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# Partnerships between health care agencies and faith communities

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# PARTNERSHIPS BETWEEN
# HEALTH CARE AGENCIES AND FAITH COMMUNITIES

A Thesis

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ABSTRACT

PARTNERSHIPS BETWEEN
HEALTH CARE AGENCIES AND FAITH COMMUNITIES

by Rebecca M. Herr

This thesis identified organizational factors critical to the sustainability of partnerships between health care agencies and faith communities. Using a non-experimental, descriptive survey design, data were collected from 36 key informants in 29 different partnerships, in 28 different states and the District of Columbia.

Key informants identified four factors critical to the sustainability of the partnership: (a) communication, (b) clearly defined goals, (c) adaptability and flexibility, and (d) positive relationships among partners. The majority (75%) of the partnerships reported having nurses on staff and 63.9% of the partnerships had nurses serving on the Board of Directors.

This research study provided preliminary data on important factors to consider when establishing partnerships between health care agencies and faith communities. This information can be used to: (a) develop nursing curriculum, (b) assist community health nurses working in partnerships, and (c) help partnerships between faith communities and health care agencies develop effective organizational strategies.

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# Chapter 1

## INTRODUCTION

This research study explored partnerships between health care agencies and faith communities. The researcher became interested in this topic as a result of experiences as a community health nurse, a community volunteer, and a member of the Health Ministries Association. These experiences, combined with the current restructuring of health care services, provided the motivation for exploring more effective avenues for the delivery of health care services within our communities.

The improvement of health outcomes in our communities is dependent upon the utilization of a wellness model for health care that includes improving access to health services and the development of new health education and health promotion strategies. As the wellness model evolves and the delivery of health care services shifts from being institutionally based to community based, it becomes increasingly important that nurses, if they hope to remain the largest and the most vital group of health care providers in the community, improve their knowledge and skills regarding community management. Nurses require a sound knowledge of community organizing and a new sense of responsibility and accountability for their professional leadership role in the community.

This research study provided preliminary research data on important factors to consider when establishing partnerships between health care agencies and faith communities and factors which are necessary to sustain partnerships. This information can be used by nurses: (a) to develop community-based nursing curriculum, (b) to assist community health nurses working in partnerships, and (c) to help partnerships between faith

communities and health care agencies develop effective organizational strategies.

## Study Problem

The changes in the health care environment in which nurses practice today include: (a) shifting the delivery setting from the "institution" to the community, (b) altering the type of health care services offered, (c) developing new strategies for the delivery of services, (d) changing the number and training of health care professionals, and (e) shifting client roles. For nurses and other health care professionals, the rapid changes occurring in health care are seen as chaotic and are viewed with bitterness. For others, the chaos is seen as an opportunity: (a) to develop new directions for health care, (b) to shift from a model of "cure" to one of wholeness, (c) to partner with the community, and (d) to improve health outcomes and encourage joint accountability. Leland Kaiser (1995), speaking at the Healthcare Forum's Healthier Communities Summit, stated that "the function of chaos is new creation." He viewed chaos as a constructive force that permitted repatterning "as long as we embrace the chaos and possible solutions" (Kaiser, 1995). To do this, he stated that we must break down boundaries that prohibit us from seeing solutions to the chaos facing health care and focus on the new emerging structure of healthier communities.

In addition to the changes occurring within the health care delivery system, our communities have changed. The health care challenges facing nurses and public health practitioners have changed from sanitation, communicable diseases, and screenings to complex social problems, whose treatment involves changing the life style practices of individuals, families, and

communities. The community's health is no longer defined solely in terms of nursing and medical science but also encompasses social justice. Traditional public health practices have not proven to be effective in meeting such complex, interrelated problems as hunger, shelter, violence, substance abuse, teenage pregnancy, and chronic disease caused by life style health habits.

Public health departments in order to survive financially have had to redefine their market and expand their scope of services to include services traditionally offered by hospitals and other home health agencies. Public health services no longer are limited to health promotion, health education, and disease prevention, but they also encompass the delivery of skilled services that were once almost totally within the domain of hospitals and home health care agencies.

At the same time, the roles of nurses and other health professionals have also changed. Health professionals functioning in institutional care models are faced with a declining need for inpatient services, and they are attempting to redefine their roles in the community setting. Home health nurses and other providers, although familiar with the community setting, find their role changed as the level of skilled care needed by clients has swiftly risen and as a new emphasis is placed on prevention. The role of almost every health care professional and institution has changed. A search for new solutions and resources has motivated public health departments and other health care agencies: (a) to establish new partnerships improving access to target populations, (b) to improve health outcomes, and (c) to be cost effective. As a result, partnerships with faith communities are now being recognized as one

effective means for improving the delivery of health care services to individuals, families, and communities.

Consumer attitudes have also changed. Clients who were previously content being silent partners are demanding more accessibility to services and more accountability for rising costs and health outcomes. Clients, whether individuals, families, communities, or the nation, expect to be active participants in health care delivery. Because clients expect to be "partners" and health care providers are looking for new solutions and resources to reach at risk populations cost effectively, one trend in health promotion and disease prevention has been the establishment of community partnerships. One type of community partnership that has seen rapid growth recently is the faith and health partnership. The ability to create, sustain, and establish accountability for these partnerships is crucial in the current atmosphere of funding only cost-effective programs.

The emergence of this new style of health care delivery requires that nurse researchers examine the roles and responsibilities of the nurse in this new service setting. It is important to examine nursing skills and knowledge related to: (a) client services, (b) community organization, and (c) community leadership. However, there is limited literature currently available that provides direction for nurses and other health care professionals who wish to work in partnership with faith communities.

## Purpose of Study

The purpose of this research study was to survey key informants in partnerships between health care agencies and faith communities to determine their perceptions of the critical organizational factors that were necessary to

sustain partnerships. This research study specifically targeted partnerships in which the faith and health partners had equal representation on the governing body and partnerships which included at least one health care agency and one faith community.

## Research Question

In order to sustain effective partnerships between health care agencies and faith communities, the organizational factors which were critical to their sustainability had to be identified. Therefore, the primary research question for this study was: What are the organizational factors that appear to be critical to the sustainability of partnerships between health care agencies and faith communities? This research was guided by the assumption that such partnerships were organizations functioning as "open systems" and exhibiting many of the characteristics of open systems as outlined by Scott (1992). Characteristics that were expected to be identified were: (a) environmental influences, (b) boundary setting and maintenance activities, and (c) a process for the flow of information into and out of the partnership.

## Definition of Terms

For purposes of this study, the following five key terms were used as adapted from Scheie et al. (1994, p.13):

1. Partnership referred to the inter-organizational structure comprised of at least one faith community and one health care agency, formed to meet a community need. It was a vehicle through which individual partners, having an interdependent relationship, combined resources to meet a community need.

2. Partner referred to an individual organization that was actively participating in the partnership by having a formal representative on the Board

of Directors of the partnership and by sharing in the planning and in the decision making of the partnership.

3. Health care agency referred to any public or private organization, whose primary purpose was the delivery of a health care service.

4. Faith community referred to a religious institution including congregations, churches, and other religious bodies. It might be a local congregation, an ecumenical coalition, a denominational organization (local, state, or national), a cathedral, a storefront church, a synagogue, or any other system of religious belief.

5. Board of Directors referred to the governing body, or group of individuals, who made management and administration decisions regarding the partnership. This group might be referred to as a committee.

A sixth term, sustainability, referred to the ability of the organization to maintain its open structure over time by responding to environmental needs, resources, and energy. This term was based on Scott's (1992) definition of self-maintenance and was used interchangeably.

## Summary

In summary, solutions to the health care challenges facing our nation will not be solved by nurses and health care professionals working in isolation. Community based projects and partnerships are a recognized method for delivering nursing services and improving health outcomes. As responsible professionals, nurses must begin to study the organizational factors critical to the sustainability of partnerships between health care agencies and faith communities.

# Chapter 2

# CONCEPTUAL FRAMEWORK AND REVIEW OF LITERATURE

## Conceptual Framework

The conceptual framework that provided direction for this study was adapted from Scott's work on organizational theory. In his work, Organizations: Rational, Natural, and Open Systems, Scott (1992) defined organizations as "social structures created by individuals to support the collaborative pursuit of specialized goals" (p. 10). Organizations can be analyzed by studying: (a) the size and productivity, (b) the behavior or attributes of the participants within the organization, (c) the characteristics of the organizational structure, or (d) the characteristics of the actions of the organization. This study examined the processes necessary for sustaining the organizational structure of partnerships between health care agencies and faith communities.

In studying the partnerships, it was assumed that they were a "collective entity" in which the partners had an interdependent relationship. Scott (1992) referred to this as the "social structure" (p. 17). Therefore, an organization is a collective entity with a social structure. He identified two components of the social structure of the organization, normative and behavioral. Normative structure included the values, norms, and role expectations of individuals within the organization. Behavioral structure focused on the actual behaviors of the participants which linked them together in a common network of activities, interactions, and sentiments (p. 17). This study looked at partnerships (organizations) with social structures made-up of these two components, normative and behavioral, but it primarily examined the behavioral component.

Organizational Structure

Scott presented three explanations for organizational structure: (a) rational, (b) natural, and (c) open (1992). The rational system perspective viewed an organization as "collectivities oriented to the pursuit of relatively specific goals and exhibiting relatively highly formalized social structures" (p. 23). The natural system perspective viewed an organization as "collectivities whose participants share a common interest in the survival of the system and who engage in collective activities, informally structured to secure this end" (p. 25). The open system perspective viewed an organization as "systems of interdependent activities linking shifting coalitions of participants; the systems are embedded in–dependent on continuing exchanges with and constituted by–the environments in which they operate" (p. 25).

It was assumed that partnerships between health care agencies and faith communities functioned as open systems. Although each partner had their own activities, objectives, and preferences, they came together in partnership to meet a common goal. If the partnerships studied were rooted in the open systems framework, Scott stated that two fundamental characteristics could be expected: (a) self-maintenance and (b) loose coupling (pp. 82-83).

Self-Maintenance. Self-maintenance referred to the ability of the organization (partnership) to sustain its open structure over time by responding to environmental needs, resources, and energy (Scott, 1992, p. 83). This required loosely structured organizational boundaries that allowed participating partners to exchange energy and resources. In this study it was assumed that health care agencies and faith communities would maintain their own uniqueness within their subsystems and contribute only specific activities and

behaviors to the partnership necessary to maintain the larger system (partnership). Neither the partners nor the individual participants would be enclosed by organizational boundaries. The energy that individuals and partners received from their environment would help to restore energy to the partnership, helping the partnerships respond to new needs within the environment and to breakdowns within the organizational structure. In this way, the partnerships would demonstrate self-maintenance.

Loose Coupling. Coupling referred to the connections between the partners. In a social system such as the partnerships studied, the connections between the system components (partners) were assumed to be loose. It was assumed that little constraint was placed on the behavior of one partner by the conditions of the others. This allowed the partnership to be more sensitive to environmental changes and encouraged partnership adaptation to local circumstances. However, the couplings within the partnership were more tightly coupled (Scott, 1992, p.77).

Processes of the Organizational Structure

Studying the organizational structure required examination of the processes needed to sustain the organization. Processes that Scott (1992) identified as important to the organizational structure were: (a) goal specificity, (b) resource mix, (c) environmental influences, (d) boundary setting and maintenance, and (e) information flow.

