop policies and plans that support individual and community health efforts</td>
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Assessing Partnership Activities in LPHSs

Public health assessments have been used to capture performance in these 10 essential services of partnerships as a system and with several agencies within the system. The NPHPSP, a national assessment, measures baseline and ongoing improvements related to overall system public health performance. Within the NPHPSP, several
activities assess LPHSs’ efforts in mobilizing partnerships among private, public, and voluntary organizations.

Within the NPHPSP assessment, two performance standards assess LPHSs’ performance in mobilizing community partnerships. Constituency development examines the process LPHSs use to establish relationships among current and potential stakeholders and community partnerships examine existing relationships that encourage organizations and individuals within LPHSs to share resources and identify ways to improve community health. Seven indicators of constituency development and community partnerships are used to measure the level of activity in order to increase understanding of current performance in mobilizing partnerships. In addition, other essential services examine partnership activities as it pertains to educating population through health promotion, participating in emergency preparedness coalitions, and establishing a community health improvement process to address priorities as identified by LPHSs. Together, these indicators can be used by LPHSs to improve their efforts in partnership mobilization and implementation (Figure 1.1).

Although mobilizing and implementing partnerships is being encouraged, the public health field still lacks information regarding specific partnership-related activities conducted by LPHSs. Several studies have assessed each public health service and overall performance; however, specific activities related to partnership mobilization in the NPHPSP have not been reported from a national perspective. Examining these activities is needed to assess the current state of partnership mobilization occurring in LPHSs. This information can then be used to improve effectiveness of current partnerships and help encourage new partnerships.
Theoretical Perspectives Concerning Partnerships

Theoretical propositions and constructs can serve as an additional framework for LPHSs to use when examining elements that are present or absent in their partnerships. Limited research has studied specific public health partnership-related activities that align with theoretical constructs related to partnership and collaboration. One study identified constructs rooted in social network analysis that considers the relational ties and strengths of interactions between LHDs and their partners within LPHSs. Several studies described core partnership activities used in community assessment models, such as Mobilizing Action for Planning and Partnerships (MAPP), in building internal capacity of LPHSs. No studies, however, have conducted a national examination of specific public health partnership-related activities conducted by LPHSs using a theoretical framework.

Several theoretical models, such as the Community Coalition Action Theory and the Partnership Synergy assessment, examine partnership formation, sustainability, internal and external dynamics among members, and efforts in achieving goals and
implementing strategies.\textsuperscript{2,22} Foster-Fishman, Berkowitz, Lounsbury, Jacobson, and Allen (2001) developed a theoretical framework that describes key processes and core competencies related to collaborative capacity.\textsuperscript{23} Collaborative capacity considers key capacities necessary for effective and sustainable partnerships. According to this model, member, relational, organizational, and programmatic capacities are essential for partnerships to effectively mobilize, operate, and sustain their function over a period of time or until overall goals and objectives are achieved (Figure 1.2). \textbf{Member capacity} includes knowledge and skills that members of these organizations bring to the partnership. These attributes are based on organizational members’ ability to work with others, create effective programs, recruit and retain members, and build a structure where the partnership may carry out its mission in an organized and participatory manner. Members must have positive relationships about one another and also be committed to implementing strategies and programs developed by the partnerships. \textbf{Relational capacity} concentrates on the development of a shared vision, power sharing, and positive external relationships and creating a climate where values and diversity are respected. \textbf{Organizational capacity} focuses on the operational structure of the partnerships that include, but is not limited to, roles and responsibilities; formalized communication and decision making procedures; and financial, human, or in-kind resources to sustain partnership efforts over time or until goals are achieved. Lastly, \textbf{programmatic capacity} considers the evaluative function of the partnership that allows the partners to determine if goals have been accomplished and improvements made in their efforts. It is driven by the need to have specific, realistic, and measurable objectives that are unique in meeting population-based needs.
Figure 1.2: Theoretical Framework for Examining Collaborative Capacity among Local Public Health Systems (LPHSs)

This framework was created based on an extensive literature review of work on coalitions and partnership practices in public health and community development. The Collaborative Capacity Framework has been documented in social sciences.\textsuperscript{24-25} The framework, however, has not been used to assess collaborative capacity of governmental public health, particularly of those that work on mobilizing partnerships from a systems approach. This framework was selected as a means of examining what capacities are needed to strengthen the infrastructure in which these partnerships operate.
Influence of Perceptions in Initiating and Operating Partnerships

Several public health assessments have been developed to quantify the work and activities of public health practitioners in mobilizing and operating partnerships. The National Association of County and City Health Officials (NACCHO) National Profile Study, for example, captures types of organizations who collaborate with LHDs in various activities. The NPHPSP examines levels of activity and ongoing improvements in coordinating and delivering public health services of organizations within LPHSs, which includes efforts made by LHDs. These assessments, however, do not capture all factors that might affect initiation and functioning of partnerships, such as involvement of influential people and organizations; roles of partners, credibility and commitment from partners, structure, and setting in which a partnership is located. Any one or combination of these factors alone can contribute to the success of partnerships. Given public health's current approach as a system, it is important to understand how factors contribute to building successful partnerships within LPHSs.

Governmental health agencies, non-governmental organizations, and volunteers may vary in their views about, as well as approaches to, developing partnerships within the LPHS. For instance, there may be differences in the approaches to initiating and developing partnerships, who in the partnership are taking leadership roles, how community assessment processes work, structure of the partnership, and interactions within the partnership that impact LPHS partnerships in unique ways. These differences may affect the overall effectiveness of partnerships being used to address public health issues. In determining how these factors impact partnerships within the LPHS, it is
important to gather the perceptions of these practitioners at the "ground level" and the people representing organizations and individuals. Limited studies have explored perceptions among public health practitioners and their partners concerning characteristics that contribute to successful partnerships. Identifying these factors can improve LPHSs' efforts in partnership mobilization and maintenance.

**Related Purposes of the Three Studies**

The central purpose of this dissertation is to examine specific partnership activities and explore perceptions of public, private, and voluntary organizations within LPHSs in mobilizing and executing partnership activities. The three studies are related, but independent studies (Figure 1.3). Findings from this dissertation align with previous studies examining partnership activities occurring within LPHSs that were primarily conducted by LHDs.\(^{16,29,30}\) However, this dissertation extends beyond LHDs by examining specific partnership activities conducted at a national level among public, private, and voluntary organizations and individual volunteers within the public health infrastructure.

The first study examines the frequency and level, in which partnership activities are mobilized as reported by LPHSs. Secondary data analysis was used to determine the frequency with which partnership-related activities were being conducted in a national sample of 110 LPHSs participating in the second version (2008-2009) of the National Public Health Performance Standards Program (NPHPSP). Specific individual activities and an example of partnership (i.e. emergency preparedness) being conducted by LPHSs were examined in order to identify current level of performance in the U.S. The
Collaborative Capacity Framework was used to describe the level of performance in three areas: relational, organizational, and programmatic capacities. Analyzing data using this framework will serve as a guide to further understand characteristics needed to build successful partnerships within LPHSs.

The second study explores perceptions of LHD practitioners regarding characteristics contributing to their partnership mobilization practices with private, public and voluntary organizations. Semi-structured interviews were conducted for data collection and a theatre metaphor was used to interpret key findings. In addition, characteristics contributing to partnership mobilization were explored through the everyday experiences of practitioners responsible for mobilizing and operating partnerships. This study was conducted to provide more information about how and why partnership mobilization practices occurred that were not assessed in the NPHPSP, such as the role of LHD, the structure in which these partnerships occur, and the approaches used to recruit organizations and individuals to participate in public health issues.

The third study explores characteristics from the perspectives of individuals representing public, private, and voluntary organizations and volunteers that participate in partnerships with LHDs. Interviews were also used for data collection and thematic analysis was conducted. This study gathers new perspectives from partners about their role, beliefs, and the resources that contributed to their efforts in working with LHDs. It is important to explore these perspectives in order for LHDs to improve effectiveness and to identify ways to further cultivate relationships with their partners.
Figure 1.3: Objectives of Three Research Studies

Study 1: Foundational study
- Determine frequency and level of activities by using Collaborative Capacity framework
- Test association of specific partnership capacities

Study 2: Micro Study
- Explore perceptions related to partnership mobilization from LHDs' perspective

Study 3: Micro Study
- Explore perceptions related to successful partnership from LHD partners' perspective

Implications for public health practice are discussed within each study. The discussion of Chapter V integrates the key findings across the three studies by revisiting the Collaborative Capacity framework to identify areas necessary to optimize partnerships within LPHSs. These three studies were conducted to contribute to strengthening organizational and structural components of LPHSs by examining the level and quality of partnership activities conducted as a system as well as the perspectives of partnership from front-line workers.

References


CHAPTER II

A MULTI-STATE EXAMINATION OF PARTNERSHIP ACTIVITY AMONG LOCAL PUBLIC HEALTH SYSTEMS USING THE COLLABORATIVE CAPACITY FRAMEWORK

In a 2002 Institute of Medicine report, governmental public health agencies were encouraged to improve the delivery and coordination of public health services through the use of multi-sector partnerships. As a result, local health departments (LHDs) are beginning to form an integrated network of partnerships to improve the quality of life of populations within local communities. This network, known as local public health systems (LPHSs), includes local health departments (LHDs), hospitals, community-based organizations, other governmental sectors, businesses, policymakers, and grassroots leaders in counties, cities, districts, and regions in the U.S. Given the shift to a more systemic approach, public health system researchers are focused on finding approaches to improve performance of LPHSs, including their efforts in mobilizing community partnerships. Several studies have focused on overall performance; however, researchers have not examined specific activities related to partnership mobilization as reported by LPHSs nationally. By examining partnership mobilization in this manner, researchers would be able to determine the current types and levels of activities occurring and utilize this information to improve the effectiveness of partnerships in the future. Therefore, the purpose of this study is to conduct a multi-state examination of
partnership-related activities conducted by LPHSs using the Collaborative Capacity Framework.

Mobilizing community partnerships is one of ten public health services and involves convening partnerships to raise awareness about public health issues and coordinate public health services.\textsuperscript{4,11} Under ideal conditions, mobilization occurs in the initial phase of partnership, in which a core constituency of organizations and people organize around a particular or set of issues within the context of the community.\textsuperscript{12,13} Results of mobilization efforts empower members to create solutions to public health issues, plan new programs or enhance existing ones, and implement these programs to improve community health.\textsuperscript{13-15}

As it pertains to activities conducted within LPHSs, mobilization of public health-related partnerships primarily has been reported through activities conducted by LHDs. These activities have been reported by the types of partnerships that LHDs have formed with other organizations. Partnerships were formed to respond to natural and man-made disasters, coordinate and deliver health and human services initiatives, and educate the general public about health concerns.\textsuperscript{16-21} In addition, LHDs have implemented community assessment processes such as Mobilizing Action through Planning and Partnerships (MAPP) in order to engage constituents in public health issues, work on prevention activities, and create policies involving community constituency in system-wide changes.\textsuperscript{22,23}

Given the broad scope of work involved in improving the public’s health, more attention is being given to LHDs working in partnership with organizations and individuals within LPHSs to address public health issues.\textsuperscript{1,24} LPHS partnership-related
activities are being documented in the National Public Health Performance Standards Program (NPHPSP), a national assessment that measures baseline and ongoing improvements in regards to overall system public health performance. As one of the major organizations in the LPHS, LHDs facilitate the mobilization and implementation of community partnerships in an effort to improve overall public health performance (Figure 2.1).

Figure 2.1: Conceptual Framework of Local Public Health Systems (LPHSs) and Community Partnership Mobilization

To date, most of the research has focused on overall performance of LPHSs in the NPHPSP with limited emphasis on partnership performance. Several studies have reported higher levels of activity among LPHSs in investigating health issues, enforcing laws that protect the public from serious hazards, and linking populations to services. Within these studies, performance scores related to partnership mobilization ranged from 43-68% in reference to a total performance score of 100%. Specific partnership-related activities, however, have not been examined within this and other public health services
in the NPHPSP from a national perspective. By determining the current level of performance in partnership-related activities, LPHSs will be able to identify areas where they are meeting standards and areas that need to be improved.

Although activities reported by LPHSs primarily have been examined through the NPHPSP, theoretical frameworks are also helpful in examining the capacity of partnership activities. Models such as The Community Coalition Action Theory and the Partnership Synergy Assessment have been developed to examine partnership formation, sustainability, internal and external dynamics among members, and their efforts in achieving goals and implementing strategies. Another theoretical framework, the Collaborative Capacity Framework, describes the ability of partnerships to effectively function and sustain community change. Developed by Foster-Fishman et al. (2001), collaborative capacity is based on four key constructs (membership, relational [internal and external], organizational, and programmatic capacities) and was created through an extensive literature review on formal and informal partnership structures. This framework, primarily citing key characteristics important for effective functioning of coalitions, may also be used to further assess partnership capacity of LPHSs.

In this model, membership capacity includes a broad representation where diverse viewpoints can be shared. Characteristics that assess member capacity are skills and knowledge to create effective programs and build an effective infrastructure, positive attitudes about working together and towards other partners, and provision of social, logical, or organizational support to involve partners in activities. Relational capacity describes the importance of developing relationships within and outside the partnership. Internal relationships are fostered by creating a positive working climate and developing
an internal communication structure to resolve conflict and make decisions. External relationships involve working with community residents, key community leaders and policymakers, organizations not represented in the partnership, and existing groups and coalitions focused on similar issues. Organizational capacity is defined as having strong leadership, a formalized process in clarifying staff and partners’ roles, internal communication that promotes information sharing and a forum to discuss problems and resolutions. In addition, organizational capacity considers the manner in which resources are allocated to conduct partnership activities and methods used by partners in responding to general feedback and evaluation data, and contextual changes in the partnership. Last, but not least, programmatic capacity involves the design and implementation of programs based on identified community needs. Resources are more likely to be awarded to partnership activities based on planned approaches.14

Theoretical frameworks examining partnership capacity have not been used to evaluate partnership-related activities occurring within LPHSs. The NPHPSP identifies areas that need improvement and allows for LPHSs to develop quality improvement measures to strengthen overall capacity of their LPHS. Public health practitioners, however, also need to examine community partnership mobilization activities aligned with theoretical constructs that are consistent with the development and sustainability of effective partnerships. Frameworks, such as the Collaborative Capacity Framework, can provide more detailed information regarding the status of partnership building and maintenance. Therefore, the purpose of this study was to examine partnership mobilization activities reported by LPHSs utilizing the Collaborative Capacity Framework.
Methods

Population and Study Design

Secondary data analysis of the second version of the National Public Health Performance Standards Program (NPHPSP) local assessment was conducted. In 1998, the CDC partnered with five other public health organizations—National Association County and City Health Officials (NACCHO), the Association of State and Territorial Officials (ASTHO), the National Association of Local Boards of Health (NALBOH), the American Public Health Association, and the Public Health Foundation—to develop a set of performance standards reflecting best practices in public health with the aim of improving health system performance and making it accountable for its use of resources. The first version of the NPHPSP assessment was administered from 2002-2006 until LPHSs were recommended to use a second updated version in 2007. The purpose of the NPHPSP local assessment is to measure national, state, and local organizations’ ability to leverage resources in building a strong system infrastructure.

Each local assessment captures the contributions of these organizations within LPHSs, through the measurement of performance standards based on the ten essential public health services. The assessment is designed to be completed by organizations and individuals within local jurisdictions regarding their collective contributions to the public health system and to consider areas of strengths and improvement. Due to the length of time required to complete the assessment, LPHSs are recommended to host one or a series of meetings to discuss their performance in meeting ten essential public health services and related performance standards. Scores for each standard are decided by
consensus among persons participating in the assessment. Following the meeting, LHDs enter scores into an online reporting system maintained by the Public Health Foundation and forwarded to CDC to compile into a national dataset.4

This study utilized the NPHPSP local assessment dataset including demographic data and raw scores reported by LPHSs. The second version of the NPHPSP local assessment commenced in 2007 with the first assessments filed in the electronic system in 2008 and with the latest assessment filed in September 2009. Over 100 LPHSs (n = 116) representing twenty-one states voluntarily completed the assessment. Permission to use the NPHPSP dataset was obtained from the CDC and research procedures were approved by the Western Michigan University Institutional Review Board.