Goal Specificity. Goals help an organization determine strategies, adopt a course of action, and allocate resources. Goals help link the organization with the environment and determine boundaries and products. Goals are the central reference point for all organizations. Scott (1992) stated "The goals an

organization espouses, the goals it appears to be serving, the goals it embodies and is perceived to represent–these symbolic goals have, important effects on the organizations ability to acquire legitimacy, allies, resources, and personnel" (p. 285).

The setting of organizational goals can be done by one powerful individual, by consensus of all participants, or by a dominant coalition. A dominant coalition is a group of individuals within an organization pursuing shared interests. Coalition members negotiate agreements and seek out allies with other groups within the organization in order to secure cooperation and define an acceptable course of action (Scott, 1992, p. 288).

Scott viewed the "dominant coalition" as the most widely accepted approach to goal setting (p.289). Factors effecting the dominant coalition were: (a) ownership, which may be tied to funding and the decision making body, (b) managerial power, (c) labor, and (d) representatives of the boundary setting groups or target population. Scott (1992) stated that with the use of the dominant coalition, individual participants did not necessarily have equal power. However, critical to the sustainability of the organization were clearly articulated goals, arrived at through coalition building during the mobilization phase, which were embraced by member consensus, responsive to perceived need, and sensitive to changes in the environment and organization.

Resource Mix. Scott (1992) stressed that organizations did not spontaneously emerge but required resources, such as: (a) human, (b) material, and (c) capital. Once established, organizations tended to retain the characteristics present during their emergence. Therefore, the resources

available and utilized at the establishment of the partnership were extremely important as they impacted the sustainability of the partnership.

Scott (1992) cited human participants as the most critical resource for partnerships and stated, "The creation of an organization is not a one-time event but a continuing process, and particularly fateful for the later stages of this process are the numbers and types of participants recruited earlier" (p. 175). Not only must the organization attract participants, but it must motivate them to stay and to continue to give time, resources, and effort. Three types of incentives which may be used to retain participants were: (a) material, (b) solidary, and (c) purposive (Scott, 1992, p.172). Material incentives were monetary rewards; solidary incentives were intangible rewards related to social recognition, good fellowship, prestige and publicity; and purposive incentives were rewards related to the goals of the organization.

The purposive incentives, which resulted when individual and organizational goals coincided, were assumed to be the primary motivators in partnerships between health care agencies and faith communities. These partnerships relied on their goals to attract and hold partners and individual participants (Scott, 1992, p. 173). Scott described this as the "ideal organizational arrangement: members join because they wish to help achieve the goals espoused by the organization, and the organization, in achieving its goals, supplies inducements to its members to secure their continuing contributions" (p. 173).

Another key consideration for the mobilization of resources was the "mix of participants" or the demography of the organization (Scott, 1992, p.174). The demography of the organization referred to "the aggregated characteristics of its

members, including their age, sex, education, ethnicity, and length of service.... increasingly recognized as a major determinant of organizational structure and performance" (Scott, 1992, p. 174). The partnerships that were studied were community based; it was assumed that to be successful partners would need to reflect the demographic composition of the population served. The process of organizational representation increased community acceptance and ownership of the project by the target population. This was particularly important in minority populations who had been traditionally underserved by the health care system. Group solidarity, including religious and kinship ties, could provide conditions of high trust that increased the mobilization and pooling of resources (p. 176).

Material and capital resources were also important. Traditionally health care providers have looked to the community for monetary resources to help fund partnerships. Health care providers must begin to place higher value on the other resources which an underserved population can bring to a partnership, such as the ability to organize and access their communities. Health care providers can contribute professional skills, funding, and initial leadership. Acknowledging the value of the resources brought to the partnership by the community creates an atmosphere of mutual trust, equality, and power sharing.

According to Scott (1992), the likelihood for organizational failure was greater for small, new organizations. If health care professionals did not assist community groups in resource mobilization and ownership of community based projects, partnerships ran the risk of being dependent on conservative foundations and mainstream groups who generally did not subsidize change in the health care delivery process. This may result in decreased control,

influence, and ownership by the target population and negative effects on important health outcomes.

Environmental Influences. Scott stated that in an open system's framework organizations and their environments were inseparable. "How an organization relates to its environment–indeed, what its environment is–is influenced by the organization's structure and strategy, and, conversely, the characteristics of the organizations structure are strongly affected by the organization's environment" (Scott, 1992, p. 123). Organizations constructed boundaries across which they related to the environment. How impenetrable these boundaries were was of critical importance. "In a fully developed open system conception, all of the 'materials' used to create organizations–resources and equipment, but also personnel and procedures–are obtained from the environment" (p. 146). This study focused on the relationships between a group of organizations (partners), referred to as an areal organizational field or interorganizational field model (p. 128). "This approach emphasizes not the individual organizational units or even their characteristics as an aggregate, but rather the network of relations among them" (p. 128). Individual partners had individual goals but participated in a structure (partnership) with more inclusive goals, ratified by members.

Environmental influences included: (a) partnership make-up, (b) belief systems, (c) target population, (d) geographic setting, (e) decision making processes, (f) standards of practice, and (g) resources. In determining environmental influences, an organization must first determine its organizational domain, those it serves and the services it will provide. Consensus among partners of the proper domain would be essential. Generally

organizational domains were defined by geographical boundaries, resources, products and services, and the social environment. Whatever the determinants of organizational domain, it must be recognized that the boundaries defining the organization were dynamic and changed over time (p. 128). However, once the organizational domain had been determined, environmental influences would only be important if they affected the activities of the organization (Scott, 1992, pp. 126-127).

Two types of environments exist: (a) the technical environment in which the organization provided a product or service and (b) the institutional environment which consisted of the rules to which individual organizations must conform in order to be part of the partnership. Each organization was exposed to these two types of environments along a continuum. Many of the partnerships in this study were exposed to both strong institutional pressures and strong technical pressures. They were expected to meet institutional pressures such as: (a) delivering services related to the goals, (b) developing an acceptable structure, (c) meeting government and professional standards of practice, (d) being accountable to individual partners and the community, and (e) being responsive to cultural and ethnic diversity. Technical pressures related to the ability to mobilize skilled and knowledgeable personnel in the delivery of services and developing accountability and evaluation guidelines.

Boundary Setting and Maintenance. A theme that Scott (1992) stated as central to the understanding of organizations in an open system was that an organization was never complete but always open to influences from the environment (p.180). By definition an organization was a collectivity of groups, a social structure, with a defined boundary that distinguished it from other systems

(Scott, 1992, p. 181). The social system within the organization, or in the case of this research the partnership, was defined by the linkages of "social relations" between the partners and the linkages between the individual participants (p.181). Many organizations were subsystems of other larger systems, and connections or couplings with the larger system also influenced the local partnership and local actions. Organizational boundaries must be set and maintained for the organization to survive, but flexibility and adaptability to these environmental influences required that organizational boundaries change. Scott stated that "the single best indicator of an organization's capacity to adapt successfully to its environment is its continued existence–its survival" (p. 217).

The process of boundary setting for an organization included: (a) identification of need and the services to meet the need, (b) recruitment of members, (c) identification of the knowledge and skills of personnel, (d) identification of operational costs, and (e) attainment of goals. Boundary maintenance included: (a) a clear understanding of the demand for services and activities needed to produce desired services, (b) a stable supply of resources, (c) commitment and agreement among partners regarding future direction, and (d) incorporating groups into the decision making structure of the organization. Scott stated that involving the target population in the decision making process of the organization "is an important indication of interdependence and an effort by all the organizations to coordinate their activities" (Scott, 1992, p. 200). This was referred to as co-optation (p. 199). Boards should reflect the environment they represented, experts in the field, and the resources needed for the organization. These partners would then

share in the decision making. Shared decision making was key to boundary setting and maintenance. Assuming this premise to be true, this study excluded partnerships in which the partners did not share in decision making.

The decision making process, established during the mobilization phase, impacted all other factors and was critical to maintaining the organization. In trying to negotiate and reach decisions, participants (partners) imposed a set of rules by which they based decisions. Scott (1992) presented Herbert Simon's theory of decision making which proposed that decisions which individuals make within an organization were a result of influences from within the organization as well as influences which they were subjected to in the environment. Scott stated that the "primary way in which organizations simplify participants' decisions is to restrict the ends toward which activity is directed....Goals supply the value premises that underlie decisions" (p. 45). These goals can be established by mutual consensus or by decree. Making decisions based on goals may eliminate conflict by removing alternative possibilities, by structuring participants expectations, and by molding commitment to only one course of action ( p. 53). However looking at goals in this manner may equate them with outcomes, making the decision-making practices restrictive, and resulting in decreased motivation, creativity, and commitment to sustaining the partnership (p. 61). Since organizations were continually adapting to the environment, one key to sustainability was the ability of the organization and its participants to respond to environmental change in a creative way without restricting the decision-making practices. For sustainability, focus should not be on day-to-day decisions but on critical decisions that once made may affect the very structure of the organization (p. 65).

Flow of Information. Lastly, in order to achieve the goals of the partnership and obtain resources and information, the organization must enter into a relationship with the community. Partnerships cannot survive isolated from the community. Therefore the system of communication, or flow of information into and out of the partnership, was vitally important. The collection and development of information drew attention to certain aspects of the partnership. The very "fact that certain information is regularly collected focuses the organization's attention on it" (Scott, 1992, p.142). Collecting information provided input into the decision making process. Information systems developed by the organization (partnership) not only helped to develop organizational structures and interventions but allowed for the transference of environmental information into the partnership. In an open systems framework, the management of information from the environment into the organization and the dissemination of information from the organization to the environment were critically important for sustainability.

Organizational Failure and Organizational Effectiveness

In presenting his organizational theory, Scott (1992) included the examination of factors related to organizational failure and effectiveness. The scope of this study did not allow the researcher to examine these factors in depth or to compare successful partnerships with failed partnerships. However, Scott's (1992) theory included clear indicators for evaluating effectiveness and failure. These factors indicated essential elements necessary for sustaining an organization.

Factors related to the failure of an organization were: (a) liability of newness, (b) liability of smallness, (c) density of like organizations in domain at

founding, (d) characteristics of the environment, (e) lack of external legitimation from agencies, (f) changes in technology or services, (g) lack of resources, and (h) impact of power struggles which result from private interests dominating attention to the public good (Scott, 1992, pp. 217-223). In an open systems framework the long term well-being of an organization was highly dependent on the ability of an organization to: (a) detect and respond to changes in the task environment, (b) acquire resources, (c) stay profitable in the pursuit of goals, (d) develop strategies for assessing information, (e) maintain structural units that were loosely coupled and had maximum sensitivity to the environment, (f) develop activities and evaluation criteria that were goal directed, and (g) maintain a single program goal that was pursued by all partners (pp. 344-348).

Indicators for determining organizational effectiveness were dependent on what criteria were used to evaluate the organization. Scott stated that "Setting of standards is a central component in establishing criteria for evaluating the effectiveness of an organization" (Scott, 1992, p. 352). Two types of tests existed to measure effectiveness: (a) instrumental tests for clear cause and effect relations and (b) social tests when standards were ambiguous.

Indicators used to assess organizational effectiveness were: (a) outcomes, (b) processes, and (c) structures. Outcome indicators were difficult to use as the quality of performance was dependent on environmental influences which may be out of the control of the organization. Process indicators focused on the quality and quantity of activities and evaluated efforts rather than achievement. Although process measures may be viewed as conformity to a program and not measures of effectiveness, Scott felt that this

need not be viewed as pathological unless the "means and ends become disconnected" (p. 356). In many organizations, such as the faith communities in this study, the process of defining need and developing programs was critical to the ability of the providers to deliver health interventions to a specific population. The process of accessing the target population became an outcome. To ensure successful outcomes, this process may have necessitated conformity to what Scott calls "ritually defined procedures" (p. 356).

"Structural indicators assess the capacity of the organization for effective performance" (Scott, 1992, p. 357). Included were measures to evaluate facilities, equipment, qualifications of staff and other resources. Structural measures evaluated the "capacity" of the organization to perform work, "not the activities carried out by the organizational participants but their qualifications to perform work" (p. 357).

In choosing a means to evaluate organizational effectiveness: (a) outcomes, (b) process, and (c) structural indicators may be a guide but valid indicators for each organization must be chosen. In an open system framework" many different causal paths can lead to the same effect" (Scott, 1992, p. 361). It was not only important that the organization survive but that it also continued to serve the interest of the target population.

Summary of Conceptual Framework

In summary, Scott's (1992) organizational theory identified five processes which were essential to the organizational structure: (a) goal specificity, (b) resource mix, (c) environmental influences, (d) boundary setting and maintenance, and (e) the flow of information into and out of the organization. These five factors were used as a framework to design the survey

tool which was used to collect data from partnerships between health care agencies and faith communities. This study reported on these processes in relationship to sustaining the organizational structure in the following manner: (a) environmental influences, (b) boundary setting and maintenance, which included goal specificity and resource mix, and (c) the flow of information.

Assumptions which guided this research were: (a) partnerships functioned in an open system, (b) health care agencies and faith communities were subsystems of a larger system, (c) partners were loosely coupled, (d) partner mix included representatives of the target population, and (e) purposive incentives were the primary motivation for staff and volunteers to stay with the partnership. If one accepts the assumption that the partnerships functioned in an open system, then all other assumptions would be valid (Scott, 1992). The characteristics of the organization and the process of sustaining the organization would radically differ if one were to assume that the partnerships functioned as rational or natural systems.

## Review of Literature

### Improved Health Through Partnerships

This decade has seen the rise of a new public health vision. This vision, one of "healthy people in healthy communities" (Baker et al., 1994, p. 1277), comes in the wake of health care reform and decreased national and local spending for public health services. In this century, public health funding has decreased from 1.2 cents of the national health care dollar to 0.9 cents, which has had predictable negative consequences. The need to provide medical care for the poor and uninsured has "exacted a huge toll in lost opportunities for preventing morbidity and mortality in vulnerable populations and for promoting

optimum health conditions for the entire community" (Baker et al., 1994, p. 1277). Dr. David Satcher, Director of the Center For Disease Control (CDC) and Prevention, concurred with this point: "Only about 1% of our almost one trillion dollar health expenditures in this country go to support population based prevention" (Evans et al., 1994, p. 5).

To make this new vision of public health a reality, new avenues for the delivery of disease prevention, health education, and health promotion services must be established. Health care practitioners are looking to community partnerships as a means for realizing this vision. By sharing resources and empowering individuals and communities to participate in community health planning, practitioners hope to continue offering basic prevention services such as screenings and immunizations, as well as to improve health outcomes that result from unhealthy life styles and socioeconomic problems. Partnerships and collaborations may well become the expected mode of operation in the next century. Dr. Caswell Evans stated in his opening remarks at the 1995 American Public Health Association Annual Meeting that:

> It is through partnerships that public health will be most beneficial in achieving its goals. And I say we need partnerships because we simply do not have the resources to be successful working in isolation, because working in partnerships forces us to define our role and demonstrate our value, because partners hold us accountable for relevant deliverables, and because all of us are smarter than any of us. Partnerships create an interface, a plane in which different disciplines and talents, ideologies, lifestyles, and cultures come together in a way that creates energy. It unleashes imagination and results in mutually beneficial change. And public health leaders must be potent agents of change. The change we craft must also be sustainable and clearly beneficial to society.

Himmelman (1995) also saw community collaboration as being necessary and cited as his reasons the political changes which are presently

occurring: (a) an increase in local governance and democratic renewal, (b) an increase in class disparity, (c) an increase in economic disparity, and (d) declining resources. In an atmosphere of community stress, Himmelman believed that networking gave everyone hope. Networking with churches appeared to be important since 60% of the money going in to the non-profit sector (the third sector) was church based. However, doing more with less was not the only reason that public health workers should collaborate with churches and other community organizations. Community leaders and churches are risking their credibility and this must be recognized as a valuable, important resource. Collaboration must include shared risks, shared responsibilities, and shared rewards. Health care institutions must empower communities by sharing power and authority. If community groups are used only to obtain resources and only in an advisory capacity, it is not a partnership.

Faith Communities as Partners

Delivering health care services through partnerships with churches has been a frequently used research model (Davis et al., 1994; Eng, Hatch, & Callan, 1985; Erwin, Spatz, & Turturro, 1992; Hatch & Lovelace, 1980; Herbert, Fruchter, Camilien, & Grant, 1995; Lasater, Wells, Carleton, & Elder, 1986; Levine et al., 1992; Lewis, 1989; Olson, Reis, Murphy, & Gehm, 1988; Scandrett, 1994; Thomas, Quinn, Billingsley, & Caldwell, 1994; Weist & Flack, 1990; Williams, Scarlett, Jimenez, Schwartz, & Stokes-Nielson, 1991). Although this model is not new, it has gained recent popularity as an efficient means to reach large numbers of individuals, families, and communities in a cost effective manner. Many reasons have been given by health professionals, who have worked in partnerships with churches, to the question "Why churches?" The

following responses demonstrate overwhelming support for the delivery of health care services through partnerships between health care agencies and faith communities (DePue, Wells, Lasater, & Carleton, 1987; Eng, Hatch, & Callan, 1985; Lasater, Wells, Carleton, & Elder, 1986; Levine et al., 1992; Salewski, 1993; Scandrett, 1994; Scheie et al., 1994; Solari-Twadell, 1995; Stillman, Bone, Rand, Levine, & Becker, 1993; Thomas et al.,1994):

1. Churches have a long history of effectively serving those in need and addressing unmet health needs.

2. Churches exist in all areas of the country, which increases the ability to build on any research findings nationally.

3. Churches have a philosophy and an organizational structure that is consistent with health prevention and health education.

4. Churches have a history of volunteerism.

5. Churches have a large membership which is likely to facilitate the diffusion of information within the church and the community.

6. Churches have an educational framework that provides opportunities for health interventions.

7. Churches can provide a network of social support to promote and sustain behavioral change.

8. Churches provide access to large, diverse populations as well as access to the underserved.

9. Churches are generally the most stable and influential subsystem of the community.

10. Churches are viewed as credible institutions.

11. Churches play a leadership role in the community.

12. Churches have resources such as buildings, meeting rooms, trained leadership, volunteer support groups, and an educational infrastructure.

13. Churches influence individuals of all ages, families, and communities.

14. Churches are comprised of people who tend to be positive and who have highly motivated attitudes toward life.

15. Churches have deep roots in their communities and know who can help get things done.

16. Churches deal with end of life issues.

17. Churches have a history of dealing with values clarification.

18. Churches are committed to a mission of healing.

19. Churches are already participating in health screenings, health education, and a wide range of service programs.

20. Churches are involved in the Parish Nurse movement.

21. Churches provide direct and continuous connections with over half of our population an important fact with such a transient and relocating society.

Faith organizations were multi-denominational, multi-dimensional, multi-ethnic, multi-cultural, localized, and both national and international. "What they all share in common is a belief in faith and dedication to the improvement of the human condition, which is exactly what public health is about, improvement in the human condition" (Evans et al., 1994, p.1). Guerra (in Evans et al., 1994), also saw the strong bonds between faith communities and public health workers. He stated that both groups were concerned about the poorest and the most vulnerable members of our society:

> The mission of public health is fulfilling society's interest in assuring conditions in which people can be healthy. Today's greatest public health concerns center around the negative health outcomes associated with high risk behaviors that are driven by misdirected individual community and cultural values and expectations....Together, our challenge is to find ways to promote both physical and spiritual wellness in environments where even a sense of community is totally absent....We must sensitize and empower communities to once again become caregivers. This is a role uniquely suited to the faith ministries coming together with public health (pp. 24-29).

Two barriers to partnerships between health care agencies and faith communities which were important to address, although they were not mentioned often in the literature, were the conflict of separation of church and state and the feeling of hopelessness in our communities. Satcher, (in Evans et al., 1994), stated that the separation between church and state is important and must be preserved. Neither the church nor the state should use partnerships as a way to gain dominance. The faith community must develop an understanding for the science base of public health, and public health needs to understand and appreciate the perspective of the faith community. Understanding each others perspectives can lead to shared values, communication, and mutual trust (pp. 8-9). Hatch (1995) described the concern regarding the separation of church and state as a "schizophrenic fear" which created a major attitudinal barrier. Kaiser (1995) concurred and stated that there was... "no boundary between public health and private health. That is a delusion. The church by definition is a primary care center. The reason is very simple, you can't separate spiritual well-being from physical well-being." Jocelyn Elders, past Surgeon General of the United States, stated (Interfaith Health Program, 1994):

> In the United States we pride ourselves on the doctrine of separation of church and state. But we need an integration of church and state in the arena of public service. We need to blend those things that the interfaith community do well, and those things that the public health sector do well. Put them together to make things happen....What we must do now is find a way to sew together everybody's quilt pieces, the faith community's quilt pieces and the government's quilt pieces, so that every American is covered by a quilt of health-care (p. 39).

And what of the hopelessness and lack of trust that many in our communities are now facing? "Two-thirds of the total years of life lost by Americans before the age of sixty-five are preventable" (Mason, 1990, p.23). With the knowledge of prevention and interventions that we already have, why is it that the majority of people with high risk behaviors fail to change their lifestyles? Hatch (1995) has said that this is due to the "stressors" in our communities and lack of programming that targets "the wholeness of existence". Communities must become a better place to live. Communities must embrace people and offer coherence. Dr. Reed Tuckson, Commissioner of Health for the District of Columbia concurred (In Mason, 1990):

> If we are trying to deal with the gap between what is known about health promotion and disease prevention and what is applied by the nation's citizens, we need to be talking about people's self-worth. If a person doesn't believe in the possibilities of the future, then what difference does health information make?...The health message is absolutely irrelevant in such a social context. That's not the work for the health commissioner. That's work for the church (p. 25).

A 1990 Gallup poll, conducted by the National Civic League and reported by the HealthCare Forum (1994) in What Creates Health?, found that lack of confidence is focused almost exclusively on the government sector with high confidence in religious institutions (57%), volunteer groups (54%), and local businesses (32%). The creation of partnerships between health care

agencies and faith communities can help to bridge this gap and bring new hope to our communities, creating healthier communities for the next century.

Faith Communities and Health Care

Are churches interested in partnerships with health care agencies? Two recent studies supported the proposition that they are natural partners. The first was conducted by the National Council of Churches in Christ (NCC) in the U.S.A. in collaboration with the National Center for Children in Poverty (NCCP) at Columbia University (NCC, 1992). A survey of churches was conducted to identify the nature and extent of church-sponsored health activities. Of the churches contacted, 41% (n=1883) of the pastors of protestant denominations responded, representing approximately 26 million adults and children in the U.S.A. (p. 3). The results of the survey showed that 78% of those responding were addressing at least one health care need and that 50% were addressing three or more health care needs (p. 5). The types of concerns addressed were nutrition, substance abuse, mental health, access to medical services, access to prenatal care, vision and hearing screening, health insurance coverage, and immunization. More than two-thirds of the congregations served the general community (p. 9). More than two-fifths (46%) of all the churches conducted health related initiatives in collaboration with public health agencies, 42% with other churches, 34% with private health organizations, and 30% with private physicians. Resources contributed by the churches were staff time, volunteers, money, food, and space (p. 13).