**Measures and Data Analysis**

Ten questions from the NPHPSP were used to measure different aspects of partnership activity. Four questions assessed activities involved in identifying and establishing working relationships with LPHS stakeholders, encouraging participation in community health issues, creating a directory containing information about LPHS organizations, and using communication strategies to raise awareness about public health. Three questions assessed using existing partnerships in addressing public health issues, having community health improvement committees, and evaluating partnership effectiveness. Three questions examined partnership activities in which LPHSs work together to deliver targeted education and promotion initiatives to reduce health risks, use processes that identify issues and resources to address needs of the population, and establish a coalition to develop and maintain emergency preparedness plans. Each
partnership question was rated on a five category scale that allowed LPHSs to describe their level of activity. Levels of partnership activity were reported as: no activity (0% of the time), minimal (1-24% of the time), moderate (25-49% of the time), significant (50-74% of the time), or optimal (≥75 % of the time) levels.

Nine partnership questions were matched with three of the four constructs of the Collaborative Capacity Framework. The three constructs that were evaluated from the Collaborative Capacity Framework were relational, organizational, and programmatic capacities. One question, participation in emergency preparedness coalitions, was an example in which organizations and individuals may participate in a specific partnership activity within LPHSs (Figure 2.2). One construct, member capacity, was not analyzed because questions were not available to assess skills and knowledge of partners within a LPHS.

Three questions from the NPHPSP pertained to relational capacity. These questions included if LPHSs have a process for identifying key constituents, encourage participation of key constituents in improving public health, and have existing partnerships in the community to maximize public health improvement. Five questions assessed LPHSs’ organizational capacity: maintenance of a directory of organizations, establishment of a community improvement process, having a broad-based community improvement committee that may be formal or informal, use of communications strategies to build public health awareness, and review of effectiveness of partnerships to improve community health. These questions involve establishing an operational process that informs communication within and outside LPHSs to facilitate their work. Last, programmatic capacity involves the design and implementation of programs based on
identified community needs. One question related to LPHS’ ability to work together in planning, conducting, and implementing health promotion activities.

Figure 2.2: Theoretical Framework for Examining Collaborative Capacity among Local Public Health Systems (LPHSs)

Collaborative Capacity

Member Capacity | Organizational Capacity | Relational Capacity | Programmatic Capacity
---|---|---|---
*Core skills and knowledge*  
• Abilities to work with others, build effective programs, and create an effective infrastructure  
*Core attitudes*  
• Holds positive attitude about partnerships, committed to issues  
*Access to member capacity*  

Effective leadership  
Formalize and develop plans and processes  
Effective communication  
Sufficient financial and human resources  
Continuous improvement orientation  
• Develop monitoring system

Develop internal relationships by:  
• Develop a positive working climate  
• Develop a shared vision  
• Promote power sharing  
• Value diversity  
Develop positive external relationships

Have clear, focused programmatic objectives  
Realistic goals  
Unique and innovative  
Ecologically valid  
• Program driven by community needs and culturally competent in design

No indicators were available to describe LPHS’ partnership member capacity.

Indicators describe LPHS’s capacity to formalized procedures such as having a directory, using communication strategies to build awareness within the partnership network and to the public, having community health improvement process and/or a community health improvement committee. Continuous improvement orientation may include seeking and responding to evaluation data, which may include reviewing partnership effectiveness.

Indicators describe LPHS’s capacity to develop internal and external relationships in creating positive working relationship by having a process for identifying key constituents, encouraging constituency to participate in community health, and having partnerships with existing groups to maximize public health improvement.

Indicator describes LPHS’s capacity to design and implement programs and initiatives such as conducting, implementing, and evaluating health promotion activities.

NPHPSP Partnership Indicators

*Developed by Foster-Fishman et al. (2001). Collaborative Capacity framework*  
**Nine questions on partnership from the National Public Health Performance Standards Program (NPHPSP) local assessment were matched with one of four capacities in the Collaborative Capacity Integrative framework.  
***The tenth question, participating in emergency preparedness coalition describes a specific partnership activity of LPHSs and was not matched with a model construct.*
Descriptive statistics were used to determine the percent of LPHSs reporting their engagement in each level of each specific partnership activity. For the purposes of analysis, minimal and moderate levels of activity were combined. In some analyses, activity level was dichotomized at optimal levels because LPHSs are encouraged to perform at this level. Due to small expected cell size, the Fisher’s exact test was conducted to test for associations between optimal and non-optimal performance between the three capacities in the Collaborative Capacity Framework.

Results

Of the LPHSs that completed the second version of the NPHPSP local assessment, approximately 55% were completed in 2008 and 45% were completed in 2009. In eight states, five or more LPHSs completed the assessment (Indiana, n = 23; Virginia, n = 16; Ohio, n = 14; Kentucky, n = 9; Montana, n = 8; Texas, n = 7; Nebraska, n = 5; and South Carolina, n = 5).

Assessing Collaborative Capacity Constructs

Overall, 78% (n = 86) of LPHSs in the total sample did not perform at the optimal level of activity in any of the capacity areas, while only 4% (n = 4) of LPHSs performed at optimal activity in all three capacities—relational, organizational, and programmatic. Among the three partnership activities in the NPHPSP used to measure the relational capacity of the Collaborative Capacity framework, 74% (n = 81) of the 110 LPHSs did not perform at optimal level in any of three activities (Table 2.1). Approximately 55% (n = 60) of LPHSs did not have optimal performance in any of the five partnership
activities measuring organizational capacity. About 87% ($n = 96$) of LPHSs performed non-optimally in the one activity measuring programmatic capacity. When examining if the majority of each capacity's activities were conducted at optimal levels, 15% ($n = 17$) of LPHSs reported performing a majority of partnership activities in the relational capacity at an optimal level followed by 13% ($n = 14$) of LPHSs in programmatic capacity and 8% ($n = 9$) in organizational capacity.

Table 2.1. Number and Percent of LPHSs Performing Majority Optimal Level and Number of Partnership Activity in Relational, Organizational, and Programmatic Capacities

<table>
<thead>
<tr>
<th>Number of activity</th>
<th>Relational</th>
<th>Organizational</th>
<th>Programmatic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$n$ (%)</td>
<td>$n$ (%)</td>
<td>$n$ (%)</td>
</tr>
<tr>
<td>0</td>
<td>81 (74)</td>
<td>60 (55)</td>
<td>96 (87)</td>
</tr>
<tr>
<td>1</td>
<td>12 (11)</td>
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<td>8 (7)</td>
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</tr>
<tr>
<td>3</td>
<td>9 (8)</td>
<td>5 (5)</td>
<td>n/a</td>
</tr>
<tr>
<td>4</td>
<td>n/a</td>
<td>4 (3)</td>
<td>n/a</td>
</tr>
<tr>
<td>5</td>
<td>n/a</td>
<td>0 (0)</td>
<td>n/a</td>
</tr>
<tr>
<td>Majority activities performed optimal level</td>
<td>17 (15)**</td>
<td>9 (8)**</td>
<td>14 (13)**</td>
</tr>
</tbody>
</table>

* Three partnership activities were defined as relational capacity, five partnership activities were defined as organizational capacity, and one partnership activity was defined as programmatic capacity. Participation in emergency preparedness coalition was not classified in any capacity, but categorized as a specific partnership activity.

** Statistically significant at $p < .05$. 

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Examining Specific Partnership Mobilization Activities

Six of the ten partnership activities across all capacities were reported most frequently at the minimal-moderate (1-49% of the time) level (Figures 2.3 and 2.4). Using communication strategies \((n = 73, 66\%)\) reviewing partnership effectiveness \((n = 62, 56\%)\), and conducting, implementing, and evaluating health promotion initiatives \((n = 56, 51\%)\) were reported the most often in the minimal-moderate (1-49% at the time) levels of the six partnership activities. One of the ten activities, having partnerships with existing groups, was reported most frequently by LPHSs as being conducted a significant amount of the time (50-74% of the time). Participating in emergency preparedness coalitions was reported most frequently among LPHSs at the highest or optimal level of activity (≥ 75% of the time). LPHSs’ reported no activity (0% of the time) in several partnership activities. The most frequently reported activity for which there was no activity were reviewing partnership effectiveness \((n = 39, 36\%)\), having a broad-based improvement committee \((n = 38, 35\%)\), and establishing a community health improvement process \((n = 29, 26\%)\).

To further understand optimal performance (≥ 75% of the time) in organizational, relational, and programmatic capacities, (Figure 2.4), the percent of specific partnership activities were examined by capacity.
Figure 2.3: Percent and Frequency of LPHSs’ Partnership Activities Defined by Organizational Capacities: NPHPSP (2008-2009)

- Have a directory of organizations within LPHS: 43 (36%), 22 (20%), 9 (7%), 5 (4%)
- Use communication strategies to build awareness in public health: 73 (62%), 32 (29%), 29 (23%), 5 (4%)
- Establish a community health improvement process: 70 (60%), 20 (17%), 12 (10%), 5 (4%)
- Have a broad-based community improvement committee: 62 (55%), 42 (38%), 38 (32%), 15 (13%)
- Review partnership effectiveness: 5 (4%), 15 (13%), 39 (35%), 62 (55%)

N=110 LPHSs

Figure 2.4: Percent and Frequency of Partnership Activities by Relational and Programmatic and an Example of Partnership (Participation in Emergency Preparedness Coalitions): NPHPSP (2008-2009)

- Have a process for identifying key constituents: 50 (45%), 40 (36%), 20 (18%), 2 (2%)
- Encourage participation in community health: 49 (44%), 41 (37%), 18 (16%), 6 (6%)
- Have partnerships with existing groups: 50 (45%), 49 (44%), 36 (33%), 14 (13%)
- Conduct, implement, evaluate health promotion initiatives: 50 (45%), 50 (45%), 36 (33%), 14 (13%)
- Participate in emergency preparedness coalitions: 56 (50%), 56 (50%), 27 (24%), 1 (1%)

N=110 LPHSs
Organizational capacity. Five questions related to organizational capacity of LPHSs’ partnership activity. About 28% \( (n = 29) \) of LPHSs performed at the highest or optimal levels in establishing a community health improvement process at an optimal level, 20% \( (n = 22) \) reported maintaining a directory of LPHS organizations optimally, and only 4% \( (n = 4) \) reviewed partnership effectiveness at least 75% of the time. Optimal levels of activity were reported least often for reviewing partnership effectiveness and using communication strategies.

Relational capacity. Among three questions measuring relational capacity, 18% of LPHSs reported \( (n = 20) \) having a process for identifying key constituents and 16% \( (n = 18) \) of LPHSs encouraged participation in community health at optimal levels. The lowest reported activity related to relational capacity was having existing partnerships with existing groups, in which 15% \( (n = 17) \) of LPHSs reported performing at optimal level.

Programmatic capacity. One partnership activity measured LPHSs’ programmatic capacity. Approximately 13% of LPHSs reported \( (n = 14) \) conducting, implementing, and evaluating health promotion initiatives at an optimal level.

Example of partnership activity. One NPHPSP measure was identified as an example of LPHSs’ capacity in performing a specific partnership activity. About 61% of LPHSs reported performing at optimal level in their participation in an emergency preparedness coalition \( (n = 67, 61\%) \).

Associations of Relational, Organizational, and Programmatic Capacities

The Fisher’s exact test was conducted to determine associations between relational, organizational, and programmatic capacities. Overall, LPHSs that reported
optimal levels of activity the majority of the time in one capacity were also more likely to report optimal levels in the other two capacities. LPHSs reporting optimal performance in relational capacity were more likely to report optimal performance in organizational capacity ($p < .0005$). Statistically significant associations also were found for LPHSs reporting optimal performance in relational capacity and programmatic capacity ($p < .0005$). Likewise, LPHSs reporting optimal activity in organizational capacity were more likely to perform optimally in programmatic capacity ($p < .015$).

**Discussion**

Organizations and individuals contributing to public health services within LPHSs are beginning to examine their level of partnership mobilization. This is evident from the number of states participating in the NPHPSP. As public health departments explore partnership mobilization, theoretical frameworks could provide useful direction. Specifically, the Collaborative Capacity Framework proved to be useful in assessing partnership activities that should be considered as key characteristics in strengthening the LPHS. Most of the LPHSs in the study did not perform optimally in relational, organizational, or programmatic capacities, although a higher percent of LPHSs did perform a majority of activities in relational capacity at optimal levels. LPHSs performing optimally in relational capacity also more often performed optimally in organizational and programmatic capacities compared to those who did not perform optimally in that capacity. When examining specific partnership activities, we discovered that most of these activities were reported at no or minimal-moderate levels, particularly in evaluation
and communication strategies. The majority of LPHSs, however, report they are participating in emergency preparedness coalitions at optimal levels.

The reasons that most LPHSs did not perform optimally in any capacity remain unknown. This result is consistent with previous studies indicating that the public health system is a fragmented system and in need of improved coordinated efforts between governmental and non-governmental organizations.\(^2,^{29,30}\) As it pertains to the LPHS' ability to mobilize community partnerships, this result suggests that public health agencies primarily focus on responding to issues and providing services and more attention is needed to building system and community capacity. Using these capacities to enhance partnerships may establish more continuity in critically assessing and improving mobilization within LPHSs.

When assessing the majority of activities performed by capacity, LPHSs reported higher levels of activity in relational capacity. Public health activities are mostly focused in establishing new relationships or building networks with existing groups. This result suggests that LHDs have taken into consideration the recommendation to partner. Thus, more time is spent in building these relationships that was not required in the past. Previous studies have shown that having positive relationships, establishing trust, creating organizationally structured partnerships, and involving the community in addressing community health issues all contribute to partnership effectiveness.\(^12,^{31-33}\) These findings may inform how LPHSs can build each capacity to encourage effective partnership and promote overall system change.

When examining the least reported partnership activities, this study reinforces the need to further encourage LPHSs to increase attention towards evaluation. Less than ten
percent of LPHSs reported significant or optimal activity (≥ 50% of the time) in reviewing partnership effectiveness. Many investigators have directed their attention to assessing factors that contribute to improved performance and effectiveness. One statewide study defined partnership effectiveness among LHDs as having financial resources, a long history of working together, and diverse participation.\textsuperscript{19} Other studies have measured effectiveness by examining benefits of partnership participation among governmental and non-governmental organizations.\textsuperscript{34,35} National organizations that work with governmental health agencies are beginning to measure processes in an effort to establish consistency in practice. For example, the \textit{Operational Definition for a Functional Local Health Department}, developed by NACCHO, assesses several process indicators such as completion of a community needs assessment, written description of a community plan with specified goals and objectives for identified health priorities, and conducting a performance assessment (e.g., NPHPSP).\textsuperscript{36} Furthermore, the CDC and NACCHO are considering quality improvement and accreditation of public health departments as a way of measuring organizations' capacity and readiness to change and to improve health outcomes.\textsuperscript{37} Other reasons, such as limited human and financial resources, may also contribute to the lack of attention in evaluation. Often LHDs do not have personnel designated to measure outcomes of community programs. Limited financial resources and time may also play a part in limited evaluation. Academic institutions should be considered as a key partner in facilitating evaluation of public health services and partnerships. In fact, formative and participatory action research have been used by academic institutions to measure strategies aimed at improving community health outcomes through the use of partnerships.\textsuperscript{38,39}
Using communication strategies to raise public health awareness is another activity where LPHSs reported limited activity. Only 29% of LPHSs reported significant or optimal activity (≥ 50% of the time) in using communication strategies. It is not evident why LPHSs reported limited activity in this area; however, these strategies are used by public health organizations to promote health practices and behaviors to the populations they serve. Social marketing and health communication have been used as strategies to improve awareness among various populations about health issues. Communication strategies could be used more often to build internal communication among health-related organizations to address population needs by enhancing service delivery and get non-health related organizations and community members to see their role in the public health system.