A study conducted by Thomas, Quinn, Billingsley, and Caldwell (1994), focusing on Northern Black Churches, showed similar results. Of the 635 churches who participated in the study, 67% sponsored a total of 1804

community outreach programs. Health issues addressed included: (a) human sexuality, (b) AIDS education, (c) drug abuse prevention, (d) pregnancy prevention, (e) mental health services, (f) food, (g) shelter, (h) health education, (i) medical care, (j) clinics, (k) screenings, (l) workshops, and (m) counseling. The authors stated that these documented collaborative efforts to provide health care services provided evidence that church sponsored programs had the ability "to reach potentially underserved, poorly served, and never-served segments of the Black community" (p. 577). Thomas et al. identified eight church characteristics that would be useful to public health professionals in identifying churches for community health outreach programs: (a) church size, (b) denomination, (c) church age, (d) economic class of membership, (e) number of paid clergy, (f) existence of other paid staff, (g) education level of minister, and (h) church ownership (pp. 576-578).

In reviewing the literature, churches have been collaborating with community agencies to meet the health care needs of citizens. A review of this literature did not identify characteristics essential to the sustainability of partnerships but provided information on the interest and potential of faith communities as partners with health care agencies.

The Academic Community and Church Health Programs

Early literature regarding the delivery of health care services through churches focused primarily on the results of partnerships between the academic community and faith groups. These partnerships were collaborative in nature but not equal. However, they demonstrated the effectiveness of health promotion projects through churches.

The first researchers to work with churches were Hatch & Jackson (1981). The Black Church Project conducted with the General Baptist Convention of North Carolina was a training project begun to reduce morbidity and mortality rates associated with hypertension, diabetes, and birth and early life survival among Blacks in rural North Carolina (p. 70). This project was developed using lay trained health workers who were part of a trusted existing social system, the church, to deliver health information. Churches were selected due to their significance in the community and their role in caring for the ill (Hatch & Lovelace, 1980, p. 23). In all, 18 participants from 8 churches were selected for 12 weeks of training with health professional students, students in: (a) nursing, (b) medicine, (c) health education, and (d) nutrition. The goal of the program was to improve the students' skills in providing health care to underserved communities. The educational benefits to the students included: (a) learning the health educator's role in the community, (b) learning how existing institutions could be used in working with the community, and (c) learning how to relate to people from a different culture (p. 25).

Eng, Hatch, and Callan (1985) proposed a conceptual framework for determining effective program planning based on the experiences that resulted from the Black Church Project. The framework was based on Social Support Theory. With the changing focus of public health from infectious diseases to behavioral change, the authors stated that the general thrust was to place programs in the "hands of people who can motivate and assist one another to adopt healthier life-styles and become more self-reliant" (p. 83). The expectation was that "through their social networks, members will not only be able to persuade one another to effect change but will also be able to offer

social support for sustaining change" (p. 83). However, to support sustained behavioral change, the authors found that individuals needed to be committed to their relationships and to the community and not just participate in isolated, "individual acts of kindness." They had to have a sense of collective identity (p. 84). The Black church was seen as a unit of identity, solution, and practice (pp. 85-90). This conceptual framework served two purposes: (a) for program planning and (b) for mobilizing resources from within the community so that long term behavior changes were not dependent on outside professionals and outside resources (p. 91).

Weist and Flack (1990), University of Oklahoma, also conducted a quasi-experimental research study based on the use of "natural helpers in a Black church community" in the delivery of a church-based cholesterol education program (p. 382). The study identified church members with high cholesterol who were willing to participate in a 6 week education course. They were compared to adults with high cholesterol, identified at other sites, who received only a referral to a physician. The results of this study suggested that coronary heart disease screening and nutrition classes to lower cholesterol, when conducted in Black churches by trained volunteers of the congregation, were an effective method of lowering blood cholesterol levels (p.386). Seventy-five per cent of the education group returned for screening 6 months later; of those, 10% had a decrease in their blood cholesterol level. The authors stated that "churches could be strong allies for public health organizations, and their members could enhance considerably ongoing efforts to lower risk for CHD in the black population" (p. 387).

Lasater, Wells, Carleton, and Elder (1986) conducted a quasi-experimental study, the Health And Religion Project (HARP), which tested "the efficacy of churches as sites for health promotion and the receptivity of church leaders and members to participation in tightly protocol led research efforts in primary prevention" (p. 125). The researchers found that churches were receptive and had strong potential as sites of major health promotion activities. These findings supported the use of churches for: (a) primary prevention, (b) cost-effectiveness, (c) reaching large numbers of individuals, and (d) assuring long term maintenance of health behavior changes (p. 131).

Olson, Reis, Murphy, and Gehm (1988 ) conducted a structured telephone interview study to determine if inner-city churches were interested in partnering or sponsoring maternal-child health programs. They found that nearly all the churches were willing to participate in some way such as: (a) advertising, (b) working with schools, (c) program support, or (d) lobbying for funds (p. 254). Barriers to program implementation were: (a) lack of funds, (b) lack of time to manage the programs, (c) lack of interest, and (d) lack of cooperation and technical support from government agencies (p. 254). The authors stated that "churches may be an effective location for innovative church and health partnership programs" (p. 256). However, to implement these partnerships, churches would need the involvement of professionals, public health agencies, and economic and technical support.

Levine, Becker, and Bone (1992) presented a synthesis of a 15 year collaborative program between Johns Hopkins Medical Institution and the African-American community in East Baltimore, MD. This quasi-experimental, community based research study focused on approximately 150,000

individuals, 90% African-American, across a 44-census tract area in East Baltimore. Through a church based program, the researchers felt they could reach 85% of the population. The research study resulted in "a significant improvement in the control of hypertension and related reduction in morbidity and mortality from this problem in patients in this population" (p. 320). The initial development phase (1974-1979) included task force development based on community assessment, determination of leadership, agencies, activities, and services. Leadership included representatives from neighborhood centers, churches, the city health department, the mayor's office, community health care providers, and Johns Hopkins Medical Institution. The second phase (1979-1987) was characterized by program implementation and the training of community residents to become certified health workers. The current phase (1987 and beyond) is directed at extending and broadening organized programs to include smoking prevention and cessation, diabetes control, obesity, nutrition, asthma, substance abuse, and cancer screening (p. 321-322). The implementation of these programs has been through a variety of community and civic organizations, but in particular through the churches of East Baltimore. Approximately 250 churches exist in the community with the ability to reach 85% of the population. This collaborative effort of Johns Hopkins and over 200 churches is now formalized into a new program, "Heart, Body, and Soul."

The Heart, Body, and Soul program offered some of the first insights published regarding the sustainability of projects between health care agencies and faith communities. Levine et al. (1992) emphasized viewing the community as a system with important subsystems, and the mobilization of these subsystems was critical to achieving desired behavior and health status

changes (p. 297). To enhance long term sustainability of the program, the project goals included developing the program under community directorship and ownership (p. 297). Initially the leadership included political, health, recreational, and social welfare representatives. Over time, it became clear that "the religious subsystem was the most stable and influential one....The church was not only a spiritual organization, but also a major social and political force" (p. 299).

Major obstacles that the Heart, Body, and Soul program faced were skepticism from the community regarding Johns Hopkins University's commitment to the project and their role in decision making, leadership, and resource control. The medical institution was concerned about the reliability of evaluation criteria (Levine et al., 1992). To bridge these barriers, commitment and adaptability from both sides was required. Long term sustainability was developed through community ownership, community based leadership, mutual decision making, interventions based on community subsystems, resources, values, culture, and training for community leadership (p. 304).

Erwin, Spatz, and Turturro (1992) reported on a non-experimental study based on "role model intervention" in African-American churches and community centers to increase breast self-exam (BSE) and mammography. A total of 78 women participated with 63% responding to a follow-up questionnaire. Among the 63 respondents, 12 women reported that they obtained a mammogram following the program. These results demonstrated that the role model design in churches was effective in motivating African-American women to learn BSE and to have screening mammograms (p. 317). The authors felt that the success of the program was due to individuals in the

churches who took a personal interest in the program and invited friends, neighbors, and relatives to the presentations thereby increasing access to a population that might not otherwise have attended a health education program.

A similar model was used in a quasi-experimental study by Davis et al. (1994) in Los Angeles County, California, to evaluate the use of lay health leaders in a cervical cancer control program. In this study 24 churches were targeted with a 96% participation rate and 30 lay health leaders were trained. A total of 1,012 women attended educational sessions and 90% of the women targeted for screening presented for follow-up (p. 500). The authors stated that these findings "suggest that a church-based model of social influence can leverage the participation of minority women in cervical cancer control, provide access to underserved Hispanic women in particular, and sustain cancer control activities beyond the life of an intervention program" (p. 500).

A similar non-experimental study was conducted by Herbert, Fruchter, Camilien, and Grant in Brooklyn, New York, in 1992 (1995). The project, Cervical Cancer: Neighborhood Outreach Program (CC: NOP) was started to "develop sustainable cancer prevention activities in Brooklyn churches" (p. 1) and to reach low income women in need of screening services. The program was developed over a 30 month period and reached 847 women in 23 churches (p. 2). The authors identified these key factors in building and sustaining a successful program: (a) an active health or social committee in the church, (b) nurses who were active in the church, (c) sharing information and results of screenings with church committees, (d) conducting programs on the day of worship, (e) helping women who needed referrals, and (f) the medical

center's (SUNY-Health Science Center) commitment to and material support for the program (p. 3).

Foundations Partnering with Faith Communities

Foundations such as the Lilly Endowment Program, W.K.Kellogg Foundation, and the R.W. Johnson Foundation have been funding partnerships that involve communities of faith. An examination of these programs, and their research results, helped to identify factors which were necessary for sustaining community partnerships in which partners from faith communities were seen on a more equal status.

W.K.Kellogg Foundation and Partnerships with Faith Communities. In 1992 the Kellogg Foundation funded a consortia in seven states to institute reform efforts around public health (W.K.Kellogg, 1995). The goal of the initiative was to "improve community health and well-being through public health approaches that are truly community-based by once again making public health a player in communities, and making communities a player in public health" (p. 1). The progress reported from these initiatives, released in May of 1995, plus information presented at the 1995 American Public Health Association Annual meeting, identified these important competencies for public health partnerships based upon site visit observations, a cost/benefit survey, and an overview of 50 key indicators:

1. Developing shared leadership demonstrated a breadth of knowledge, skills and ability. "The challenge is to figure out how all the entities, powerful leaders, and achievers can work together" (Johnson, 1995, p. 2). Shared leadership development included: (a) leadership that functioned not only in theory but in practice, (b) leadership that was consistent with a clearly

articulated vision, mission, goals and objectives, (c) leadership which had clear boundaries and clearly defined roles and responsibilities, and (d) leadership that used evaluation measures.

2. Commitment of time enabled all members to meet, to get to know one another, to build trust and relationships, and to do the work of the partnership.

3. Technical assistance was used for coalition building, leadership, and governance.

4. Partners were chosen who were the right match for the individual organization, were ready to partner for the purpose of the partnership, and could support the shared mission.