In examining the most reported partnership activity, emergency preparedness has been the primary focus of national public health efforts given community-wide efforts to increase security following September 11th events. This result suggests that specific partnerships are being driven by funding and agendas of national organizations, thus encouraging organizations to invest in participating in emergency preparedness planning. When further investigating demographic information provided by LPHSs, we found participation in emergency preparedness coalitions occurred at a very high frequency across the completed assessment years, LHD governing authority, and states. These findings also support previous research studies and public health practice literature describing the increased role of public health system partnerships in this area. Prior to 2001, governmental public health departments lacked resources to adequately prepare for natural (e.g. tornados, hurricanes), chemical, terrorist, and physical-environmental
threats and partnerships has prompted governmental and non-governmental organizations to put into place preventative measures reduce the likelihood of such threats. Financial and human resources have been provided to state and local public health systems to include emergency preparedness as a priority in its efforts to protect population’s health. Over 5 billion dollars have been allocated through federal cooperative agreements to public health departments in the U.S. to build the public health infrastructure from 2002-2007. Funding has enabled public health departments to work with organizations considered part of the LPHS to create and maintain emergency response plans, develop professional public health staff, and enhance information technology. Increased attention to emergency preparedness has expanded the public’s perspective of the role of LPHSs and has brought together organizations to improve response communication and communication with hospital, fire departments, police departments, and community-based organizations. This increased attention has brought together organizations to improve coordination between organizations and the services they provide in local communities; however, it did not lead to optimal levels of partnership activity in each specified activity across all partnerships.

This study suggests several implications for public health practice. We found that much progress is needed in mobilizing community partnerships as a system. Theoretical constructs should be considered as potential factors that improve development and ongoing operation of these partnerships. Additional factors should be explored that may influence mobilization including leadership roles assumed by organizations and individuals, community improvement models used to initiate partnerships, and how partners structure their efforts. A second implication is that national and LPHSs’ leaders
need to give more additional attention to reviewing partnership effectiveness and using communication strategies to promote health and well-being and public health services. Similar to emergency preparedness, national public health organizations may prompt more action from LPHSs to increase the frequency with which each of the partnership activities are being conducted, particularly the use of communication strategies in building public health awareness and evaluating partnership effectiveness. Organizations such as CDC, NACCHO, ASTHO, and other public health organizations that work to improve LPHSs may consider specific measures to improve these levels of activity in partnerships. Improvement in these activities should also be tracked over time to examine changes in population outcomes.

This is the one of the first studies that examined partnership-related activities using a theoretical framework describing level of activity from a multi-state perspective. The NPHPSP partnership questions serve as proxy measures that provide summative group ratings from governmental and non-governmental organizations and individual volunteers. Many LPHSs were given instructions on the administration of the assessment that was made available through a national training and an online user guide. Questions from the local assessment may be used to educate organizations and individuals about areas of strengths and need for improvement in partnership activities to better position the system to improve the public’s health.

Several limitations to the study exist. First, the sample may not be representative of the population. Data were self-reported and based on the subjective rating of participants involved in the NPHPSP. It is unknown to researchers how LPHSs took into consideration varying opinions of organizations in examining performance scores as
reported in the dataset, which may have affected the final rating of partnership activity. Partnership activities categorized in one of the three capacities were not evenly distributed. Another limitation to the study was that information was not available regarding the administration of the NPHPSP in these local jurisdictions. Strategies for administering the local assessment have been described in a user guide that is available online to organizations and at national technical assistance workshops. Organizations were encouraged to recruit government and non-government entities and individual volunteers to participate in the assessment in order to get a comprehensive perspective on the overall function of the local public health system, but the extent to which they did this is unclear. Lastly, we were unable to test the member capacity in the partnership framework that may be associated with the formation and maintenance of LPHSs. National organizations should consider adding questions to the assessment that measure contributions made by organizations and individuals that work to strengthen LPHSs.

Viewing the local public health as a system is a relatively new concept in public health practice and more attention to building systematic capacity and infrastructure is required. Using partnership frameworks may assist public health practitioners and researchers in considering the presence or absence of key elements contributing to the development and sustainability of partnerships and its impact on health outcomes. Results from this study can support ongoing work in community-based partnerships, impact of continuous quality improvement in promoting optimal public health practice, and the need for evidence-based public health practice in assessing LPHS partnership activities. Future studies should explore membership capacity of organizations within LPHSs, particularly in assessing knowledge and skills of organizational and individual
participation. Researchers should examine if increased engagement in specific partnerships, such as emergency preparedness, leads to more opportunities to perform at optimal levels. Additionally, perceptions of LHDs’ capacity to mobilize partnerships among organizations in their jurisdictions should be examined in order to further understand key elements that are integral in forming and sustaining effective partnerships.

References


National public health organizations have recommended that governmental public health agencies work more closely with various organizations to create an integrated network of partnerships. This integrated network, known as the local public health system (LPHS), includes public, private, voluntary organizations, existing community groups, and community members contributing to or benefiting from the public’s health. Due to this recommendation, local practitioners are working to improve the performance of public health by mobilizing partnerships with private, public, and voluntary organizations and volunteers in order to create a fully functioning LPHS. Partnership mobilization, a process of bringing different people and organizations together in developing an initiative to address a goal, allows for maximization of resources. Evidence indicates that many factors, alone or in combination, affect the mobilization of partnerships including involvement of influential people and organizations, knowledge of community resources, credibility and commitment from partners, leadership of lead agency, and creation of clear goals and objectives. However, little is known about the perceptions of public health practitioners at the “ground level,” regarding their partnership mobilization efforts. Given the current focus on a system approach to public health, it is important to learn directly from public health practitioners their
knowledge and beliefs regarding elements essential to partnership mobilization.

Therefore, the purpose of this qualitative study is to examine these perceptions using a metaphorical analysis. Such an analysis can provide insights into the approaches used by LHDs to build and strengthen the LPHS and enrich understandings derived from quantitative studies.

LHDs use partnerships to improve the organization and delivery of services within the public health system and to achieve health goals that extend beyond the resources supported by the organization.11-13 The LPHS created by mobilizing partnerships provides opportunities to address complex public health issues at the community level and can improve population health by improving access to health services through increased coordination among organizations in local communities.1,7,14 LHDs have used a variety of mobilization strategies, including community planning, networking, educational approaches, and the use of advocacy, to build community capacity. In addition to a LHD, the ability of a LPHS as a whole to establish a community health improvement plan that informs and educates the population about public health issues is also an important aspect of partnership mobilization.15,16

In public health, assessments have been developed to quantify the activities and experience of public health practitioners in mobilizing partnerships. For instance, the National Association of County and City Health Officials (NACCHO) National Profile Study captures types of organizations that LHDs work with in various partnership activities.6 Another assessment, the National Public Health Performance Standards Program (NPHPSP), examines levels of activity and ongoing improvements in coordinating and delivering public health services of the organizations within LPHSs.7
This assessment includes efforts made by LHDs within their respective LPHSs. Researchers have examined the level of partnerships occurring in local communities; however, these assessments do not provide information about the meaning, experiences, and expectations of LHDs in mobilizing effective partnerships that address public health issues. Understanding these perceptions may be the first step in exploring the reasons partnerships are mobilized, structured and evaluated in certain ways.

Critical factors that are not measured in public health performance assessments, and may affect public health practitioners perceptions of partnership mobilization are LHDs' role and interaction with partners in mobilizing partnerships, use of improvement and planning processes, partnership structure, and initial results. The first factor, the role assumed by LHDs in partnerships, may influence the level of participation from organizations, groups, and individuals.\textsuperscript{11,18} Since LHDs are responsible for leading the public health agenda, these agencies may exhibit a range of leadership roles in partnerships.\textsuperscript{11,19-21} Further, leadership has been linked to successful development of coalitions.\textsuperscript{21} Several studies have shown that having a population-based view (as opposed to a clinical view) of health, vision-based leadership, and having positive working relationships with others promoted the development and sustainability of partnerships.\textsuperscript{19,21,22} Identification of characteristics that encourage the use of specific leadership approaches in partnership mobilization as identified by public health practitioners has not been documented in the literature. Such information may be important in understanding the current leadership capacities of LHDs in mobilizing partnerships.
Public health practitioners likely vary in their approach to the planning processes used to develop and organize partnerships. As stated previously, national planning tools, such as Mobilizing Action for Planning and Partnership (MAPP) and the NPHPSP have been used by LHDs to identify public health issues and to strengthen LHDs' and the community's capacity to plan, implement and coordinate services.\textsuperscript{12,16,22,23} In addition, these planning processes are predicated on principles of community engagement that guide partners through a sequential process in creating a shared vision and shared responsibility to improve the public's health. However, variation exists in the level at which these planning processes are implemented. This variation in organizing community improvement efforts is evident in a recent study assessing performance of partnership mobilization among LPHSs. In a study of 110 LPHSs, only 45% reported optimal (performed >75% of the time) activity in establishing a community health improvement process and 26% reported no activity.\textsuperscript{24} Although this study demonstrated variation in the use of community improvement processes by LPHSs, it did not provide an explanation for that variation. What compels practitioners to use these structured planning processes, to what degree and in what form, remains open for inquiry. By identifying these reasons, we will be able to determine which approaches LHDs use to recruit constituents, leverage resources, and build community capacity as well as why different approaches are being used.

The structure of partnerships in public health is another characteristic that may influence LHDs' mobilization efforts. Theoretically, structure has been viewed as an important characteristic in developing coalitions, which may serve as a key factor in sustaining efforts.\textsuperscript{25-27} During the initiation process, partnerships can be arranged in
different structures depending on their purpose and the expectations of participating organizations. Coalitions are known to have a more formalized structure with operating procedures, a core membership, and a lead agency responsible for facilitating activities related to the mission of the partnership.\textsuperscript{25} Other partnership arrangements allow for informal communication and opportunities to work collectively, in which organizations maximize resources to serve a specific population or community need. Examples of these informal arrangements include meetings and community forums where networking and information exchange occur and community events such as health fairs, education sessions/classes, and conferences. A study examining partnership mobilization reported 60\% of LPHSs using existing partnerships for public health improvement efforts.\textsuperscript{24} Since LHDs are involved in these efforts, it is not known how these partnerships are structured or LHDs’ perspectives considering the importance of structure in mobilizing partnerships.

The fourth factor, partner’s interaction, produced by organizations and individuals working together on a public health issue, also is a characteristic that may influence how LPHSs mobilize partnerships. Evidence of LPHSs’ activities related to partnership mobilization has primarily been captured in the NPHPSP. These activities include specific examples of partnership activities that may be the result of mobilization efforts as well as individual activities used in the initiation and development of these partnerships within LPHSs. A previous study found on average 42\% of LPHSs reported engaging in nine specific partnership activities at least 50\% of the time. This was lower than the 60\% of the LPHSs that reported using existing partnerships at least half of the time and not one of the specific partnership activities were conducted at the same level as reporting of use of the existing partnerships in general.\textsuperscript{24} Given these findings, it is important to determine
what LHDs' perceive as the initial or key results of their mobilization efforts and how these results relate to the activities reported by LPHSs in the NPHPSP.

In sum, assessments, such as the NPHPSP and the NACCHO National Profile Study, provide descriptive information about the levels and types of partnerships occurring among within LPHSs and among LHDs and the research on these tools is extensive. However, few studies have explored how and why key characteristics, from the point of view of public health practitioners, are important to partnership mobilization to determine how to best optimize future partnerships. Therefore, this study explores public health practitioners’ perceptions related to mobilizing community partnerships. A metaphor of partnership mobilization as theatre highlights and illustrates key findings.

Methods

Participant Selection

Participants for this qualitative study were drawn from county, city, county-city, or multiple counties/district LHDs that participated in the second version of the NPHPSP local assessment between January 2008 and December 2009. Potential participants were recruited through two national public health listserves that used the NPHPSP. Both listserves contained over 100 subscribers that may have used the NPHPSP in their efforts to assess their jurisdiction’s ability to deliver ten essential public health services. A second recruitment approach was also used. Key informants working with LHDs at state health departments and universities were contacted by telephone. The key informants
were asked to identify LHDs who had completed the NPHPSP local assessment and who might be interested in participating in the study.

Criteria for selection included individuals that: (1) coordinated or assisted in the coordination of the NPHPSP for LHDs in their jurisdiction, and (2) participated in the NPHPSP local assessment. Upon receipt of informed consent, an interview was scheduled. The research protocol was approved by Western Michigan University Human Subjects Institutional Review Board.

**Participant Characteristics**

Twelve people, representing seven LHDs, participated in the study. Various geographic locations and positions within LHDs were represented (Table 3.1).

**Data Collection**

Semi-structured interviews with participants were conducted. An interview guide was developed and included questions about perceptions, processes, and examples of LHDs working with organizations in public health partnerships. Interview questions were developed based on gaps in the literature and with consultation from public health organizations that work with LHDs in administering the NPHPSP local assessment. Questions were reviewed by the co-principal investigators and revised to capture more targeted information and viewpoints (Appendix A). Interviews were conducted via telephone \((n = 4 \text{ LHDs})\) and face-to-face \((n = 3 \text{ LHDs located in the same state})\), lasted approximately one hour, and were audio-recorded.
Table 3.1. LHD Characteristics ($n = 12$)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number/Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Geographic location</strong></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>4 (33%)</td>
</tr>
<tr>
<td>Non-urban</td>
<td>8 (67%)</td>
</tr>
<tr>
<td><strong>Region/States</strong></td>
<td></td>
</tr>
<tr>
<td>Central (Kansas)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>West (Arizona)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Midwest (Kentucky, Ohio)</td>
<td>9 (76%)</td>
</tr>
<tr>
<td>East (Virginia)</td>
<td>1 (8%)</td>
</tr>
<tr>
<td><strong>LHD$^+$ geographic characteristics</strong></td>
<td></td>
</tr>
<tr>
<td>County</td>
<td>3 (42%)</td>
</tr>
<tr>
<td>County-city</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>District</td>
<td>2 (29%)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Health director</td>
<td>2 (17%)</td>
</tr>
<tr>
<td>Health planner/Health educator/Program coordinator</td>
<td>6 (50%)</td>
</tr>
<tr>
<td>Epidemiologist</td>
<td>2 (17%)</td>
</tr>
<tr>
<td>Program administrator</td>
<td>1 (8%)</td>
</tr>
<tr>
<td>Contractor</td>
<td>1 (8%)</td>
</tr>
<tr>
<td><strong>In process of implementing MAPP$^+$</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>9 (71%)</td>
</tr>
<tr>
<td>No</td>
<td>3 (29%)</td>
</tr>
</tbody>
</table>

$^+$ LHD = Local health department

++MAPP (Mobilizing Action through Planning and Partnerships) is a community health improvement process that encourages organizations and individuals to work together to identify issues and create solutions to public health concerns. The NPHPSP is one of four assessments in MAPP. Three participants, representing two different LHDs completed the NPHPSP and were not using MAPP as their community improvement process.
Data Analysis

Interviews were transcribed by a professional transcriber. Data then were organized and managed using Qualitative Solutions and Research Non-numerical Unstructured Data Indexing (QSR NVIVO 8.0) software program. Two levels of analysis were conducted. The first level of analysis was thematic coding. The primary investigator repeatedly read the interview transcripts several times to establish consistency in coding data into appropriate thematic categories. Coding involved segmenting data into units and rearranging them into categories that facilitated insight, comparison, and clustering it to a particular question or concept. Data were categorized into themes related to LHDs’ perceptions of partnerships with organizations and individuals.