5. Partners must develop group accountability and must adhere to agreed upon values, goals, and objectives.

6. An effective process for evaluation must be developed.

7. A critical mass of people must be built and maintained.

8. Financial support or release time must be provided for staff.

9. Establishing high morale, the most valued asset, can be developed from mutual trust and respect.

Major challenges to this process of partnership development were internal conflict, setting boundaries (defining community), the diverse goals of the partners, and the complexity of time needed to attain shared leadership and community ownership. Factors which were identified that promoted successful partnerships were: (a) leadership that promoted shared decision making, (b) an organizational structure that supported shared decision making, (c) high quality staff, (d) clearly defined role expectations, (e) effective and consistent formal and informal communication, (f) shared leadership, (g) commitment of time,

(h) setting limitations on numbers and kinds of projects, (i) partner representation across all areas of the partnership, and (j) flexibility in approaches versus a feeling that there is only one right way. Major barriers to sustainability were funding, measuring outcomes, time limitations, a structure that was inflexible, and choosing partners who were not consistent with program goals. The greatest obstacle identified was internal conflict, particularly conflicts around relational issues such as philosophy, goals, funding, race, and gender. To resolve these conflicts, consortiums used outside consultants and developed accountability tools for staff and partners.

Another project funded by the W. K. Kellogg Foundation was the "10 Parish Project" (Intergenerational Health Center, 1995). This project provided multi-year funding (1990-1994) for "an experiment in congregational based holistic health care" (p. 3). The goals of the project were: (a) to serve the community holistically with church based centers throughout the greater San Francisco Bay Area, (b) to produce a model to be replicated in other parishes, and (c) to bridge cultures and intergenerational boundaries by providing services that were intentionally inclusive. Data were collected by site visits and site reports. Of the original ten congregations, eight completed the project, with 65 to 70% of the clients coming from the community (p. 21).

A primary lesson learned from the "10 Parish Project" was that for the project to be successful, the congregation had to engage in a "capacity building" process. For the church to be involved in a "viable healing ministry for the community, it must first be involved in its own work of health and healing" (Intergenerational Health Center, 1995, p. 6). This "work" included pastoral leadership in holistic healing, a thorough community needs assessment, and

sustaining congregational support (pp. 6-12). Additional challenges included: (a) time, four years was felt to be too short a period for most parishes to develop a program, (b) finances including knowledge and skills in fund raising, Board support of long range funding, and fee for service development and marketing, (c) conserving resources by involving other groups in the community, (d) adaptability and flexibility, (e) providing services for church members, (f) publicizing the program, (g) maintaining constant communication between the church and the centers, (h) community involvement, (i) volunteer development to support the staff, (j) operating in a clearly defined space, (k) and leadership that includes the community and the church (pp. 18-19).

R.W.Johnson Foundation and Partnerships with Faith Communities. The Robert Wood Johnson (RWJ) Foundation found similar results when evaluating two programs, The Interfaith Volunteer Caregivers Program (Lewis,1989) and Patterns of Decision Making in Tobacco Control Coalitions (Sofaer, Sparks, & Kenney, 1995). The Interfaith Volunteer Caregivers Program funded 25 church-synagogue coalitions serving the frail elderly. To participate in the program the coalitions had to agree to an overall study program by the Third Age Center. The study process included data collection on persons served, volunteers providing services, and site visits. The programs were generally initiated by a needs assessment, a critical incident, the initiative of a charismatic leader, or by commitment of government funding to the aging (Lewis, 1989, pp. 26-27). An evaluation of these programs found that these key factors contributed to their success: (a) strong leadership was the key to success in virtually every program, (b) staff required knowledge of the community and the ability to interact with people, (c) staff and leadership loyalty was considerable despite

modest remuneration, (d) funding was not dependent on RWJ, (e) most were not collaborative in nature, and (f) there was an exclusive goal, the frail elderly (pp. 10-11).

A second component to the Interfaith Volunteers Caregivers program was collecting data from 475 key informants in 38 states to determine the 25 best practice models used by congregations to serve the frail elderly (p. 12). The results of this extensive survey study found that the best practice models were: (a) in congregations which had a staff person assigned to serve the elderly, (b) offered services at varied times and with other community organizations, (c) offered an average of four special programs, (d) maintained records for special programs, (e) served persons with no affiliation with the church as well as church members, (f) maintained a volunteer base from the congregation, and (g) received funding from not only the congregation but also from the government, private donations, foundations, and special fund raising events (pp. 13-16).

Recommendations from The Interfaith Volunteer Caregivers Program included the need for: (a) government funding and technical assistance to local congregations, (b) social service and health agencies to make greater efforts at forming partnerships and joint ventures with local congregations, (c) recognition that programs are developed over time and with the sharing of resources and knowledge, and (d) local congregations to formalize their planning processes (Lewis, 1989, pp. 17-18). Barriers to the delivery of services were lack of staff, lack of volunteers, insufficient funds, lack of time, need for staff and volunteer training, and lack of transportation for the target population (p.26).

Sofaer, Sparks, and Kenney, (1995) reported on another field research study funded by RWJ which involved tobacco control coalitions. Data were collected through interviews with key informants, observation of interactions at sites, and document analysis. The authors identified these key issues for grantees as they implemented their activities and attempted to grow their coalitions: (a) lead agencies must recognize potential costs and benefits from being inclusionary and work with organizations to achieve shared vision, shared power, and shared resources, (b) guidelines for an organizational structure must be outlined whether formal or informal, (c) states must be active participants by allocating resources to the coalitions, (d) roles for staff and coalition leadership must be clearly defined, (e) ground rules for identity and autonomy must be determined, (f) clear, consistent policies on the roles and activities of the coalition must be defined, and (g) strategies to manage conflict must be developed (pp. 6-7).

Recommendations from this study included: (a) expanding coalition members to non-traditional members, including representatives of the target population, representatives of churches and other community groups, (b) developing information flows, (c) developing organizational structures and processes for decision making, (d) carefully articulating distinct roles for staff and coalition members, (e) developing effective strategies for conflict management and conflict resolution, (f) using the media, and (g) educating coalition members and the public about their services and mission (Sofaer, Sparks, & Kenney, 1995, p. 8).

Lilly Endowment and Partnerships with Faith Communities. In 1989 the Lilly Endowment began a program entitled "Religious Institutions as Partners in

Community-Based development" (Scheie et al., 1994). The program was "based on the conviction that churches and neighborhoods need each other: that churches flourish best when they reach beyond their walls, and that neighborhoods benefit from the resources and leadership vested in local churches" (p. iii ). The Lilly Endowment report, Better Together, emphasized that religious institutions were among the most "durable and resilient features of even the most impoverished American communities" (p. 3).

The 28 projects, considered a national demonstration program, were funded and developed by Lilly. The projects used a variety of partnership structures, with a partner defined as an institution sharing in planning and decision making. The overall program had four goals: to stimulate religious institutions in community revitalization, to create new religious / community partnerships, to strengthen community ministries, and to attract new sources of funding for the partnerships (Scheie, Markham, Mayer, Sletton & Williams, 1991, pp. 4-5). Three phases of funding existed: planning, implementation, and transition. Results from the planning stages were reported by Scheie et al. in 1991 based on program evaluation completed by site visits using "Site Visit Workbooks" and by document content analysis. A variety of partnership structures or models were recognized: (a) a single organizer with one foot in the religious world and one in the community, (b) a single congregation forming a separate corporation, (c) a partnership between a community-based organization (CBO) and one or more religious institutions with the dominant decision maker the CBO, (d) a group of religious organizations coming together to form an affiliated CBO, (e) a CBO organizing a group of religious institutions to form a partnership, (f) a hybrid organization engaging a religious institution

and a CBO to create a new partnership, and (g) a classic partnership in which the CBO and the religious institution mutually initiated the partnership as peers in an equal relationship (pp. 44-62).

In addition to identifying models of practice, the evaluation of the first phase identified key concepts for developing partnerships: working together, participation and outreach, and governance. Characteristics that were found to be evidence of "working together" in successfully developing partnerships were: a clear common vision, a high level of trust and respect for partners, the identification of partner strengths and tasks divided effectively, a structure that promoted inclusiveness (ecumenical, racial, cultural, geographic and economic), and volunteers serving the partnership in multiple ways. Characteristics of governance and decision making were that: (a) the governing body exercised strong leadership and resolved key issues effectively, (b) religious leaders were involved at all levels, and (c) there was a good mechanism for local oversight. Characteristics of participation and outreach were that: (a) new partners were brought together in a clear process, (b) congregations were significantly involved, and (c) the governing body represented a cross-section of the community and was broadly ecumenical (Scheie et al, 1991, pp. 63-65 ). Characteristics of weak partnerships included: (a) work that was not shared equally by partners, (b) inadequate communication, (c) partner mistrust, (d) one or more partners with paternalistic attitudes, and (e) a partnership that ignored outreach to other community organizations (p. 66).

In light of these findings, Scheie et al. (1991) made the following recommendations for building strong partnerships with religious institutions,

noting that they were similar to those that were applied to other partnerships (1991, pp. 72-77): (a) create a foundation of shared values and goals, (b) seek mutual involvement within partner institutions, (c) communicate frequently and freely, (d) partner with the people not just the institution, (e) provide opportunities for the training and education of partners, (f) recognize the different pace at which religious institutions and other organizations work, (g) recognize that churches are multi-service organizations (the new partnership will not be their only focus), (h) be aware that religious institutions are not dependent on the CBO to continue their other programs and may view the partnership as a way to "spend money," (i) be aware that religious institutions are volunteer dependent and consent from the membership is necessary and time consuming, (j) develop partnership goals that respond to the religious institutions need to minister to people, including their own people, and (k) recognize that partnerships with religious institutions improve access to resources: public, private, and religious.

In the final evaluation report of the Lilly Endowment Program, Scheie et al. (1994) expanded on the research findings of the initial report and included information regarding sustainability. They identified six dimensions of sustainability, listed here in order of importance: (a) partnership organization and development, most importantly strong, stable leadership within the staff and Board of Directors, (b) commitment to partnership staff, not relying totally on volunteers, (c) broad based community support, (d) plans for partnership activities, (e) partnership funding to continue community development, and (f) other sustaining resources such as equipment (p. 19).

Other leaders in community-based partnerships have reported similar findings. Michael Felix (1995) identified these "struggles" regarding partnership sustainability: (a) length of time needed to see results, (b) long term financing, (c) trust versus self interest, (d) local leadership with vision, (e) local support system, (f) exchange of resources, (g) management of competition, (h) recognition of the diversity in the community, (i) accountability and outcome measurement, (j) lack of state support, and (k) the need for a nurturing community. Mayer (1992) identified three common barriers to effectiveness in the independent sector-institutions (foundations and voluntary groups): (a) limited vision, seeing the glass half empty and not being able to see strengths, abilities and capacities within the community, (b) creating barriers between the grantseeker and the grantmaker, focusing on money differentials instead of recognizing that both groups are in the same roles at different times, and (c) non-inclusiveness, racism (pp. 1-5).

## Summary of Literature Review

Partnerships between faith communities and health care agencies are one type of community partnership which have been recognized as an efficient and cost-effective way to promote healthy lifestyles and reach high risk, underserved populations in our communities. Partnerships between health care professionals and members of the faith communities seem natural, as both have a common interest in the health and well-being of the vulnerable members of our society. The literature demonstrated that faith communities were interested in the delivery of health care services, in that they have had a long history of initiating projects and collaborating with service agencies, academic centers, and foundations.

The academic community has collaborated with churches for almost 20 years by using churches as a setting for research interventions related to health promotion and health education. These projects demonstrated the effectiveness of such collaborative interventions in improving health outcomes and a willingness of the churches and the academic community to work together, but they provided little information on the process of organizing and sustaining the projects. Recent literature (1990 and beyond) showed a desire by both the academic community and foundations to assist in the evolution of these early, successful, collaborative programs into sustainable community partnerships. The most recent literature, which involved foundations collaborating with faith communities, suggested factors which would be necessary to foster the development of partnerships as well as obstacles that would need to be over come. Little research existed that identified factors necessary for the sustainability of equal partnerships between health care agencies and faith communities that was based on studies of actual partnerships.

By studying the actual partnerships, this research study identified the characteristics of the organizational structure that fostered the sustainability of partnerships between health care agencies and faith communities. The study differed from the existing literature in that it examined only equal partnerships, not collaborative relationships, between health care agencies and faith communities.

# Chapter 3

# RESEARCH DESIGN AND METHODOLOGY

## Research Design

The research design for this study was a nonexperimental, descriptive survey study, with a cross-sectional time frame. A nonexperimental study attempts to develop "a picture of phenomenon or make account of events as they naturally occur" (LoBiondo-Wood & Haber, 1994, p. 232). In a nonexperimental design the researcher is unable to control or manipulate variables and therefore explores relationships. A survey study (descriptive and exploratory) is a type of nonexperimental study that collects "detailed descriptions of existing variables and uses the data to justify and assess certain conditions and practices or to make more intelligent plans for improving health care practices" (p. 233).

This research design (non-experimental, descriptive survey) was chosen due to its appropriateness in regard to the purpose, research question, and conceptual framework of the study. The partnerships (sampling units) which were studied represented a relatively new model of health care delivery, partnerships between health care agencies and faith communities who had equal representation on a governing body. Limited research was available on this model of health care delivery. Therefore, this research study collected descriptive data from key informants (unit of analysis) in each partnership regarding the characteristics of the organizational structure that were important to sustaining the partnership.

## Methodology

### Subjects and Setting

Subjects. Key informants (unit of analysis) who were targeted in each partnership included Executive Directors, Project Directors, Chairperson of the Board of Directors or governing body, and other Board Members. It was assumed that these individuals would have the most in depth knowledge regarding the partnership. Identification of the key informants was done by contacting each partnership by telephone and describing the research question and inclusion criteria. Staff were asked to identify two individuals who would possess the most comprehensive knowledge about the partnership. The purpose of this telephone screening was to: (a) make personal contact with each partnership, (b) identify key informants, (c) improve the return rate by making personal contact, and (d) verify mailing addresses.

Setting. The setting for this study was partnerships (sampling unit) between health care agencies and faith communities. The inclusion criteria for the study were that the partnership: (a) be at least one year old, (b) consist of at least one health care agency and one faith community, and (c) have a Board of Directors or governing body with representation from the health care agency and the faith community. Sample selection was not limited to partnerships which consisted of only these two types of organizations. Partnerships could include other agencies as partners who also influenced their organization. Partnerships that were less than one year old were excluded because this researcher was primarily interested in variables that contributed to the sustainability of a partnership and it was felt that these variables would not be evident in the first year of the project. Partnerships that existed for the primary

purpose of research were also excluded due to their short life span and organizational structures which were not reflective of "equal" partnerships.

The partnerships studied were heterogeneous. The study included a purposeful sampling of partnerships identified through the Interfaith Health Program at the Carter Center of Emory University, Health Ministries Association (a national interfaith organization), Center for Disease Control, W.K.Kellogg Foundation, Robert Wood Johnson Foundation, Lilly Endowment, National Civic League, American Public Health Association, nonprofit organizations, personal contacts, and a literature search. The physical setting for the services of the partnerships included hospitals, churches, public health departments, universities, community clinics, and schools.

Human Subjects Approval

An application for Human Subjects Approval was submitted to San Jose State University Human Subjects-Institutional Review Board on October 26, 1995. It was approved without revision on October 30, 1995 (Appendix A). The application included: (a) the data collection instrument, (b) a self-administered mailed survey developed by the researcher, (c) the cover letter, and (d) a brief description of the study.

Risk to respondents was determined to be minimal (Category A). To insure confidentiality each questionnaire was coded. The code list identifying partnerships was kept in a safety deposit box and separated from the returned surveys. All identified materials are to be destroyed five years after the completion of the study. The major benefit to respondents was a copy of the study results, mailed to all respondents on completion of the data analysis.

A cover letter (Appendix B) was included with the questionnaire and contained: (a) the purpose of the study and criteria, (b) the definition of key informants, (c) estimate of the time required to complete the questionnaire, (d) the anticipated risks and benefits to the participants, and (e) the outline of measures to protect their anonymity. Consent to participate was implied if the participant returned a completed questionnaire. Consent for the site visit was included on the survey tool. Participants were also encouraged to contact the researcher and/or the Graduate Studies Office if they had questions or complaints regarding the research project.

Data Collection

The researcher developed a semi-structured, non-standardized questionnaire that was used for data collection. The data were collected to: (a) describe the partnerships, (b) indicate relationships, and (c) assist in the development of organizational plans. After receiving Human Subjects approval, the questionnaire was piloted on one partnership in San Francisco. Minor revisions were made to three multiple choice questions on the survey and it was mailed to all key informants on November 18 and 19, 1995. Included in the initial mailing were: (a) the cover letter, (b) the survey, (c) a card with key definitions necessary for the completion of the survey, and (d) a stamped, self-addressed return envelope. Key informants were asked to try and return the completed survey, if they chose to participate, by December 5, 1995.

A tracking form was developed to maintain an up-to-date status report on surveys. Tracking was done by identification number and included: (a) recording the date that completed surveys were returned, (b) recording calls and questions form key informants, (c) making corrections to addresses,

(d) recording whether they gave consent for a site visit, and (e) recording the number and types of follow-ups.

Planned follow-up procedures included the mailing of post cards to all non-respondents after December 9, 1995, and telephone interviews of all non-respondents two weeks after the post cards were sent if the response rate remained less than 10. The post card (Appendix C) reminded the key informants of the importance of their participation and the need to return the survey in a timely manner. If fewer than 10 informants had responded after the initial mailing in November, the entire survey packet would have been mailed by priority mail to all non-respondents.

In addition to the mailed surveys, the researcher collected data by making five site visits to partnerships that were determined to be typical of the sample studied. Ideally all projects would have been visited. However, this was impractical due to geographic spread and financial limitations. However, the five site visits gave the researcher the opportunity to validate information received on the surveys and observe partnerships in their natural setting. Structured interviews, using open ended questions, were conducted with key informants and staff. A written record of the interviews and observations made during the visits was kept by the researcher. These findings were not included in the findings of the study.

Instrument

A search of the literature was completed to identify previous research that might have been replicated or a data collection instrument which could have been used to identify factors that were critical to the sustainability of the partnerships. Unable to identify such a tool, the researcher designed a new

instrument based on the format of several related studies (Lewis, 1989; Moxley & Hannah, 1986; Pearson & Theis, 1991; Scheie et al., 1991; Scheie et al., 1994; Thomas, Quinn, Billingsley, & Caldwell, 1994; Wickizer et al., 1993). These studies used key informant surveys with both open-ended and closed-ended questions, structured interviews, and site visits as data collecting methods. Therefore, using this background information, the researcher developed a key informant questionnaire that utilized both open-ended and close-ended questions to elicit data concerning the processes under investigation: (a) goal specificity, (b) resource mix, (c) environmental influences, (d) boundary setting and maintenance, and (e) flow of information. Open-ended questions were adapted from "Religious Institutions as Partners in Community Based Development" by permission of David Scheie (1991) (Appendix D).

The mailed survey (Appendix E) consisted of 68 questions using multiple choice, simple answer, and open-ended questions, as well as a Likert scale. The survey was designed to measure five factors. For ease of reporting and readability the findings were reported under three processes: (a) environmental influences, (b) boundary setting and maintenance, which included goal specificity and resources, and (c) information flow. The 68 questions on the survey included those related to: partnership history (9), faith community partners (5), health care agency partners (5), funding resources (4), partnership goals (4), staffing (9), target population (9), Board of Directors (6), management of the partnership (4), key informant information (6), and questions related to building stronger partnerships (7). Of the 68 questions on the survey, 10 were open-ended questions. The time required to complete the questionnaire was approximately 45 minutes. Included with the questionnaire was a card that

listed the definitions for partnership, partner, health care agency, faith community, and Board of Directors.

To increase the validity of the survey instrument, the questionnaire was reviewed by a panel of expert reviewers from the Center for Disease Control, The Interfaith Health Program at the Carter Center, the Washington Health Foundation, and faculty advisors. To test the reliability of the instrument a pilot test was completed on one partnership. The final draft of the questionnaire can be found in Appendix E.

Data Analysis

Data generated from the key informant survey were both quantitative and qualitative in nature. The measurements were primarily nominal and ordinal, thus data analyses were descriptive in nature and included the computation of frequencies and percentages for each item. A statistician developed a coding system and an IBM program in which he entered the data using the Statistical Package for the Social Sciences (SPSS). Means and standard deviations were determined for items 1, 10, 15, 35, 36, 37, 38, 39, 53, and 65. A conjoint analysis was completed on item number 34, the Likert scale, combining the five scales into three: (a) unimportant-somewhat important, (b) neutral, and (c) important-extremely important. This statistical procedure was done due to the insufficient number of key informant responses in each of the five categories. Combining the five categories into three improved the ease of reporting frequencies and percentages for the individual categories.

Analyses of the 10 open-ended questions were done by content analysis by the researcher. Responses were analyzed by listing all responses, assessing for common themes and categorizing. Categories were determined

by listing those that were identified specifically, for example goal setting was mentioned by 15 key informants, or by combining themes such as openness, trust, honesty, respect with relationship responses.

# Chapter 4

# FINDINGS AND INTERPRETATION

## Description of Sample

Data collection for this study included the selection of a purposeful sampling of 57 partnerships (sampling unit) and the identification of one to two key informants (unit of analysis) in each partnership. Surveys were mailed to each of the key informants, a total of 114 mailed surveys on November 18 and 19, 1995. After two weeks, 20 completed surveys had been returned. On December 9, a follow-up mailing (post card) was completed to the non-responding key informants. Twenty additional surveys were returned after the second mailing. A total of six calls were received from key informants asking for clarification regarding inclusion criteria. The last survey was received on January 4, 1996. Due to a key informant response rate of 35% which represented 50% of the partnerships, telephone interviews were determined to be unnecessary. Of the 40 surveys returned, 36 key informants of 29 partnerships were eligible for inclusion in the study. In addition to these mailed surveys, five site visits were made to partnerships who had returned surveys and consented to visits, one in California, two in Illinois, and two in Ohio. These visits were made to validate survey information.