The second level was metaphoric analysis. Metaphors use visual or narrative representation to communicate the meaning of results that is not often captured through coding and categorization in themes. Metaphors have been used in qualitative studies to further understand and interpret results by taking an idea and drawing similarities between it and another idea.

A list of possible metaphors was initially created by the principal investigator based on review of transcripts and discussions with public health and non-public health practitioners. Through a process of comparison of the data and the metaphor language by the principal investigator the metaphor of theatre emerged as the most coherent representation for the findings.
Key Findings

Theatre, as a metaphor, best captured the perceptions described by public health practitioners about partnership mobilization in the interviews. During the review of transcripts, partnership mobilization was indirectly described by public health practitioners as a dynamic and continual process, similar to a theatre. Just as a theatre is more than the structure itself, so were partnerships described. Theatres consist of a continuum of activity and processes that involve the participation of “cast and crew” who assume many roles including producers and directors working behind the scenes; actors in starring or supporting roles; and persons responsible for lighting, staging, costumes, and marketing. When these elements and processes come together in theatre presumably a performance occurs that meets the needs of the audience.

Similar to theatre, partnerships were also described as including key elements that stimulate the need for and support continuous activity such as the people involved, the nature of their relationships and the structure in which they operate. Also, in the mobilization efforts described here, the theatre gives the director and the cast creative space to work together in a unique way; each person may participate for similar or different reasons—to produce, perform, to serve a purpose, and to achieve some “end”; however, the underlying purpose is to get people to work together. As a result, the metaphor, partnership mobilization as theatre, was selected to illustrate key findings of the study.

In reporting key findings of this study, this metaphor analysis identified five elements of the theatre that help illustrate public health practitioners’ perceptions of
partnership mobilization: (1) the director/stage manager, (2) the script, (3) the stage, (4) the rehearsals, and (5) the performance (Figure 3.1). These elements revealed the "dynamic process" of LHDs' leadership role, planning processes used to engage partners, informal and formal structures, partners' interaction with one another, and the results of coming together as understood by public health practitioners in their regular practice of mobilizing partners.

Figure 3.1: Key Elements Perceived by Practitioners Related to Partnership Mobilization

The Director/Stage Manager: Practitioners' Roles in Partnership Mobilization

In theatre, a director requests financial resources from the producer, has the artistic vision of the performance, recruits actors and potential members of the crew, and prepares cast and crew to provide input to future performance. The stage manager, on the other hand, organizes all aspects of the performance from "behind the scenes" by maintaining lines of communication between the director, the production crew, and the cast. In interviews, practitioners described both their style of engaging organizations to participate in public health issues as well as their role in the administrative aspects in
mobilizing partnerships. In some cases, the primary job responsibility of several public health practitioners was to mobilize partnerships. These descriptions revealed the dual roles of public health practitioners serving as a director and/or a stage manager.

In some situations, the director may request from the producer (who is responsible for making business and financial decisions) more resources and support to achieve the creative vision of the theatre. Several LHDs provided logistical support by hosting partnership meetings at their facility. This activity was perceived as increasing meeting attendance among organizations and individuals. Additionally, public health practitioners described organizational support from their agency to activities related to mobilization efforts. Financial resources were secured from national and state grants to support partnership activities and staff positions to conduct outreach and promote availability of services. One participant shared:

My position, which is an outreach position, and that’s what it’s always been even before, and that’s I think used especially to help …vulnerable populations or even tribal populations to let them know about … these services, but we also certainly use it to go to some of the existing hospitals or community health clinics or health-related agencies, and let them know about these services as well so they can let our clients know.

In assuming the “director” position, practitioners brainstormed names of organizations and individuals with interest, common interest, or positional leadership to participate in partnerships. A participant in the initial process of implementing MAPP in an urban community, shared:

... the first thing we need to do is identify who in our community needs to be a part, ... [we] sat down and said, “Okay, so who do we need to get involved with this?” And then once we got that group identified and they said, “Yeah, sure, they come.” And although we made suggestions to obviously the people that we thought in organizations that we felt needed to be at the table, they also … through their connections said oh, I know such-and-such is working on a Chamber
health committee. He or she needs to be on this. And so that’s how we were able to then identify all those other participants ... The ones who were going to sort of oversee the whole process through the planning phase.

While brainstorming potential partners, recruitment was not limited to public health practitioners’ recommendations and extended to recommendations from other pre-established partnerships. Diversity among individuals and organizations participating in partnerships was viewed as important because diverse perspectives play a part in identifying, interpreting, and finding creative solutions to issues or problems. Thus, diverse organizations and individuals were invited to participate in partnerships and viewed as potential stakeholders, just as theatre has different types of people in the cast and crew working on a set for a performance. One participant shared:

We looked at all the main agencies in the county. We looked at the Chamber of Commerce from the business community. We identified key businesses and key individuals who were with those entities. We looked at our policy-makers and trying to get as many of them involved as possible, and then all the business sector in our health care community. The hospital, social services—we identified all those key groups.

To ensure that a diverse group of actors are obtained, the director uses various media channels, existing networks, agents, and word of mouth to communicate the opportunity to audition for the performance. Public health practitioners also used multiple recruitment strategies to recruit potential partners to participate in existing or new partnerships. LHDs recruited potential constituents at community meetings and existing partnerships to encourage their participation in public health issues. Electronic, telephone, or face-to-face communication channels were considered as useful tools in an initial call for participation. Specific recruitment approaches included sending letters, emails and
press releases in newspapers, making telephone calls, conducting one-on-one interviews, and word of mouth, and networking community meetings:

We did ...Save the Day cards where we sent out announcements as well to organizations or individuals kind of thing. You know, “Hold these dates” and so we were trying to get people, and then a lot of it was mainly phone calls and face-to-face... “...we wrote like a press release and sent it out to our newspapers, and our subcommittee members would send it out in print mail, like work newsletters ... there were email blasts.

Once the production team and cast are assembled, the director’s job is to see how all the key elements of the performance come together and to communicate this vision to the cast and crew. Similarly, public health practitioners discussed the importance of having and maintaining a “big picture” point of view in mobilizing partnerships. Participants communicated to potential partners that addressing the public’s health involved not only LHDs, but organizations and individuals that are part of a large public health infrastructure, in effect a director’s artistic vision. Additionally, public health practitioners were not only focused on the LHDs’ interest, but on the interest of the entire system. One practitioner who was a Health Director, from a rural community, emphasized the value of having a system-oriented perspective from the LHD in working with other organization as a LPHS:

I think your leadership in your health department is key. You need leaders who embrace the importance of collaboration. You have some individuals who want to be an island unto themselves. They want to be just totally cut off and do everything for themselves, and see things in the silo approach instead of us being all joined and doing it.

The director also may request working with actors from previous performances especially if a rapport was established and they worked well with one another.

Relationships with organizations and individuals through previously established
partnerships were also shared among participants, in which trust was already developed. Additional benefits in using these groups included avoiding duplication of services and programs and providing human or financial resources to new or existing initiatives. One participant alluded to the ease of engaging organizations in their mobilization efforts:

I know all of these people. I mean everybody who came I know their first and last name and where they work, and can email them in a heartbeat, and they've worked with me on coalitions. Some of these people we've traveled for different kinds of projects that we've worked on around different issues in the past. So it's not like we're inviting strangers to this effort. These are people that we know and we've worked on significant issues with them in the past.

In the theatre to ensure ongoing collaboration among the director, cast, and crew, the stage manager coordinates different aspects of the production from "behind the scenes." A responsibility of the stage manager is to maintain communication between the director, production, team, and cast. Similarly, practitioners described their role in community assessment partnerships, for example, as maintaining communication with partnerships between meetings. Additionally, practitioners handled administrative aspects of the partnership, which included sending securing meeting location, meeting reminders, recording meeting minutes and creating the agenda—in short, stage managing the production from "behind the scenes." A practitioner, who was responsible for beginning a community improvement partnership stated:

... we basically took a lead role in putting MAPP together, and it kind of involved putting together and sending out letters telling people what MAPP was about and why we're doing MAPP, and then also the importance of conducting a MAPP plan ... it involved us doing the agendas, setting up the meetings initially... getting it rolling ...

A stage manager is also responsible for ensuring that the director's artistic choices are achieved for the performance. Similarly, practitioners described their role as being
responsible for maintaining balance between the leader of the partnership (which may or may not be a member of the LHD) and participating members. To ensure that partnerships are not owned or viewed as solely driven by the LHDs, some participants described maintaining balance by facilitating efforts as opposed to leading efforts. One participant further differentiated the difference in leadership and facilitation between the responsibilities of the LHD and community leaders:

... [we] needed to make sure that we understood what our roles were, and what the roles were of those two co-chairs of Vision 2015. And we made sure we were "staying in our lane," as our district director likes to say. We were only there to facilitate. We could troubleshoot and answer questions, but we really ... educate[d] the people who were actually in those leadership roles so they understood what needed to happen between now and the next meeting.

Last, but not least, the stage manager makes sure that the actors have the necessary props and follows the cues and script as prescribed by the director. As with the stage manager, practitioners support the participants through activities such as mentoring community leaders who serve in visible leadership positions.

The Script

The theatre script has several purposes. It is used by the director to prepare for the performance and determine what is needed for successful execution. It also contains cues and lines of cast members so each person is able to clearly perform their role in the performance. The script also may be executed as it is written or improvised to allow for more originality and flexibility and to inform the director’s vision in working towards the performance.
During the initial review, the script may be used as it is written. Maintaining the integrity of the script may include directing actors to recite the lines as written as well as advising the production team to use props, wardrobe, and setting as described. In some mobilization efforts, the “script” represented a proxy for a prescribed national public health model that provided the rationale for partnering, as well as associated specific strategies for achieving the objectives of the national and local work of the partnerships. Nine of the twelve practitioners used MAPP and the NPHPSP, and three practitioners only used NPHPSP, to create new or strengthen existing partnerships.

In this study, MAPP was perceived among these practitioners as a community planning process that allowed for organizations and individuals to collectively decide on issues that are important for the community to solve together. The MAPP framework, or script, was perceived as useful in mobilizing partnerships. It included instructions on recruiting potential partners to participate in the process, provided several assessments to collect and analyze data on community strengths and rated progress of the LPHSs in promoting population health, and using these results to shape recommendations. One practitioner that recently began implementation of MAPP mentioned,

... the whole purpose of MAPP is also to get partners together, let them know about what we’re doing, and the different issues that are identified through the assessments ... finding out what residents feel are top health concerns [and] finding out from public health stakeholders [what’s] good or not so good ... in different areas. Doing a data-related assessment so that we know where we’re looking at ... and setting up ... steps [to] put together ... goals. For example, it could be to maybe increase mobilizing partnerships and increase the outreach to different partnerships, and then having ... action step[s] in effect to make that happen.

Not all mobilization efforts, however, used a national framework, such as MAPP or NPHPSP, just as a script may be improvised instead of being used as written. In this
case where a national model was not used, a specific issue served to catalyze partnership mobilization. Mobilization efforts were also influenced by a need pre-determined by participation in an existing group or community process, availability of resources, or knowledge of mobilizing partnerships through previous experience. One participant stated:

"... mobilizing community partnerships means that they're issue driven over a larger thing ... we have a health alliance and [we] develop some principles for that alliance, and then [we] seek to invite people who want to work together to support the principles ..."

Public health practitioners provided examples of partnerships in which an informal process of mobilization was used. Such informal partnerships focused on a specific health issue such as emergency preparedness, obesity, tobacco prevention, diabetes, and immunizations.

Whether maintained in its original state or improvised, the script allows the director, cast, and crew to see the significance of their individual role in the theatre.

Similarly, public health practitioners described that the NPHPSP showed the importance of private, public, and voluntary organizations as well as volunteers within the public health infrastructure. Many participants referred to a visual illustration of the public health system. This illustration (known as the “egg or jellybean diagram” by several participants) showed different organizations and community members represented in the public health infrastructure. Within their examples, participants mentioned health-related and non-health related organizations such as hospitals, clinics, community-based organizations, chambers of commerce, fire and emergency medical services, local businesses, and universities in NPHPSP. One practitioner, using the NPHPSP to represent
district health department, described this shift to public health improvement and the importance of a multidisciplinary approach to create comprehensive strategies:

... the local public health system is so far beyond the health department, and I think with this kind of “new age” in public health is really looking at population-based assessments and looking at the community, you have to have kind of a multi-disciplinary approach, and have people from all different groups engaged in order to really be comprehensive and to be effective in the community.

Additionally, the script allows for the director, cast, and crew to see how each cast member is contributing to a larger purpose beyond their individual function. Similarly, practitioners mentioned that the national models, such NPHPSP and MAPP, educated the community about their role in the LPHS. One practitioner, who implemented the NPHPSP as part of MAPP, shared:

[The assessment] really helps us educate our community partners about how they are a part of the local public health system, and I think that tool, if it's presented properly, really does a good job of showing the community that they are a part of it.

Using the script as written may be motivated by the audience’s demands, e.g. an audience may expect and prefer to see Shakespeare’s King Lear performed exactly as written. The audience contains people interested in the theatre, critics, and patrons and those persons provide resources and financial support for the performance. Likewise, several practitioners were using MAPP and NPHPSP to prepare for accreditation, in effect using the script as written to please a segment of their audience. These assessments and community improvement processes such as the NPHPSP were seen as beneficial partnerships because it fulfilled state mandated accreditation requirements to show evidence of continuous quality improvement efforts within their jurisdiction:

... we are charged with doing a community assessment every three to five years. We focused on the Performance Standards, the NPHPSP, to look at the public
health delivery system here in our community and to really focus upon how our partners saw us as a player in that system.

Based on the practitioners' perceptions, the use of a national framework (MAPP or NPHPSP) or a non-national framework was motivated by preparing or meeting national objectives (patrons) or local needs (audience). Whether it was a prescribed or non-prescribed script process, similar steps in mobilizing partnerships were described by public health practitioners. These steps were identifying and inviting key constituents to participate in public health improvement, conducting assessments, and creating a plan. The overall goal was to encourage more participation and leaderships from organizations and individuals beyond the LHDs.

**The Stage**

The stage is a designated space for the cast to perform and a focal point for members of the audience to watch the performance. A stage may have limited number of props or many props to support the content of the script. Similarly, public health practitioners have varying descriptions about the "space," or structures in which mobilization of partnerships occurred. LHDs reported both informal and formal structures in mobilizing partnerships and considered formalized partnerships as a higher level of functioning.

A permanent stage may be used in theatre to support ongoing performances, just as formal structures may be established during mobilization. These formalized structures were used to clarify roles and expectations, as well as provide accountability for achieving goals. Memorandum of understanding and contracts were used to create formal
structures. These tools helped maintain continuity in partnership work and also help new members or leaderships transitioning to new positions in partnerships understand the expectation and purpose of the partnership. One participant stated:

… letter of agreement, or Memorandum of Agreement, gave consistency through the changing leadership so that we were able to maintain the process, even though leadership had changed substantially.

Practitioners also mentioned the development of formal subcommittees. Subcommittees were described as part of the partnership structure operating based on procedures. These procedures included having agendas with issues requiring ongoing discussion, decision-making on important topics, and delegation of tasks. Formal partnerships were described as having a chairperson facilitate the meeting; more than one person or organization as co-chair to share responsibility in facilitating partnership activities.

Some theatre stages are not fixed, can be easily altered, and provide more flexibility in meeting the needs and changes made by the director, cast, and crew. Similarly, some mobilization efforts were described as not having a formal structure. These "loose" arrangements, however, were mostly dependent on the partnership's purpose. For instance, several LHDs mentioned partnerships that were intended to provide a forum for organizations and individuals to network and share information. These partnerships were initiated for LHDs to give updates about public health concerns and engage new and existing partners in potential projects that may have the opportunity to become more formal. Organizations and individuals may or may not have similar goals; however, they may serve the same population. One practitioner defined his definition about partnership:
... it’s really just whether we have relationships with an agency now. And if they at any time work with the population of people that would be impacted by our work they should be involved. Mainly because we serve everyone in the county, and so there’s no agency that wouldn’t be a central partner ...

Whether using a permanent or flexible stage, participants discussed informal and formal structures that were useful in working with organizations and individuals in their communities. These structures varied depending on the purpose of the partnership. The distinction was made, however, in the purpose of the partnership that determined formalization. Examples of partnerships in which LHDs described a formalized structure included exchange of money or resources, documentation outlining roles of partners, and operating processes such as agenda and tasks.

Rehearsals: Interactions Between the Director, Cast, and Crew

During rehearsals, the director, actors, and crew begin to build relationships and learn to work together in the hopes of delivering a successful performance. In working with others, LHDs reported their role in cultivating relationships with community partners. The director uses rehearsals to ensure that quality of the performance is obtained. To obtain this quality, the director may use a collaborative style of leadership to encourage active participation and build relationships with the cast and crew.

The same dynamic was expressed by several participants who described partnership mobilization as being based on good relationships. One participant shared,

All good work happens within the context of a relationship. If we’re going to partner we have to have a good relationship. You have to be comfortable with me. I have to be comfortable with you, and we have to be able to come to this mutual understanding about how we’re going to work together to benefit each other....
Key characteristics that contribute to a good relationship were seeking mutual benefit when possible, having a previous work history, establishing positive environment, supporting partners’ activities and programs. Seeking mutual benefit was important even if it was not possible to obtain at all time. One participant stated:

Any time I am approaching someone else about engaging in a partnership, I want to come in there and say, “This is how this partnership will benefit you and your agency.” This is how we will make it easier for you to access this population. This is how your people will benefit from this involvement. This is how you as an agency will benefit.

Being honest and cooperative and reaching out to one another to solve mutual problems facilitated the development and sustainability of good relationships. Creating an atmosphere of openness, honesty and effectively dealing with conflict are essential in cultivating internal dynamics of partnerships. One participant shared,

One of the things to me about a good working relationship is you can be honest, even when they don’t want to hear your side of it, and that’s one of the things that I’m very open and up front with people I partner with. I tell them, “You will always know where you stand with me, and I’ll always be honest. You may not always like to hear what I have to say, but I will always be honest and give you the best information.

Rehearsals are necessary to avoid delivering poor performances, and thus require a lot of time, just as practitioners recognized developing partnerships required time from all parties involved. Participants agreed, however, that the time placed in mobilizing partnerships was worth the investment participants place towards it. A Health Director who described the importance of developing partnerships mentioned:

For partnerships to work, you have to invest time. And you can’t just show up for meetings. You got to work ...
Several public health practitioners articulated that their LHDs have made progress in mobilizing partnerships and are better positioned to work with organizations. Participants recognized, however, that time and more work, i.e., more rehearsal, are needed to advance their partnership efforts. One participant shared:

I still see us almost not in our infancy stages of learning how to mobilize in partnership. But getting ready to move to [another level]...which is good and bad. We know how to do it. We’re doing some things right. Other things we’re doing not quite so well. And then other people say they want to come to the table, but when it’s time they don’t really come to the table. But we’re sort of at that phase in a while where we do have people still working in silos. We still have some organizations that are trying to protect their turf for various reasons. We’re working through it.

For cast and crew members who are neophytes to the use of rehearsals, the director may take a more active role in leading the first few roles. In future rehearsals, more input may be sought from the cast and crew so they can assist in the development of the performance. In the same manner, some public health practitioners expressed a desire for their organization to move from leading mobilization efforts to allowing partners to lead the partnership. Practitioners noted that as more partners became more comfortable with the purpose of the partnership and members’ contributions, LHDs assumed fewer responsibilities while other organizations and individuals assumed a more active role. One participant stated,

...[as]we were getting a little more comfortable and people are understanding what we are doing, we can kind of step back a little bit and get someone else that’s interested in taking a lead role.
Discussion

The partnership mobilization as a theatre metaphor proved useful in interpreting the transcripts. Initiating partnerships contain elements that are evident in theatrical productions. Like theatre, mobilization involves the leaders on and off stage guiding the process, a script that can be followed as written or improvised, staging, management and cultivation of relationships, and achievement of a certain result.

In this study, LHDs described being a director and stage manager in mobilizing partnerships, as well as a desired to become a member of the cast. Findings from this study are consistent with other studies, in which multiple activities are conducted by LHDs in partnerships including facilitation, convening groups, and providing in-kind resources.\textsuperscript{6,11,13} This study also found that LHDs staff expresses a desire to become a part of the cast, and not to always assume a director's role in mobilizing partnerships. This underscores the importance for LHDs not to feel compelled to always create new programs and services, but, to also use existing relationships as a means of achieving some goals.

For LHDs remaining as the director/stage manager, the value of developing an environment in which partners may benefit from their participation in partnerships was perceived as important. Previous studies have reported that achieving mutual benefit, trust, and respect as key components in creating an environment where partnerships are successful, particularly in the development phase of partnering\textsuperscript{25,27,33} and these LHDs appear to understand this concept. Collaborative leadership allows people with different perspectives to come together to discuss issues and find ways of solving problems or
achieve broader goals. It is a leadership style that encourages partners to establish trust, share in decision-making, promote self-reflection of one’s leadership abilities, and fosters professional development through ongoing mentoring and coaching.\textsuperscript{21} Collaborative leadership may be effective in public health planning that involves multiple stakeholders who share common interests. One partnership in particular, the Turning Point initiative, emphasized principles of collaborative leadership among LHDs working with multiple sectors and volunteers.\textsuperscript{31} It should not be assumed, however, that public health practitioners have the necessary tools and skills to work with organizations, community leaders, and residents. Effective partnership mobilization requires practitioners to understand the principles of collaborative leadership and the value of addressing public health issues from a systems perspective. Trainings are typically not offered to assist public health practitioners to form, maintain, and evaluate the outcomes of effective public health partnering. LHDs participating in opportunities affiliated with the Turning Point Institute may have received and benefited from training and resources that promote a collaborative style of leadership. These trainings are often times targeted to public health directors and may not be available to employees responsible for mobilizing partnerships. Therefore, LHDs should seek consider partnering with universities or public health leadership institutes that provide more practice-based education focused on collaborative approaches to lead and facilitate partnerships.

Because community mobilization efforts include processes that LHD staff might not be equipped to lead, national planning process such as MAPP and NPHPSP proved useful to many of the LHDs in this study. These scripts, so to speak, provided direction in creating new partnerships or setting the stage for meeting national objectives, similar to
audience (observers and patrons) influencing the use of the script. Findings from this study suggest that practitioners are beginning to use established community improvement processes, such as MAPP and NPHPSP, to prepare for voluntary accreditation.\textsuperscript{35} Accreditation assesses LHDs' performance in providing services to their service population and is seen as a potential avenue for LHDs to establish consistency and reduce variability in delivery of services created through partnerships.\textsuperscript{36} Following the script as written may limit creativity and may not fit the talents and skills of the cast. Similarly, the use of national planning models may constrict the flexibility and adaptability of LHDs especially if staff and resources are limited. Previous studies have reported that a major part of MAPP and NPHPSP implementation was dependent on staff and financial resources.\textsuperscript{12,15,16} It was also reported that most community assessment partnerships are primarily funded by the LHD and very little financial support comes from other organizations.\textsuperscript{32} As a result, careful consideration must be taken into account for LHDs that may have limited resources to implement these processes.

Various stages are needed to rehearse and perform as a partnership. Certain stages, or structures, may be more conducive in facilitating the development of partnerships to produce long term outcomes. This study showed that both structures, permanent and flexible, are present in practitioners’ mobilization efforts. Previous studies show that coalitions and partnerships based on contractual agreements have been viewed as more formalized arrangements, thus suggesting this type of structure may establish continuity and provide accountability of resources. These findings suggest that relationships may have time to develop and partners are able to document the use of partnership and are able to link improvements to health outcomes because a formalized structure exists. It is
important to note, however, that not all partnerships need to have a formal structure. Informal partners provide opportunities to initiate and develop potential partnering relationships, just as flexible stages meet the needs of the director, cast, and crew as changes are made to the performance. Theoretical frameworks point to the importance of examining structure in contributing to the development of partnerships by organizing people in a way that allows for tasks to be completed in order to produce results.\textsuperscript{21,22} Operational processes and effective leadership are two conditions postulated as enhancing organizational capacity of partnerships, just as the stage provides a context for the performance. Other partnership studies have showed the value of partnering organizations providing staff to assist with mobilization efforts to maintain continuity and focus on goals.\textsuperscript{35,37,38} These conditions may strengthen LHDs’ capacity to partner with organizations and individuals in their community. These findings emphasize the importance of understanding the context and mission in which partnerships are formed. Therefore, LHDs should consider the intent and balance of partnership arrangements that meet the organizational goals of LHDs and needs of the population needs.

Just as the performance is designed to emote an emotional or intellectual response from the audience, mobilizing partnerships produced different results depending on the goal and expectations of participating partners. In this study, practitioners described the specific activities that allow mobilization to occur with organizations and individuals. Previous studies reported highly levels of emphasis on specific partnership activities used by LHDs or LPHSs such as participation in emergency preparedness activities, tobacco cessation, and maternal and child health, just as performances may have a specific genre (i.e., comedy, historical, tragedy).\textsuperscript{4,24} This study is unique in that public health
practitioners, in their role as director/stage manager, described individual partnership activities that were used as part of the mobilization process before achieving the result, such as brainstorming potential partners and inviting partners to participate in community health issues. These individual activities, in addition to some specific partnership activities, are measured in the NPHPSP; however, it does not address "who" are conducting these activities on behalf of the LPHSs. Therefore, national public health organizations responsible for using the NPHPSP to measure system performance should consider questions that examine the organization or group of organizations within the LPHSs that carry out individual activities related to partnership mobilization.

Several implications are apparent for LHDs to consider in improving partnerships with organizations in their jurisdictions. Assessment/planning models may serve as a framework for LHDs and organizations so they may mobilize and evaluate their efforts more effectively. National public health organizations, however, should remain flexible in considering the use of community health improvement processes because LHDs are using different approaches to address public health issues due to resources, community need, and availability of staff to facilitating efforts. These assessment/planning models have been very useful to public health practitioners who are interested in showing evidence of mobilization efforts, however, there may be LHDs that do not have the resources to implement or sustain these processes over a long period of time. It is more important for LHDs to be aware of resources in order to engage their community in public health improvement and to realize that these efforts are feasible without the use of a structured assessment model, although a more permanent "stage" for these activities may still remain a long-term goal. Although partnership arrangements may vary in formality, a
model may serve as a tool to track progress and change in partners’ expectations and goals over time. LHDs should also consider more innovative approaches of improving partnership capacity. Assessments provide opportunities for LHDs to examine their areas of strength and areas where they need to improve. One tool designed based on social network analysis, PARTNER, has been developed to measure the quality and interaction of partnership ties between LHDs and other organizations. The benefit of this tool is that it provides quantitative estimates of partnerships that can be used to determine which partnerships are working well and its relationship to health outcomes.

Several implications are apparent for LHDs to consider in improving partnerships with organizations in their jurisdictions. Community planning models can serve as a framework for LHDs and organizations. Keeping with the purpose of these models, they may act as an impetus of LHDs’ mobilization and evaluation efforts. These processes have been very useful to public health practitioners need to show evidence of mobilization efforts, however, there may be LHDs that do not have the resources to implement or sustain these processes over a long period of time. National public health organizations should remain flexible in considering the use of community health improvement processes because the use of certain models is influenced by LHD resources, community needs, and availability of staff to facilitating efforts.

Although partnership arrangements may vary in formality, a model may serve as a tool to track progress and change in partners’ expectations and goals over time. LHDs should consider more innovative approaches of improving partnership capacity. Assessments provide opportunities for LHDs to examine their areas of strength and areas where they need to improve. One tool designed based on social network analysis,
PARTNER, has been developed to measure the quality and interaction of partnership ties between LHDs and other organizations. The benefit of this tool is that it provides quantitative estimates of partnerships that can be used to determine which partnerships are working well and its relationship to health outcomes.

Several strengths are evident in this study. This is the first study to qualitatively explore perceptions of partnerships by public health practitioners. Findings from this study provide an initial analysis of perceptions about partnerships that may inform ongoing evaluation and implementation practices. These findings may be considered to promote and improve mobilization of community partnerships by LHDs. This study provides more details than previous studies on strategies used to engage organizations and individuals in public health, characteristics considered successful in mobilizing partnerships, and examples of partnerships and LHDs’ contributions. Furthermore, we were able to gather perspectives from LHDs representing different states and jurisdictions that included city, county, district, and combination of city-county authorities. Information obtained from this study may apply to LHDs that work with a broad representation of public and private organizations and community residents and are involved in coalitions, information/resource sharing partnerships, and coordinated activities.

Our sample consisted of LHDs that were using a community health improvement process, (MAPP), or a system assessment (NPHPSP) to improve public health performance and delivery of public health services in local communities. The participants in this study were specifically hired by their LHDs to mobilize partnerships or sought additional resources from grants or other partners. Additionally, participants in this study
should be considered early adopters and very proactive in their quest to improve partnerships. Several practitioners were using MAPP to prepare for national accreditation and demonstrate a high level of competency in mobilizing partnerships gained through field experience and their profession. Some limitations were noted as well. For instance, LHDs that did not use NPHPSP were not represented in the sample. Secondly, several LHDs represented the Midwest, thus there was a lack of public health practitioners’ perceptions about mobilizing partnerships from southern, western, and northeastern portions of the U.S.

In summary, theatre, like partnership mobilization, is a dynamic process that requires many elements to come together in the successful execution of the opening night and future performance. Prior to the Institute of Medicine’s recommendation, LHDs were encouraged to mobilize partnerships as an opportunity to expand public health services in local communities. Now, the bar is set for LHDs to not only establish systematic partnerships, but to produce evidence of engaging in these partnerships. Public health practitioners play multiple roles and a collaborative approach in mobilizing partnerships as well as use planning processes, whether “scripted” or improvised, that other organizations and community leaders are unfamiliar with, to advance partnership efforts by introducing a new framework or integrating it into existing partnership infrastructure. Further research should consider exploring the perceptions of organizations and individuals working with LHDs in public health partnerships. Also, it may be beneficial to conduct a comparative effectiveness analysis of LPHSs reporting optimal and minimal activity to assess similarities and differences in partnership practices. Finally, future
studies should consider processes used to mobilize partnership attributed to improved leadership and health outcomes.

References


28. Qualitative Solutions and Research Non-numerical Unstructured Data Indexing (QSR NVIVO 8.0).


CHAPTER IV

PARTNERS' PERCEPTIONS IN WORKING WITH LOCAL HEALTH DEPARTMENTS

In a 2002 report, the Institute of Medicine (IOM) recommended that governmental public health agencies use partnerships as a means of increasing the effectiveness and productivity of community initiatives.1 In response to this call, local health departments (LHDs) are intentionally engaging public, private, and voluntary organizations in partnerships creating local public health systems (LPHSs).2,3 To date, partnership-related activities have been examined primarily through national assessments. Information about the types of partnership activities that LHDs conduct to address public health issues and the perspectives of LHD practitioners regarding their efforts to mobilize partnerships is documented.3–5 In contrast, the perspectives of LHD partners regarding characteristics that promote effective partnerships remain unexplored. It is important to explore these perspectives in order for LHDs to maximize partnership development and further cultivate relationships. Therefore, the purpose of this qualitative study is to explore the perceptions of organizational representatives and individuals regarding their participation with LHDs in the public health system.