Data regarding the partnerships were collected by the use of key informants in each partnership. Table 1 describes the demographic make-up of the key informants. Of the 36 key informants, 20 (55.5%) identified themselves as either an executive director or a project director, 6 (16.7%) as staff, 4 (11.1%) as members of the Board of Directors, 2 (5.6%) as volunteers, and 4 (11.1%) as other. The professional backgrounds of the key informants were primarily health

## Table 1 - Demographics of Key Informants

**N = 36**

| | n | % |
|---|---|---|
| **Role** | | |
| Executive Director | 12 | 33.3 |
| Project Director | 8 | 22.2 |
| Staff | 6 | 16.7 |
| Board of Directors | 4 | 11.1 |
| Volunteer | 2 | 5.6 |
| Other | 4 | 11.1 |
| **Background** | | |
| Health Care Professional | 21 | 58.3 |
| Clergy | 5 | 13.9 |
| Business Leader | 2 | 5.6 |
| Other | 8 | 22.2 |
| **Years @ Partnership** | | |
| Less than 1 year | 2 | 5.6 |
| 1 year to less than 3 years | 16 | 44.4 |
| 3 years to less than 6 years | 7 | 19.4 |
| 6 years. to 10+ years | 11 | 30.6 |
| **Age** | | |
| 26-40 years | 7 | 19.4 |
| 41-55 years | 20 | 55.6 |
| 56-65 years | 9 | 25.0 |
| **Gender** | | |
| Male | 8 | 22.2 |
| Female | 28 | 77.8 |
| **Ethnicity** | | |
| White | 32 | 88.9 |
| African-American | 4 | 11.1 |

care 21 (58.3%) and clergy 5 (13.9%). The majority (44.4%) had been with their partnership for 1-3 years, 19.4% for 3-6 years, and 30.6%% for 6-10 or more years ( M= 50.86 months). Over half of the informants (55.6%) were 41-55 years old and 25% were 56-65 years old. The majority were female (77.8%) and white (88.9%).

## Findings

This research was based on an interpretation of Scott's (1992) organizational framework. Based on his framework, the researcher believed that attention to three critical areas was necessary to sustain partnerships: (a) environmental influences, (b) boundary setting and maintenance which included both goal specificity and resources, and (c) the flow of information.

### Environmental Influences

Environmental influences discussed by Scott (1992) were: (a) partnership make-up, (b) belief systems, (c) target population, (d) geographic setting, (e) decision making processes, and (f) standards of practice. Data analysis regarding these environmental influences will be discussed in the following section.

Partnership Make-up and Belief Systems. The sampling unit for this study was the partnership. The 36 returned surveys represented 29 different partnerships or 50% of the sampling units. The partnerships were located in 28 different states in the continental United States and the District of Columbia. All regions of the United States were represented, 10 in the northeast, 9 in the south, 2 in the northwest, 3 in the southwest, and 5 in the central region. The age of partnerships (years in existence) ranged from 1-12 years (M=5.25, SD=3.35). Partnership size varied from those with 2 partners to those with 77.

The number of current faith partners (n=34) ranged from 1-40 (M=7.32, SD=8.9, Mdn=3) and the number of health care agency partners (n=35) from 1-30 (M=4.14, SD=5.18, Mdn= 2.5).

Partnerships were influenced by the culture and belief systems of the faith communities, health care agencies, Board of Directors, and the target population. The primary faith influence was from the Christian Church as all partnerships (100%) reported partners from the Christian faith. Christian faiths with the largest representation were: (a) Catholic (58.3%), (b) Methodist (55.6%), (c) Baptist (50%), (d) Lutheran (50%), (e) Presbyterian (27.8%), and (f) Episcopal (22.2%). The only other faith communities reported to be active in partnerships were Jewish (11.1%) and Buddhist (2.8%).

The greatest influence by health care agencies came from hospitals which were represented in 80.6% of the partnerships. Other health care agencies represented in the partnerships were: (a) public health departments (44.4%), (b) physician groups (33.3%), (c) clinics (25%), (d) home health agencies (25%), (e) mental health agencies (22.2%), and (f) schools of nursing (22.2%).

In addition to the formal members of each partnership, key informants were asked to identify other agencies which they had collaborated with in the past. Although these agencies were not formal members of the partnership, they represented another sphere of influence that impacted the partnerships. These agencies had a culture, a belief system that indirectly influenced the partnerships. The rank order of these responses were: hospital (83.3%), faith community (80.6%), public health department (77.8%), school system (75%), mental health agency (66.7%), university (63.9%), clinic (58.3%), physician

groups (58.3%), welfare department (55.6%), youth organization (52.8%), home health agency (52.8%), housing department (50%), police department (44.4%), recreation department (36.1%), employment agency (33.3%), and social service agency (19.4%).

Other belief systems which influenced the partnerships were those of the Board members. The majority (80.8%) of the partnerships had a Board of Directors which consisted of 1-15 members (M=11.1, SD=6.9, Mdn=9.5). The professional backgrounds of members were: clergy (75%), business leaders (69.4%), nurses (63.9%), medical doctors (55.6%), community volunteers (52.8%), faith community volunteers (47.2%), representatives of the target population (44.4%), public health officials (33.3%), allied health professionals other than those listed (22.2%), chaplains (13.9%), educators (13.9%), health system representatives (13.9%), and attorneys (5.6%). The majority (80%) of the Board of Director members were reported to have had prior experience with community projects.

Target Population and Geographic Setting. The majority of partnerships served urban populations (61.1%). Other geographic settings were: mixed service areas (22.2%), rural (11.1%), and suburban (5.6%). The ethnicity of the those served: White (88.9%), African-American (88.9%), Hispanic (61.1%), Asian (50%), Native American (30.6%), Pacific Islander (13.9%), Middle Eastern (13.9%), and other (13.9%). When asked if any one ethnic group represented over 50% of their clients, 86.1% stated yes and of that group 47.2% were White, 36.1% African-American, and 2.8% Native American. The majority of partnerships served all age groups (38.9%) or mixed age groups (30.6%) and more females (50-74%) than males (25-49%).

Decision Making Process and Standards of Practice. The decision making process for most partnerships was established by Board of Director consensus (72.2%) including determining a mutually agreed upon goal (94.4%) and setting standards of practice (86.1%). Other influences reported for the establishment of standards were health care agency guidelines (66.7%), faith community guidelines (41.7%), and government regulations (36.1%).

Boundary Setting

Factors identified by Scott (1992) as important to boundary setting were: (a) identification of need and the services to meet the need, (b) recruitment of members including resource mix, (c) identification of the knowledge and skills of personnel, (d) operational costs, and (e) goal specificity and goal attainment. Operational costs and goal attainment were not examined in depth in this research. Examination of operational costs was limited to the sources of funding. Goal attainment was examined by looking at the process by which partnerships were measuring success.

Identification of Need and Services. To identify need, 75% of the partnerships said they completed a community needs assessment. Of the 25% who said they did not complete the assessment, 11.1% relied on personal knowledge and observations, 8.3% were in the process of doing a needs assessment, 8.3% used secondary statistics, and one partnership (2.8%) responded to a call for grant applications.

Matching programs to community needs was identified as one of the most critical factors for sustaining a partnership (97.2%). Services which were offered by this sample were: (a) health promotion and health education (88.9%), (b) referrals (77.8%), (c) health screenings (72.2%), (d) support groups (58.3%),

(e) counseling (58.3%), (f) physical assessments (52.8%), (g) immunizations (50%), (h) advocacy (50%), (i) primary care (44.4%), (j) nutrition (33.3%), (k) transportation (27.8%), (l) dental care (8.3%), and (m) optometry (5.6%).

Recruitment of Members. When asked to identify all criteria which were used for the selection of partners, 77.8% of the respondents selected bringing resources to the partnership, 69.4% similar missions, 66.7% completely voluntary, 66.7% geographic proximity, 52.8% expertise with community projects, 44.4% support from a key individual other than the pastor, and 38.9% pastor support. When asked if one criteria was more important than the others, 61% stated yes and identified similar missions (27.8%) and resources (19.4%) as the most important criteria for choosing partners.

Resources. Resources were recognized by Scott (1992) as integral to both organizational processes, environmental influence and boundary setting and maintenance. They were reported on under boundary setting due to their relationship with recruitment of members.

Table 2 presents the priority rankings by the key informants regarding resources related to the sustainability of the partnership. The greatest resources brought by the faith communities were human (83.3%), facility (72.2%), and access to the target population (63.9%). The three greatest resources contributed by the health care agencies were professional skills (94.4%), technical skills (88.9%), and equipment and materials (83.3%).

All sources of funding for the partnerships were reported to be: (a) foundations (94.4%), (b) local faith communities (55.6%), (c) businesses (47.2%), (d) community groups (41.7%), (e) hospitals and health care systems (33.3%), (f) state government (30.6%), (g) local government (25%),

**TABLE 2 - Sustaining Partnerships: Boundary Setting, Resources**
**N = 36**

| | *n | % |
|---|---|---|
| **Resources of Faith Communities** | | |
| Human | 30 | 83.3 |
| Facility | 26 | 72.2 |
| Access to Target Population | 23 | 63.9 |
| Professional Skills | 22 | 61.1 |
| Norms and Values | 20 | 55.6 |
| Economic | 17 | 47.2 |
| Equipment and Materials | 13 | 36.1 |
| Technical Skills | 11 | 30.6 |
| Organizational Structure | 10 | 27.8 |
| Administrative | 7 | 19.4 |
| Clearly Defined Goals | 7 | 19.4 |
| **Resources of Health Care Agencies** | | |
| Professional Skills | 34 | 94.4 |
| Technical Skills | 32 | 88.9 |
| Equipment and Materials | 30 | 83.3 |
| Economic | 29 | 80.6 |
| Human | 29 | 80.6 |
| Facility | 24 | 66.7 |
| Access to Target Population | 24 | 66.7 |
| Administrative | 23 | 63.9 |
| Organizational Structure | 23 | 63.9 |
| Goals | 21 | 58.3 |
| Norms and Values | 16 | 44.4 |
| Other | 2 | 5.6 |

*Informants circled more than one response

(h) denominational organizations (25%), (i) federal government (19.4%), (j) client fees (19.4%), (k) individual donors (16.7%), and (l) third party reimbursement (13.9%). When asked to identify their major source of funding, key informants stated: (a) foundations (30.6%), (b) hospitals and health care

systems (30.6%), (c) local faith communities (11.1%), and (d) state government (8.3%).

Identification of the Knowledge and Skills of Personnel. Key informants were also asked to report on their staffing. The number of staff ranged from 0-67 (M=14.9, SD=16.1, Mdn=8). Fifty percent of the partnerships had a staff of 0-8, 25% from 9-20, and 25% from 21-67. Two partnerships (5.6%) paid none of their staff, 4 (11.1%) reported paying one staff person, 3 (8.3%) paid two, and 3 (8.3%) paid four (M=11.6, SD=14.7, Mdn=6). Three partnerships reported paying large staffs of 35, 40, and 67.

Other staffing characteristics related to experience and professional background. Prior experience in health care partnerships was reported by the majority (58.3%). The professional backgrounds of staff were nurses (75%), health educators (50%), community volunteers (41.7%), representatives of the population served (41.7%), clergy (38.9%), church volunteers (38.9%), medical doctors (36.1%), church lay leaders (30.6%), allied health professionals (27.8%), business leaders (25%), administration (16.7%), clerical (13.9%), chaplains (8.3%), dentists (5.6%), attorneys (5.6%), and massage therapists (2.8%).

Twenty-nine (80.6%) stated that commitment to the partnership was a key factor in maintaining staff. A majority of the key informants (91.7%) stated that well defined goals were necessary to maintain a staff committed to the partnership. Other informants identified monetary rewards (55.6%), social recognition (52.8%), good working environment (19.4%), and support by Board of Directors (5.6%) as important in maintaining a staff committed to the partnership.

Goal Setting and Goal Attainment. The importance of goal setting permeates all aspects of the partnership. It has been demonstrated in previous sections that goal setting was critical to the identification of needs and services, decision making, and the recruitment of members and staff. Forty-two (41.7%) percent of the key informants identified goal setting as a key factor in partnership sustainability.