As an LHD considers approaches to building its constituency, it is important for all partnering organizations and individuals to be respected and viewed as contributors.6,7 Including multiple sectors of the community in partnerships provides more opportunities for different skills and resources to be used in building core capacity and cultivates a
However, partnerships can also be indistinct and falter when trying to incorporate diverse perspectives from a multitude of organizations. The literature suggests that understanding and identifying the strengths of partnering organizations and participating individuals can improve coordination and sustainability of activities in these complex partnerships. Therefore, it is important to consider partners’ perspectives in working with LHDs in public health efforts.

Understanding the reasons that prompt participation of individuals is a necessary first step in the development of partnerships. As organizations and individuals are recruited, understanding the motivation for partnering can increase participation and member involvement. Researchers have found social responsibility, the use of incentives, personal/self interest in issue, and requirements or mandates associated with a professional’s line of employment as motivations to partner. Kaye (2001) asserts that individuals who are recognized for their contributions, receive respect from other members, have a valuable role, and are able to build relationships with other members are important in promoting member involvement. A study on LHDs and faith community partnership found that LHDs are likely motivated to partner because of the opportunity to share information and to improve coordination of services. This study, in addition to other studies, did not examine the motivations of the LHD partners. Therefore, it is not clear if they also have the same motivations as LHDs.

Once a partnership is formed, several elements are needed to build the internal capacity of partnerships. Member capacity is one area that is critical to the success of partnerships. This capacity focuses on the knowledge, skills, and motivations of participating individuals to access resources, perform activities, and work with others in a
collaborative manner. In coalitions, Downey (2001) asserts the importance of partnerships allowing their members to use their individual attributes to successfully complete tasks. Previous research suggests that non-governmental organizations, other governmental sectors, and community volunteers participate in partnerships through specific activities that include facilitating meetings, coordinating activities, recruiting volunteers, providing services, and advocating for underserved or vulnerable populations. With the wide variety of activities conducted in these partnerships, LHDs, as the center of the LPHS, have a responsibility to align member capacity with activities.

Securing human and financial support is important is also important in the development and sustainability phases in partnerships. In LPHSs, resources consist primarily of money, facilities, and people, including their skills and expertise as well as ability to convene and share information. Even with motivation to partner and a shared vision, challenges in securing and maintaining financial and human resources can impact the ability of a partnership to be developed or maintained. In short, when resources are scarce, partnering can be difficult. In a study of a community public health assessment projects, sites lacking a full-time coordinator had lower partnership activity levels than sites with such a coordinator. Evidence that having limited number of resources and staff may be impacting the ability of those from smaller jurisdictions to partner has been reported in several studies. One national study of LHDs and faith-based organizations partnerships, found that LHDs in large jurisdictions were more likely than those in smaller jurisdictions to conduct higher level partnership activities. Another study, that examined allocation of public health resources, reported that LHDs in urban areas with more funding and staff developed a greater number of partnerships with other
organizations and provided more health services than rural and metropolitan LHDs.\textsuperscript{5} There is little information describing how the use of resources among organizations within LPHSs strengthens the partnering experience.

Despite the time, effort and resources needed for development and sustainability, partnerships continue to be recommended because of the belief that it allows public health to successfully reach goals.\textsuperscript{1} However, partnership success remains unclear at times and difficult to measure. The literature conceptualizes that partnership success be defined as the interaction of organizations and individuals working together on a common goal, sustainability of effort, improvement in service delivery or health outcomes of the population.\textsuperscript{21-23} Much of the attention in public health has focused on assessment and process measures for partnership effectiveness, such as type of partnership activities, number of partners involved in public health partnerships, and performance.\textsuperscript{3-5,24-25} One study examining LHD partnerships in Wisconsin found having a budget, receiving financial contributions from partners, and having a long term partnership resulted in effectiveness.\textsuperscript{3} Yet another study examining partnership-related activities conducted by LPHSs in 23 states found that LPHSs were infrequently reviewing partnership effectiveness at all, only 4% of LPHSs were conducting this activity at least 75% of the time (Chapter II). Interestingly, researchers have not explored LHD partners' perspectives concerning measures of partnership success.

Literature regarding partnership practices occurring within LPHSs remains sparse.\textsuperscript{3,26} In general, research studies have primarily focused on the perspective of LHDs, with no emphasis on exploring factors from the LHD partners' perspectives.\textsuperscript{3-5,27-29} In order to develop and maintain partnerships, LHDs must be aware of their partners'
motivations, attributes, resource levels, and their perspectives regarding project success. Findings may provide guidance to LHD administrators and the broader public health system who are seeking to initiate and sustain partnerships.

**Methods**

**Participant Selection and Design**

Organizations (governmental and non-governmental) and individual volunteers working with county, city, county-city, or multiple counties/district LHDs were recruited to participate in interviews. In a concurrent study on partnership mobilization, participants representing seven LHDs were asked to recommend organizations or individual volunteers they work with on public health initiatives. Identification of potential participants was based on their: (1) participation in community coalitions, task force, or advisory groups facilitated by LHDs within the past year; (2) having taken a leadership role (e.g. chair, coordinator, facilitator) on a community initiative involving LHDs within the past year; or (3) receiving or providing human or financial resources to a community initiative involving the LHD for at least one year. Representatives included upper or middle management or persons working with or providing services to target population of the partnership. Several emails were sent to encourage participation following the initial request for recruitment in the study. The research protocol was approved by Western Michigan University Human Subjects Institutional Review Board.
Data Collection

Data were collected via semi-structured interviews with participants. An interview guide was developed and included questions about definition of partnership, perceptions, processes, benefits and challenges of participation, and markers of success (Appendix B). Interview questions were developed based on the extant literature and with consultation from public health organizations that work with LHDs. Questions were reviewed by the co-investigators and revised to capture more targeted information and viewpoints. Interviews were conducted via telephone (n = 7), lasted approximately one hour, and were audio-recorded.

Data Analysis

Interviews were transcribed by a professional transcriber and data were coded. Transcripts were reviewed several times by the principal investigator as a means of systemically coding data in appropriate thematic categories. Data were organized and managed using Qualitative Solutions and Research Non-numerical Unstructured Data Indexing (QSR NVIVO 8.0) software program.

Two levels of analysis were conducted. First, open coding was used to categorize factors influencing organizations and volunteer participation in public health partnerships. Coding involved segmenting data into units and rearranging them into categories that facilitated insight, comparison, and clustering to a particular question or concept. Then, results were further interpreted and constructed through thematic analysis using Owen's criteria. These criteria inform the development and identification of themes through
repetition, depth in contextual meaning of the data, and usual or different meanings of a phenomenon or event shared by participants.

Participant Characteristics

Seven participants were interviewed in the study representing four different states, three geographic locations, and three different types of organizations within LHD partnerships (Table 4.1).

Table 4.1. Participant Characteristics (n = 7)

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Number/Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Region/States</strong></td>
<td></td>
</tr>
<tr>
<td>Central (Kansas)</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>West (Arizona)</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>Midwest (Kentucky, Ohio)</td>
<td>4 (57%)</td>
</tr>
<tr>
<td><strong>Status</strong></td>
<td></td>
</tr>
<tr>
<td>Governmental/public sector</td>
<td>2 (14%)</td>
</tr>
<tr>
<td>Non-governmental/private sector</td>
<td>4 (57%)</td>
</tr>
<tr>
<td>Individuals/volunteers</td>
<td>1 (14%)</td>
</tr>
<tr>
<td><strong>Type of organization</strong></td>
<td></td>
</tr>
<tr>
<td>Health-related organizations</td>
<td>4 (57%)</td>
</tr>
<tr>
<td>Non-health related organizations</td>
<td>2 (29%)</td>
</tr>
<tr>
<td>Grassroots/community leader</td>
<td>1 (14%)</td>
</tr>
<tr>
<td><strong>Occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Marketing specialist</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Epidemiologist</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Professor at academic institution</td>
<td>1 (14%)</td>
</tr>
<tr>
<td>Administrators</td>
<td>3 (43%)</td>
</tr>
<tr>
<td>Retired</td>
<td>1 (14%)</td>
</tr>
</tbody>
</table>

Fourteen partnerships were described by organizations and the volunteer working with LHDs (Table 4.2). Number of years that partners worked in LHDs in these
Table 4.2. Geographic Description, Partnership Focus, Motivation to Partner, Roles, and Years in Partnership as Described by LHD Partners

<table>
<thead>
<tr>
<th>Partner</th>
<th>Geographic description</th>
<th>Partnership focus</th>
<th>Motivation to partner</th>
<th>Role in partnership</th>
<th>No. years in partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rural area</td>
<td>Community health improvement</td>
<td>Access more people considered part of their clientele</td>
<td>Supporter: attended meetings, provided incentives to LHD for community meetings and at health-related events</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Exercise programs for seniors</td>
<td></td>
<td></td>
<td>&lt;1</td>
</tr>
<tr>
<td>2</td>
<td>Rural area</td>
<td>Identification of health services in jurisdiction</td>
<td>Expand amount of services provided to their clientele</td>
<td>Supporter/administrator: Liaison between organization and partnership; coordinate activities between organization and LHD</td>
<td>1 1/2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Infectious diseases reporting to state</td>
<td></td>
<td></td>
<td>++</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Referrals – sexually transmitted diseases</td>
<td></td>
<td></td>
<td>++</td>
</tr>
<tr>
<td>3</td>
<td>Urban area</td>
<td>Health and wellness coalition, specifically focused on physical activity and nutrition</td>
<td>Educate and access more people considered part of their clientele</td>
<td>Leader/administrator: initiated coalition, facilitate meetings, communicate with partner between meetings, coordinate coalition-related activities</td>
<td>5</td>
</tr>
<tr>
<td>4</td>
<td>Rural suburban</td>
<td>Alcohol, tobacco, and other drugs (ATODs) advisory board/coalition</td>
<td>Mandated by state agency to build community capacity</td>
<td>Leader/administrator: initiated coalition, coordinate activities</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tobacco cessation</td>
<td></td>
<td></td>
<td>+</td>
</tr>
<tr>
<td>5</td>
<td>Rural</td>
<td>Community health improvement</td>
<td>Personally interest in health-related issues</td>
<td>Administrator/Supporter: co-chaired subcommittee, secretary of a local coalition, local expert on quality improvement/accr...</td>
<td>1 1/2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Annual community event promoting physical activity</td>
<td></td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetes coalition</td>
<td></td>
<td></td>
<td>5</td>
</tr>
<tr>
<td>6</td>
<td>Urban area</td>
<td>Community improvement</td>
<td>Organization interest</td>
<td>Administrator: strategic planning, data collection, and analysis, facilitation</td>
<td>2</td>
</tr>
<tr>
<td>7</td>
<td>Rural area</td>
<td>Community health education initiative</td>
<td>Organization's mission to conduct community outreach and service</td>
<td>Leader/Administrator: grant writing and administration, strategic planning, meeting facilitation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Building LHD internal infrastructure and public health system assessment</td>
<td></td>
<td></td>
<td>&gt;1</td>
</tr>
</tbody>
</table>

+= Number of years not provided.
++Participant described partnership in existence for several years.
partnerships ranged from one to five years. The focus of these partnerships included chronic diseases, healthy lifestyle practices, infectious diseases, alcohol, tobacco, and other drugs, performance improvement, and community improvement. The most common type of partnership involving their organization and LHDs were coalitions or advisory groups focused on a specific health issue followed by community improvement processes that involved development of a strategic plan.

Key Findings

Identification of Themes

Four themes described the perceptions of organizations and the volunteer partnering with LHDs: (1) internal and external motivations, (2) partners’ roles and governing role of LHDs, (3) use of resources, and (4) indicators of success.

Internal and external motivations. Partners described both internal and external motivations that served as incentives for organizations and individuals to work in partnership with LHDs. Internal motivations included personal interest in public health issues and having a professional philosophy of collaboration. Some partners became involved in LHD partnerships given their belief that working with others was beneficial. A partner shared:

I’m a very strong believer in collaboration and it’s something I really feel strongly about ...but I really think that there’s so much more that we can do by working together.... And that's what makes a partnership ... I think [it’s] so essential and valuable.
One partner expressed a personal interest in a particular public health issue. The sole volunteer in this study was motivated to partner with the LHD because of her personal interest in health:

I’ve always been a person who volunteers ... usually somebody asks me to do something and if it’s of interest, I’ll do it.

External motivations included following the organization’s mission or mandate or increasing their organization’s access to a specific population. Many LHD partners expressed a desire to participate in the partnership to reach a certain clientele. By participating in these partnerships, organizations helped other organizations in addressing health issues, but also saw an opportunity to inform populations about the services offered by their organizations.

I think [the organization] realized the importance of it because as a Medicaid provider we’re the largest provider here in these four counties. So they recognized the importance of having a presence ... the primary importance was making connections within the community that included providers that could drive patients to us.

Another external motivator was being prompted by an outside agency, such as a national or state organization, to partner. Several participants taking the lead described developing implement strategies used to create or enhance partnership initiatives. One partner mentioned partnering with the LHD to fulfill state mandate:

[The] ... Alcohol and Substance Abuse Policy Board ... [was] first initiated at the state level. They provided some funding. People had to work and to develop a strategic plan or whatever and apply for funding at the county level to establish these Boards ... I was actually working with some people from the Health Department at that time to get this started here in [county name] County.
Some partners, particularly working for organizations, were both internally and externally motivated to work with LHDs. For instance, one partner working for a large managed care organization participated in an LHD partnership because of her interest in improving community health. However, her participation also was motivated by the opportunity to conduct outreach to get more people to utilize her organization’s services:

On a personal standpoint as a health educator I want to see my patients, for a lack of a better word, have a healthier lifestyle... [I also want to see] an increase in our membership numbers.

Therefore, the volunteer’s participation in LHD partnership appeared to be driven by personal interest while individuals representing organizations appeared to be driven by external motivations (organizational interest, funding, or being approach by the LHD) or both internal and external motivations.

**Partners' roles and governing roles of LHDs.** Partners described the variety of roles partners assumed in partnerships involving LHDs. As one partner shared, “everyone has to play a role in ... partnership, and that means that everyone has responsibilities.” Some partners described their role as leading partnerships and in that role their responsibilities included securing funding and managing partnership activities. Organizations that led partnerships discussed managing communication with partners between meetings, facilitating coalitions or partnership-related meetings, and overseeing the administration of activities delegated to other partners. A partner working with the LHD in a large county-wide health improvement initiative stated:

we’re really leading ... because we have expertise and the knowledge in that area. The Health Department certainly does do health promotion, but they haven’t been invested in it and are not necessarily experts.
Several participants taking the lead in partnership described securing financial and human resources to implement strategies from a community-based improvement process and creating or enhancing public health initiatives.

I wrote the [grant] ... I was involved in administering the grant ... work[ed] with [the health department] to set up the clinics ... [and] the [community] outreach. I was very hands-on ... I was there for all the events.

For LHD partners not assuming a lead role, their specific function in the partnership was more of a supporting role. A partner working with the LHD on a community-wide partnership coalition shared:

The Health Department has always been running the show I guess in terms of coordinating all of these stakeholders in the community. And we’ve been like kind of consultant and contractor...

Specifically, these partners provided technical expertise or support that extended beyond the scope of the LHD. Several participants considered themselves as “resources” by presenting information on a specific subject matter, collecting and analyzing data, and connecting LHDs with new organizations. One partner described her role in supporting LHDs’ leadership in partnership:

...my role was minor. Participate in subcommittee meetings [and] local public health system assessments as a participant. And I provided [incentive items].

Regardless of their role, many partners recognized that the LHD was the governing voice and played an important role in policy development because of their mission and mandate to protect the public’s health. One partner shared that the LHD is mandated to perform certain duties and understood that their contributions, while just as important, should complement the LHD efforts:
Our role...is not to do community health.... We get involved with it but we just
don't have the funding and we don't have the jurisdiction to do that. The things
that we call for in our [partnership] strategies [will use] language that pertains to
public health mandate- protecting the public health. It only makes sense that we're
collaborating with them. The Health Department has a legal obligation to do
that... they have some involvement and some expertise, but they need to as well
rely on their community partners.

In addition, some organizations leading local partnerships involved the LHDs on
governing or leadership boards because their presence was critical in creating community
change as well as improving coordination of services among organizations. A partner
leading a local coalition described the importance of the LHD participation on the
leadership team:

we have our leadership team ... they really are the policy makers ... you have to
be at a very high level to be on the leadership team ... the folks that participate on
the leadership team ... expertise around a specific policy issue. The Director of
the Health Department is the key for us, because ... she is ... the one that I can
call and say look, we’re having an issue ...

In sum LHD partners assumed a range of roles. Some partners were leading the
partnership because of their knowledge and expertise while other partners supported the
LHD in their partnership activities. Partners, however, believed that LHDs were the
governing authority on public health issues and were a key player in moving partnership-
related issues forward, regardless of the role the non-LHDs organizations played.

Use of resources. These partners recognized that the effective use of resources to
further mission and goals can influence significantly the type and quality of the
partnership. A partner, representing a large medical provider, shared the importance of
being intentional in working with the LHD and others in addressing public health issues:
“It’s finding who knows what best and using the assets of each person the best way
possible.”
Partners recognized that they must be intentional and effectively use resources provided by their agency as well as from other agencies. One type of resource that was frequently described was the use of staff to accomplish partnership goals. For example, partners acknowledged that LHDs provided staff to attend meetings and coordinate activities and assist with the development of strategic planning and grant writing. One participant provided an example of staff support provided by the LHD in participating in the development of a strategic plan for a community-based coalition:

... the biggest resource is allowing the two full-time staff to participate in that process. And I'm telling you, it took a lot of time. We worked for months on this. Cause we had to develop [a] three-year strategic plan that had to be approved by the state. And so there were lots of meetings and organizing of meetings and setting agendas and such as that, and they were a really big part of that. So the biggest resource was probably the commitment, through the commitment to the project they committed those two staff to work on this through the finish of it.

For staff time to be used effectively, several partners described the importance of avoiding extraneous work not related to the partnership mission.

Another way that LHDs effectively used resources was expanding beyond their core group of partners. Going beyond the same group of people gave new partners an opportunity to contribute and offer untapped resources, thus maximizing the impact in addressing the community’s needs. Partners were able to learn from each other. One university partner shared the value of serving as a mediator in creating a new partnership between the LHD and another community organization:

I mean the people from [name of organization] learned a lot about public health that they didn’t know about, and the people from the health departments learned about the[ir] resource[s]. So it was a good thing to bring them in.

Use of resources was also described as being related to locality. A majority of the participants represented partnerships located in rural communities. Some partners
described partnership in smaller communities as a necessity resulting to individuals from
different organizations working together more often. An individual who worked for a
public sector agency in a rural community and worked with the LHD on partnership-
related activities stated:

... I do think that in a smaller community you have fewer resources and so you’re
bound and more likely to work with each other.

Use of personnel as resources in partnerships was maintaining sustained
participation over a period of time. Staff turnover in a LHD was mentioned as leading to
the LHD to being unable to effectively contribute to the work of the partnership.
Turnover was also described in relationship to short-term grant funding that allowed for
staff to participate in the partnerships for only the duration of the funding. To counteract
this limitation, several participants discussed the importance of building communication
between partners and LHDs by engaging the director of the agency. One partner shared
the importance of keeping the LHD engaged in partnership in spite of organizational
changes:

... the Health Department has had some turnover in their staff quite a bit, and
that’s the other hard part with government and, then relying on grants, and just
initiative money coming in. I can tell you one strategy that we have, to keep the
Director of the Health Department on our leadership team. That position is key
because that’s not a big turnover position, not in most Health Departments. She is
also the one that I can call and say look, we’re having an issue here or look, I’m
not trying to tell you what to do here but if we could redirect this person into
going this way. So that’s key right there, if you can keep the highest level person
engaged on their level, that gives you a lot more flexibility down on the worker
bees.

In sum, partners described having to ensure effective use of staff and their time. Rural
partners described having to partner more often.
Markers of success. Partners of LHDs provide a variety of markers of successful partnerships. Most partners described the importance of building relationships as an indication of success. Specifically, indicators mentioned by partners included assembling as a collective group, member satisfaction, involving members that can create community change, and establishing trust among members. One partner emphasized the importance of building trust:

... having those conversations and the fact that [it] builds ... trust, ... [it] keeps ... our leaders on a straight and narrow focus and not splintering off into ... other focuses ... [it] really secures and builds confidence among the members that their time is going to be valued. There is something that is going to be accomplished at every meeting ...

In order to have a good relationship, partners described the need for effective communication. Communication provided opportunities for partners to network and regularly scheduled communication was viewed as important contributor in maintaining partnership relationships. One participant described communication as:

...one of the positive things about partnerships is that it increases communication and understanding between community agencies and entities, and I think that one of the biggest barriers to progress in any aspect is a lack of communication or a lack of understanding of what other people can, or even more important, what they can’t do. That’s where a lot of confusion and resentments grow

Several partners shared the importance of maintaining focus by ensuring that the partnership was guided by their mission. One participant emphasized the value of having a mission and not allowing money to become the reason for the direction:

[When] you are focused on your mission and vision, you aren’t focused on money ... as soon as you focus on money, you are going to listen to what the media says, you are going to listen to where all this money is coming from ... you’re going to look at [the population] as a problem to solve, and as soon as that money is gone, [the population receiving service through the partnership] is no longer [our] problem.
Another major marker of success was based on the number of people in the community participating in the event. LHD partners viewed high attendance at events coordinated by the partnerships as a measure of the population responsiveness.

Attendance at health fairs, community events, conferences, participation in meetings were examples of partnership success. A partner, serving in a leadership position in the LHD partnership focused on increasing physical activity, stated:

It started ... that first year with 33, then 35, and it's been continually growing because businesses and that are hearing about it and businesses, churches, groups. Like, the Diabetes Coalition had a booth. So people want to get involved now, more than just as a participant ... it's [about] numbers. How many attended and how many vendors we were able to get. That's the tangible thing.

The actual measurement of some outcomes was also described as important to determining success of partnerships, in addition to building relationships. Some partners decided success in terms of meeting the needs of population and community; assessments assisted in the development or enhancement of partnership goals and activities. One partner in particular used assessments to collect baseline measurements of community needs and to begin evaluating progress made on goals and objectives. One partner described:

It is...an assessment tool [measuring process in] different sectors...worksites, school, community based organizations, community as a whole, healthcare rat[ed] five different areas: tobacco, physical activity, nutrition, current disease management, and leadership. [W]e did it in spring 2008 and then we had to do a reassessment in August 2009, hopefully [the assessment] will point out areas of need for [the] coalition to work on, and then doing the post, you bring those same people back in and you see if there's been any movement or improvement.

Overall, partners varied in the ways they considered success. Many partners described the importance of building relationships and as they worked together in partnership, but some
partners also began to think about ways of measuring change and impact on community outcomes.

Discussion

Important characteristics contributing to successful partnerships were ascertained from LHDs' partners. In this study, individuals were internally motivated to participate in partnership with LHDs while organizational representatives primarily were externally motivated or a combination of both. LHD partners reported assuming a leadership or supporting role in the partnership, however, they recognized that the LHD is the governing voice. LHD partnerships were viewed as an opportunity to maximize community impact by sharing resources; however, partners in rural communities reported partnering more often due to limited financial resources and staff. Success from partners varied that included building strong relationships, completing projects and measuring attendance to events, and to a smaller extent, change in community outcomes using assessments.

Determining internal and external motivations of partners can help in recruitment and retention. Findings from this study are consistent with a study on collaboration among private sector organizations in which personal and organizational motivations influenced their participation in a partnership preventing child abuse in local communities. Partnerships are rooted in individuals bringing a range of knowledge, expertise, and resources in order to achieve intended goals and objectives. Motivations, however, are not always known to all the partners involved. Often times, organizations and individuals come together during the development of partnerships to discuss issues,
plan and strategize; however, participation may decrease as members begin to implement or sustain efforts. It may be that initial benefits as recognized by partners during the formation of the partnership are diminished. This study suggests that identifying organizational and personal interests of partners should be considered in addition to common interest to partner. Therefore, LHDs should focus on establishing relationships with organizations as well as individuals that allow for clear expectations and to develop a common language that meet the expectations of all constituents involved in partnerships.

For organizations assuming a leadership role, this study showed that LHDs partners decided to participate and even serve as a lead agency of the partnership, particularly when the issue aligned with organizational interests. Cooperation of this magnitude among these organizations working with LHDs also provides increased promotion of their organization and individual efforts. These findings are consistent with previous studies that reported opportunities to influence decisions related to the coalition mission prompt participation. Other factors cited as motivators for partnering in previous studies, such as time to participate in partnerships and knowledge of governance processes, were not mentioned in this study. Findings from this study suggest that it may be beneficial for LHDs to identify and engage partners in ongoing discussions regarding their organizational and/or personal interests as a means in retaining participation. Given that these organizations were all current partners with LHDs so saw the importance of LHD partnerships, future research should examine organizations that do not currently participate in LHD partnerships.
The range of roles assumed by organizations and individual volunteers' roles are evident in this study. In some partnerships, organizations assumed a lead role while other organizations and individuals played a very specific role. Findings from this study are consistent with previous studies reporting community-based organizations, voluntary agencies, and universities assume a leadership role in conceptualizing, creating, and providing initial support in public health-related partnerships. Studies also support findings from this study that confirm existing groups, organizations and individuals provide their expertise and contribute resources to support LHDs as the lead agency on public health initiatives and assessment processes. Although LHDs may serve as a lead agency, one qualitative study discovered that public health practitioners serving in a lead role (as the director and stage manager as reported in Chapter III), and would like to more frequently become a supporting member. LHDs have assumed a non-leadership position in partnerships when participatory approaches are used to encourage shared decision making and community empowerment. More research is needed to determine what leadership-related activities LHDs specifically would like partners to complete and how often each partner is currently conducting these activities.

Use of resources, whether plentiful or scarce, influence partners' ability to work together and address public health issues. Expertise and resources provided partnering organizations are necessary to address complex public health issues that expand beyond their capacity. In certain communities, the geographic setting in which partnerships are located may present several benefits as well as unique challenges in addressing public health issues. In this study, partners working with LHDs in rural communities described having limited resources and staff to facilitate partnership activities. These findings are
consistent with one study reporting that numerous communities with limited emergency, medical, and public health services face almost insurmountable challenges in which collaboration is essential. Findings are not consistent, however, with other partnership studies reporting both urban and large LHDs (serving a jurisdiction greater than 500,000) engaged in higher level of partnerships and developing more relationships with non-governmental organizations than those in smaller jurisdictions. It may be that urban areas present more opportunities to connect with various types of organizations leading to a wider array of partnerships. Given the scarcity of resources in many rural areas, the same organizations and volunteers must work together in multiple partnerships. Additionally, certain activities considered as partnership activities may not be viewed in the same manner and may also account for differences noted in the assessment tools. For instance, information exchange in an urban community may be perceived and counted as a partnership activity whereas, in a rural area, it may be viewed more as relationship building due to the close knit nature and easier opportunities to know all or most of the key organizations and leaders in the community.

Rural communities are being held to the same standards as urban areas in addressing public health issues despite differences in the availability of human and financial resources. Several innovative partnerships, including the Turning Point Initiative and Rural Health Outreach Initiative and, were developed to place more emphasis on inter-organizational efforts to improve public health outcomes. Efforts have resulted in developing community coalitions and integrating health system so community members may access public and medical services in one place that is centrally located. Ongoing efforts should continue from national public health organizations, such as Centers for
Disease Control and Prevention (CDC) and NACCHO, in providing training and technical assistance to organizations and individuals seeking to strengthen partnership with rural LHDs. The NPHPSP is a tool that can serve as a means of identifying and prioritizing public health services that need more immediate attention within the rural public health system. Rural communities may have to use state resources (i.e., state health departments and state associations) and technology (web conferencing) to further develop a network of partners in urban areas to reduce burnout. Building partnership capacity in this manner can help LHD partners efficiently manage resources to enhance the operation and sustainability of these partnerships.

In this study, characteristics that promote the development and sustainability of strong relationships were essential to partnership success. These factors may also assist in determining the level and quality of contributions made by organizations and individuals interested in improving population health. Trust and the ability of partners to resolve conflict have been considered as key characteristics in improving interaction among partners. Previous research supports that trust, respect, the use of conflict to stimulate new ideas, and fair distribution of power are key attributes that impact partnerships' ability to work as a collective entity. Previous research conducted on factors influencing partnerships suggest that synergy, ability of partners to work together, is also crucial in partnership success. Synergy takes into account how partners are able to improve upon their strengths and weaknesses. Documenting the completion of projects and other process measures were also noted as important in partnership success with a growing interest in tracking outcomes. An extensive literature review on measuring outcomes show initial efforts made in public health in linking partnership activities and
social, environmental, and behavioral change. However, more empirical research needs to be conducted and caution is given in considering the strengths between these linkages. Researchers continue to postulate that having a clear vision, intentional planning, supportive leadership, and ongoing documentation of progress, in addition to enhancing relationships, are key contributors to effectiveness. Community based participatory research has been well documented by universities working jointly with private and public sector entities and to address social, economic, and health inequities and to measure outcomes. Similar practices may be transferred to public health systems and services research examining the organization, financing, and delivery of population-based services as performed by LHDs, private and public sectors, and individual volunteers. This approach may be further studied to determine aspects that are instrumental in enhancing the local public health system infrastructure.

There are several strengths to this study. This is one of the first studies exploring perceptions of organizations and individuals regarding their partnerships with LHDs. Previous studies have primarily focused on characteristics or broad-based approaches (Turning Point) that build community capacity and promote positive partnership practices. Given the bureaucratic and financial challenges that working with governmental health agencies, this study provides an initial perspective in how organizations and individuals provide their expertise and contribute resources in addressing complex public health.

Several limitations of this study should be considered when interpreting key findings. Six organizations and one community volunteer participated in this study. Although participants resided in various communities throughout the U.S., this is a
qualitative study and should be seen as an initial step in the development of a research agenda examining the role and contributions of private and public organizations' and volunteers’ efforts in public health practice. A second limitation is that LHDs recommended participants for this study and likely chose very high functioning partners. Organizations and individuals, in which partnerships were less highly functioning, should be included in future studies to compare and contrast factors influencing their ability to work with LHDs. Finally, more LHD partners located in urban areas should be recruited to capture more descriptive differences to compare with LHD partners working in rural areas.

In summary, organizations and individuals may have different motivations for partnering. LHDs should be aware of these reasons. Partners were willing to lead partnerships or support LHDs, but looked to LHDs to take an active role in policy-related issues. In addition, LHD partners focused on the importance of using resources and perceived that rural areas were particularly impacted. Finally, partners had varying indicators of success that focused on building relationships, enhancing communication, but also included using assessment and outcome related measures. As LHDs are engaging these constituents in public health practice, it is crucial to balance organizational pursuits in improving population health status with inter-organizational and community engagement. Understanding the context and meaning of partners’ perceptions may provide more information in studying factors that influence the ongoing development of LHD partnerships.
References


CHAPTER V

CONCLUSION

This final chapter is used to revisit the overall purpose of the dissertation, summarize and integrate key findings of the three research studies presented in Chapters II through IV, present implications for public health practice, and recommendations for future research.

Purpose of the Dissertation

The overall purpose of this three-paper dissertation was to conduct a multi-state examination of partnership-related activities conducted by LPHSs and explore partnership practices from the perspectives of organizations and individuals within LPHSs. In Chapter II, partnership-related activities were examined using the Collaborative Capacity Framework to assess the current level of performance in three core areas. Following this quantitative study, two qualitative studies were conducted to explore the perspectives of LHD practitioners and their partners regarding characteristics important for partnership formation and maintenance. Chapter III focused on the perceptions of LHD practitioners while Chapter IV focused on those of their partners.
Summary of Study One

In the first study, specific activities related to partnership were examined. Secondary data analysis was used to determine frequencies of partnership activities from a sample of 110 LPHSs. Nine questions from the second version (2008-2009) of the NPHPSP were matched with relational, organizational, and programmatic constructs from the Collaborative Capacity Framework and one question related to emergency preparedness was used as a measure of a specific partnership activity. Results revealed that approximately 86% of LPHSs reported non-optimal performance in all three capacities. When examining how often the majority of activities in each capacity were conducted optimally (i.e., ≥ 75% of the time), relational and programmatic were performed most often at that level, with 15% and 13% of LPHSs performing at an optimal level respectively. Activities in the organizational capacity (8%) was performed less often at optimal levels. The example of a partnership, emergency preparedness, was conducted optimally by 61% of LPHSs; however, specific partnership activities were performed optimally less frequently ranging from 4% to 28%. Review of partnership effectiveness (4%) and the use of communication strategies (11%) were reported to be conducted optimally by the least percent of LPHSs. Statistically significant associations between the three capacities in the Collaborative Capacity Framework were found, suggesting that LPHSs that were performing partnership-related activities optimally in one capacity were also more likely to be performing the other two capacities at optimal levels.
Summary of Study Two

The second study explored perceptions about partnership mobilization among public health practitioners working in LHDs using the metaphor, partnership mobilization as theatre, to report and analyze key findings. Semi-structured interviews were conducted with practitioners to describe key characteristics contributing to partnership mobilization efforts. Public health practitioners described initiating and administering activities related to mobilizing partnerships, just as the director/stage manager oversees the development of a theatrical performance. Interestingly, some practitioners desired to move from leading (director role) to supporting organizations and individuals in fulfilling partnership mission (cast member). Among LHDs assuming the director/stage manager’s role, practitioners facilitated relationships with organizations and individuals in meeting partners’ expectations and preferred to use leadership approaches that allowed partners to take a visible and active role. Practitioners used “scripted” national assessment models (e.g. MAPP and NPHPSP) as well as “unscripted” general community building principles to mobilize partnerships. Whether a permanent or temporary stage, formal and informal structured partnerships were used in mobilization efforts, although practitioners preferred to formalize partnerships by using contracts, memoranda of understanding, and subcommittees. Just as theatre rehearsals are used to prepare for the performance, LHD practitioners valued the time spent in building relationships with their partners. Whereas quantitative assessments have focused primarily on the frequency with which partnership-related activities are conducted, this study found LHD practitioners focused instead on style of leadership and relationships. The participants in this study valued collaborative
leadership and were interested in their partners taking more of a leadership role. In addition to using collaborative leadership, practitioners believed that building relationships with their partners was important in their mobilization efforts.

**Summary of Study Three**

The third study, using thematic analysis, explored perceptions of organizations and individuals identified by LHD partners. Semi-structured interviews were conducted with LHD partners to describe key characteristics contributing to successful partnership practices with LHDs. Results revealed that individuals were internally motivated to participate in LHD partnerships, whereas organizational representatives primarily were externally motivated to partner. Partners also reported assuming both leadership and supporting roles in partnerships; however, regardless of their role, they recognized that the LHD has governing responsibility for moving the public health agenda forward. LHD partnerships were viewed as an opportunity to fully share resources and the participants expressed the need for effective use of those resources. Partners in rural communities reported they believe they work together more often than those in urban areas due to limited financial resources and staff, but also felt that burnout, leading to a lack of partners, was of greater concern for them. Indicators of success as reported by partners varied from building strong relationships, to completing projects and measuring attendance at events, and to a smaller extent, change in community outcomes using assessments. In the literature, it is postulated that having a common interest in an issue or activity encourages participation of organizations and individuals in partnerships. For the participants representing organizations in this study, additional external factors
including organizational mandate, funding, and access to a specific population were noted as motivators. Common interest alone may not be sufficient in engaging organizations in partnerships. Therefore, LHD practitioners must give more consideration to determining the external motivations that may prompt organizations to participate as well as remain actively involved in health-related partnerships.

**Discussion**

In discussing the key findings from this mixed-methods dissertation, the Collaborative Capacity Framework (Figure 5.1) will be used in considering important elements that may optimize overall partnership performance in LPHSs. The framework is rooted in four core capacities. Member capacity focuses on the knowledge and skills that individuals bring to the partnership. Relational capacity considers the means with which individuals create an environment based on a common goal, shared decision making, and respect for diverse perspectives. Organizational capacity relates to the structure in which partners work in achieving their agreed upon goals. Lastly, programmatic capacity focuses on activities performed by members that address population-based needs.

**Member Capacity**

According to the framework, the knowledge, skills, and motivations that may prompt participation in partnerships are a major asset in building member capacity. The NPHPSP assessment did not include measures regarding the knowledge or skills that partners bring to the LPHS. However, in interviewing LHD partners, motivations driving their participation in partnerships with LHDs emerged as a key theme. Individual
volunteers reported participating in partnerships because it was an area of interest, whereas organizational representatives were driven to participate by mandates, funding, and fulfilling organizational missions to promote community health. Some organizational representatives also stated that they partnered because of their professional belief in partnership serving as a beneficial approach to address complex health issues. On the contrary, LHD practitioners appeared to be more focused on building relationships with organizations in LPHSs and finding individuals to take more of a leadership role. Theoretical literature suggests that partnerships often times begin with informal opportunities in which individuals become acquainted with one another and then decide if they would like to enter into a long-term partnership. These current findings suggest that
having a common interest in a particular issue may not be sufficient and both LHD practitioners and various partners were motivated to partner for different reasons. Therefore, it is important to identify motivations of organizations and individuals prior to initiating contact to maximize the likelihood of partnering. This could be done by reviewing organizational mission statements and learning about other’s interests through networking. Furthermore, national organizations should consider including questions on public health assessments related to member capacity. By doing so, more targeted approaches may be developed for engaging organizations and individuals in partnerships and these approaches could then be measured in the assessments.

**Relational Capacity**

Relational capacity is based on the partnership’s ability to build crucial internal and external networks in working towards a common goal. The first study revealed that a higher percentage of partnership activities related to relational capacity were performed at optimal level than activities associated with organizational and programmatic capacities. Results from study two and three found more of an emphasis on internal and external characteristics related to relational capacity, such as shared decision-making and vision and seeking input from partners and existing groups. For LHD practitioners focused on building relationships, a critical component was the use a collaborative style of leadership. Several LHD partners also mentioned the importance of focusing on the partnership mission as opposed to being driven by other factors such as funding. Research points to the importance of trust, respect, mutually-beneficial arrangements, and shared decision-making as key attributes influencing partners’ ability to work as a collective
entity. Given the high level of activity reported in relational capacity and several references to relationship building in interviews, it appears that characteristics focused on internal relational capacity were important to the participants. However, more external measures of relational capacity were still absent.

Organizational Capacity

Organizational capacity focuses on the operational structure of the partnerships that include roles and responsibilities, formalized plans and processes, communication strategies, and use of resources. In study one, the majority of activities associated with organizational capacity were performed at the least optimal level of activity. Key findings of studies two and three revealed that LHD practitioners and their partners identified the effective use of resources, formalization of partnerships, and roles assumed in partnerships as important in development and sustainability. It is unclear why the importance of organizational capacity shown in the qualitative studies did not translate to higher levels of organizational capacity activities in the quantitative study.

Programmatic Capacity

Programmatic capacity considers evaluative function of the partnership allowing for partners to monitor goals and improvements in meeting population-based needs. From the first study, the activity associated with programmatic capacity was reported at lower optimal activity than activities related to relational capacity. LHD practitioners and partners described a range of health issues that address population-based need, but information was limited in specifying how programmatic goals were obtained. Many of
the LHD partners expressed partnership success through the lens of relationship building and it may be that few partnerships are yet systematically monitoring programmatic goals.

**Connections Between Relational, Organizational, and Programmatic Capacities**

In the first study, associations were found between relational, organizational, and programmatic capacities. However, it was not known why some LPHSs performed optimally in these capacities. Studies two and three provide more specific information as LHD practitioners and partners described being able to work together, having a community-based process to guide their efforts, working within a formalized structure to achieve desired work (at times), and garnering, and effectively utilizing, sufficient resources as important characteristics in their partnerships. Previous studies have pointed to partnership synergy as the essential element that allows individuals and organizations to combine their knowledge, skills, and resources to develop and implement comprehensive interdisciplinary strategies and interventions, consider perspectives of goals of key stakeholders involved in the partnership, communicate expectations, and garner community support. More specifically, a study found that partnerships with a high level of synergy reported productive interactions among members, effectively obtained and used both in-kind and financial resources, and possessed non-bureaucratic style of management and administration. Additionally, partnerships focused on advancing health status outcomes that had high levels of synergy also reported enhanced system capacity of the overall public health infrastructure. In considering the commonalities between dissertation findings and previous research, LPHSs performing optimally in all three capacities may possess high levels of synergy influenced by the relationship, processes,
organizational structure, and resources that promote effective partnerships within the system. We do not know, however, if high level of synergy or effective functioning in one capacity preceded effective operation in another capacity. Future studies should examine characteristics of LPHSs performing optimally across all capacities.

Implications for Practice

Several implications may be considered in future research examining the contributions and capacities of public, private, voluntary organizations and individual volunteers that are mobilizing partnerships in LPHSs. First, style of leadership employed by organizations and individuals was not measured in the NPHPSP, but may prove useful in building the capacity of LPHSs. Second, many LPHSs are engaging in emergency preparedness partnerships. Given that the majority of LPHSs' are participating in preparedness partnerships, they can use this unusual, but now relatively common structure, to formulate new partnerships. Specifically, LHDs can use that template where they do not provide the services (of the fire and police department in the case of emergency preparedness); however, they do use their expertise in planning and coordination to link populations with service provided by other organizations.

Another implication of this study relates to communication. Although the use of communication strategies was reported at lower optimal levels of activity in the first study, both LHD practitioners and their partners credited communication as an important factor in promoting successful partnerships. It may be that are different aspects of communication that strengthen the manner in which partners both build relationships and organizational capacity. It may also be that though these partners understand the need for
communication, they lack knowledge of specific communications strategies. Communication strategies are also important from a programmatic perspective in connecting with population about their health needs and services. Future studies will need to examine the state of communication in LPHSs in more fine detail.

This is one of the first studies providing a multi-state perspective of the NPHPSP ten partnership activities of LPHSs by level of performance using a theoretical model. Previous studies have examined overall performance of partnership mobilization by certain demographic characteristics, but have not assessed the current level of performance on specific partnership-related activities conducted by LPHSs. In addition, interviewing organizational representatives and individuals working within LPHSs, captured the lived experiences of people involved in improving the system that could not be ascertained from national public health assessments. These perceptions provided additional information on style of leadership, relationship building among partners, and motivations that encourage partners to work within LPHSs. These characteristics might influence the development, functioning, and sustainability of partnerships occurring with LPHSs. Key findings from semi-structured interviews cannot be used to generalize results to all LPHSs; however, information can be used in including partnership-related measures on the NPHPSP that promote effective partnerships.

**Recommendations for Future Research**

By using the NPHPSP, LPHSs are meeting some partnership standards as evidenced in their participation in emergency preparedness coalitions; however, this result has been mainly attributed to financial support from federal and national
Conducting partnership-related activities as a LPHS is still a relatively new concept. Further studies are needed that examine change in performance of partnership-related activities over time. More specifically, does development of preparedness partnerships lead to improvement in quantity and quality of other partnership activities conducted by LPHSs. Measuring ongoing performance of LPHS partnership activities is needed to determine trends, in addition to, predicting associations between specific partnership activities and outcome measures. Using partnership frameworks, such as the Collaborative Capacity Framework, and learning from the lived experiences of public health practitioners and their partners can assist researchers in considering important elements contributing to the development and sustainability of partnerships within LPHSs. Future research should focus on:

**Individual Partnership Activities**

*Theoretical implications in LPHSs' partnership mobilization*

1. Use theoretical frameworks to determine key partnership components that are present or absent in LPHS.

*Critical factors impacting LPHS performance in partnership mobilization*

2. Identify factors contributing to successful partnerships in other public health issues (e.g. tobacco, obesity prevention, diabetes) and compare with factors contributing to successful partnerships in emergency preparedness.

3. Examine linkages between partnership approaches and health outcomes.

4. Examine influences of leadership and performance in mobilizing partnerships.

*Critical factors influencing participation of LHDs partners*
5. Identify benefits and cost to non-traditional partners (e.g. businesses, advocacy groups, faith communities, urban planning offices) of participation in LHD partnerships.

References


Appendix A

Local Health Department Interview Questions
## Interview Topics and Questions

<table>
<thead>
<tr>
<th>Topics</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Views about NPHPSP</strong></td>
<td>1. Why did your local health department decide to participate in the NPHPSP?</td>
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<tr>
<td></td>
<td>2. Please tell me how the local health department engaged different organizations to participate in the NPHPSP local assessment.</td>
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<tr>
<td></td>
<td>3. Prior to the NPHPSP local assessment, how would you describe the local health department’s ability to mobilize community partnerships?</td>
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<tr>
<td></td>
<td>4. Since conducting the NPHPSP local assessment, how has the local health department’s ability to mobilize community partnership changed?</td>
</tr>
<tr>
<td><strong>Views about partnership mobilization</strong></td>
<td>5. When you hear someone say, “The local health department is an agency responsible for mobilizing community partnerships to identify and solve public health issues,” what does that mean to you? What does community partnership mobilization involve?</td>
</tr>
<tr>
<td><strong>Activities describing partnership mobilization</strong></td>
<td>6. Please tell me 2-3 examples in which the local health department is engaged in partnership with different organizations in addressing public health issues.</td>
</tr>
<tr>
<td></td>
<td>7. What activities does the local health department believe are essential to community partnership mobilization? Why do you believe these activities are essential?</td>
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<td></td>
<td>8. What activities pertaining to community partnership mobilization does the local health department seek to improve?</td>
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Appendix B

Local Health Department Partner Interview Questions
**Interview Topics and Questions**

<table>
<thead>
<tr>
<th>Topics</th>
<th>Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activities describing partnership with local health departments</td>
<td>1. Please provide a brief description of your partnership with your local health department?</td>
</tr>
<tr>
<td></td>
<td>2. Please tell me how your organization became involved in a partnership with the local health department?</td>
</tr>
<tr>
<td>Defining partnership</td>
<td>3. What does partnership mean to you?</td>
</tr>
<tr>
<td>Factors influencing partnership</td>
<td>4. What factors influence your partnership activities with the local health department?</td>
</tr>
<tr>
<td></td>
<td>5. What do you think your organization’s contributions have been to the partnership with the local health department?</td>
</tr>
<tr>
<td></td>
<td>6. What are the benefits of your organization working in partnership with your local health department?</td>
</tr>
<tr>
<td>Success indicators</td>
<td>7. What indicates that your partnership with the local health department is successful or not?</td>
</tr>
<tr>
<td></td>
<td>8. What challenges have you encountered that makes it difficult to achieve goals and to meet expectations in your partnership with the local health department? What strategies would you recommend to improve the partnership?</td>
</tr>
<tr>
<td></td>
<td>9. Has working with the local health department improved the public health issue addressed through the partnership’s efforts? If so, please provide me examples where you see improvement.</td>
</tr>
</tbody>
</table>
Appendix C

Human Subjects Institutional Review Board
Letter of Approval
Date: August 5, 2009

To: Amy Curtis, Principal Investigator
Priscilla Barnes, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 09-07-01

This letter will serve as confirmation that your research project entitled “A Mixed-Methods Study on Community Partnership among Local Health Departments and Governmental and Non-Governmental Organizations” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: August 5, 2010