Goal attainment (achievement) was also recognized as a key factor in sustaining the partnerships by the key informants (22.2%). When asked in an open-ended question how they evaluated achievement, 50% (n=18) reported relying on process evaluation by either partner input and evaluation, written reports, and/or client surveys. Outcome measurement was reported by 41.7% (n=15) and included measurements related to objectives and number of clients served. Structural evaluation was reported by 38.9% (n=14) and included resource procurement, staffing, and facility. Goal attainment ranked fourth in order of importance for partnership sustainability.

Boundary Maintenance

Based on Scott's (1992) organizational theory, boundary maintenance activities included: (a) a clear understanding of the demand for services and activities needed to produce desired services, (b) a stable supply of resources, (c) commitment and agreement among partners regarding future direction, and (d) incorporating groups into the decision making structure of the organization. The identification of needs for services and resources were reported on previously under boundary setting, therefore they will not be reported on in this section. Two factors critical to boundary maintenance which have not been

addressed and will be discussed in this section are commitment and shared decision making.~

Commitment. Two questions on the survey related to the measurement of commitment to the partnership. In response to an open-ended question, 16.7% of the key informants stated that commitment was critical to sustain the partnership. Length of service on the Board of Directors was also a measure of commitment. The majority of the members of the Board of Directors served from 1-3 years (44.4%) and 3-5 years (41.7%).

Shared Decision Making. Table 3 represents the key informants' knowledge of decision making within the partnership. Equality in decision making between the partners was reported by 77.8% of the key informants and 41.7% reported resolving management conflicts with Board consensus.

To evaluate whether the target population also shared in decision making, three questions were examined: (a) ethnicity of the target population, (b) ethnic groups represented on the Board of directors, and (c) origin of leadership for the Board of Directors. As reported earlier 88.9% of the partnerships served both the White and African-American community. Thirty-one of the partnerships reported that over 50% of their clients represented a single ethnic group. Of those 31 partnerships, 17 (47.2%) served a predominately White clientele and 13 (36.1%) served an African-American clientele. Ethnic groups represented on the Board of Directors were White (100%), African-American (72.2%), Hispanic (22.2%), and Asian (11.1%). The primary sources of leadership for the Board of Directors were 33.3% from health care agencies and 19.4% faith communities.

**TABLE 3 - Sustaining Partnerships: Boundary Maintenance, Key Informants' Knowledge of Decision Making**
**N = 36**

| | n | % |
|---|---|---|
| **Decision Making Equal Among Partners** | | |
| Yes | 28 | 77.8 |
| No | 6 | 16.7 |
| Unknown | 1 | 2.8 |
| Missing | 1 | 2.8 |
| **Management Conflicts Resolved** * | | |
| Board Consensus | 15 | 41.7 |
| Executive Director | 5 | 13.9 |
| Organizational Redesign | 3 | 8.3 |
| Reeducation | 1 | 2.8 |
| Missing | 1 | 2.8 |
| Unknown | 2 | 5.6 |
| Other | 3 | 8.3 |
| No Major Conflicts | 6 | 16.7 |

* Informants circled more than one response

Flow of Information

When asked in the open-ended question to describe how the flow of information into and out of the partnership was managed answers were generally disorganized and non-specific. Table 4 reflects the general areas of response as determined by content analysis. The greatest number of partnerships (38.9%) reported information into the partnership through the media which included the use of television, radio, newspapers, bulletins, newsletters, brochures, E-Mail, and advertisements. Twenty-five percent of the partnerships reported receiving information into the partnership through the Board of Representatives. Twenty-two percent of the partnerships reported

**TABLE 4 - Sustaining Partnerships: Information Flow Into and Out of the Partnership**
**N=36**

| | n | % |
|---|---|---|
| **Information Flow into Partnership** | | |
| Media | 14 | 38.9 |
| From Board Representatives | 9 | 25.0 |
| Informal | 8 | 22.2 |
| Referrals | 1 | 2.8 |
| Client Surveys | 1 | 2.8 |
| Other | 17 | 47.2 |
| **Information Flow out of Partnership** | | |
| Meetings | 18 | 50.0 |
| Media | 15 | 41.7 |
| Written Reports and Minutes of Meetings | 14 | 38.9 |
| Informal | 12 | 33.3 |
| **Delegated Responsibility** | | |
| Staff | 10 | 27.8 |
| Board Representative | 8 | 22.2 |

receiving information into the partnership by informal means, such as telephone calls, listening, and word of mouth. Information flow out of the partnership was primarily by meetings (50%), media (41.7%), written reports and minutes of meetings (38.9%) and informal (33.3%). Key informants rated communication as one of the most important factors (100%) for sustaining a partnership (Table 5). However, only 50% of the partnerships reported assigning the responsibility of communication to a staff member (27.8%) or a member of the Board of Directors (22.2%).

Factors Identified as Important to Sustaining Partnerships

Table 5 shows that the three most critical factors identified as important to sustaining partnerships were communication (100%), a clearly defined mission (100%), and adaptability and flexibility (100%). Almost as important were matching programs to community needs (97.2%) and community support (97.2%). Funding availability (94.4%), mutual goal setting (94.4%), and shared decision making (91.7%) were also recognized by most informants as being critical to sustainability. The last six factors on Table 5 all related to either the origin of leadership or staffing. Seventy-five percent or less of the key informants saw these as critical factors to sustaining the partnership.

**TABLE 5 - Summary of Factors Identified on a Likert Scale as Important to Sustaining Partnerships**
**N=36**

| | UI-SI | N | I-EI |
|---|---|---|---|
| Communication | 0.0 | 0.0 | 100.0 |
| Clearly Defined Mission | 0.0 | 0.0 | 100.0 |
| Adaptability and Flexibility | 0.0 | 0.0 | 100.0 |
| Matching Programs and Needs | 2.8 | 0.0 | 97.2 |
| Community Support | 2.8 | 0.0 | 97.2 |
| Funding Availability | 5.6 | 0.0 | 94.4 |
| Mutual Goal Setting | 5.6 | 0.0 | 94.4 |
| Shared Decision Making | 5.6 | 2.8 | 91.7 |
| Sharing resources | 16.7 | 5.6 | 77.8 |
| Leadership from those Served | 19.4 | 0.0 | 75.0 |
| Salaried Staff | 25.0 | 5.6 | 69.4 |
| Leadership from HCA | 11.1 | 0.0 | 68.9 |
| A Board Reflecting those Served | 22.2 | 8.3 | 66.7 |
| Leadership from Clergy | 25.0 | 5.6 | 63.9 |
| Social Recognition of Staff | 33.3 | 8.3 | 58.3 |

UI-SI=Unimportant to Somewhat Important
N=Neutral I-EI=Important to Extremely Important

Key informants were asked to name the most critical factors necessary for partnership survival (Table 6). The majority (44.4%) identified issues related to the relationship between partners as the most critical factor affecting the sustainability of a partnership. The relationship category included such comments as holistic management, openness, honesty, trust, understanding, respect, enthusiasm, energy, sharing the credit and appreciation, flexibility, appreciating differences in philosophy, faith, and health, and ownership by all partners. Goal setting (41.7%) and communication (41.7%) were ranked next. Goal achievement, which included accountability and outcome measurement, ranked fourth (22.2%). Resources other than funding were selected by 16.7% of the respondents and funding by 13.9%. Environmental influences (13.9%) included involvement from the community, concern for the population served, faith belief, and involving new people. Leadership was considered the least important factor to sustaining partnerships (8.3%).

**TABLE 6 - Key Factors Respondents Identified in an Open-Ended Question as Important to Sustaining Partnerships**
**N = 36**

| | n | % |
|---|---|---|
| Relationship Between Partners | 16 | 44.4 |
| Goal Setting | 15 | 41.7 |
| Communication | 15 | 41.7 |
| Goal Achievement | 8 | 22.2 |
| Commitment | 6 | 16.7 |
| Resources other than Funding | 6 | 16.7 |
| Funding | 5 | 13.9 |
| Environmental Influences | 5 | 13.9 |
| Leadership | 3 | 8.3 |
| Other | 8 | 22.2 |

## Summary

The purpose of this study was to identify organizational factors critical to the sustainability of partnerships between health care agencies and faith communities. Clearly the findings from this study (Tables 5 & 6) showed that the key informants found four factors to be critical for partnership sustainability: (a) communication, (b) clearly defined goals, (c) adaptability and flexibility, and (d) positive relationships among partners. Other findings which were significant regarding each of the organizational processes were:

1. Environmental Influences: Partner influences were primarily the Christian Church and hospitals. Professional belief systems included clergy, business leaders, nurses, medical doctors, volunteers, and the target population. The two primary ethnic groups served were White and African-American. Standards of practice were set by mutual consensus and institutional guidelines.

2.. Boundary Setting and Maintenance: The majority of the partnerships completed a needs assessment and believed that the matching of identified needs to services was important. The most important factors for partner selection were resources and similar missions. Most partnerships had paid staff with the majority of staff being nurses. A well defined goal was the most important factor in staff retention. Most partnerships relied on process evaluation to measure goal attainment. The majority of the key informants believed that there was equality between the partners in decision making.

3. Flow of Information: Information into the partnership was received through the media, the Board of Representatives, and informal means. Information out of the partnership was dependent on meetings, the media,

written reports, and informal means. Only half of the partnerships had assigned the responsibility of communication to a designated person.

# Chapter 5

# DISCUSSION

## Introduction

This study used a descriptive, self-administered mailed survey to key informants to identify factors critical to the sustainability of partnerships. The survey, which was developed by the researcher, was based on the literature review and Scott's (1992) open systems organizational theory. This framework emphasized the environment's influence on the organization, viewing the two as inseparable. Critical to the sustainability of this organizational structure were environmental influences, boundary setting and maintenance (including goal specificity and resources), and the flow of information. Components of these factors were: resource identification, process of decision making, target population, belief systems, standards of practice, geographic setting, costs, communication, recruitment of members, skills and knowledge, commitment, needs, services, sharing of decision making, and stable resources. Attention to these factors helped protect the organization from failure while allowing input from the environment regarding needs, resources and energy thus permitting self-maintenance. In this open system, power and authority were shared. Key informants reported that power and authority were critical to the relationship between partners. Many of the health care partners had historically functioned within clearly defined walls and with complete authority. Working in an open system in the community, with shared decision making was challenging for them at best.

Key Informant Characteristics

The data collection method was based on the ability to identify key informants in each partnership who were able to answer the questions as objectively as possible. The results showed that the majority of the key informants were project directors or executive directors and qualified to answer the survey. Two surveys were delegated to volunteers. Because the majority of the partnerships relied heavily on volunteer support, these volunteers may have been reliable informants also.

Other factors positively effecting the quality of survey responses were the informant's length of service with the partnership, age, and professional background. The majority had been with their partnership three years or more, were 41 years or older, demonstrating maturity and experience, and were health care professionals. Two surveys were sent to each partnership, one to a representative from the faith community and one to a representative of the health care agency. A higher number of health care professionals returned completed surveys. This may have skewed the results toward health care agency concerns.

Environmental Influences

Six factors were analyzed to identify the environmental influences on partnerships: (a) partnership make-up, (b) belief systems, (c) target population, (d) geographic setting, (e) decision making processes, and (f) standards of practice. Partnerships included in this study ranged from 2-77 partners, but the majority had 2-10 partners. Therefore, most partnerships had other partners in addition to their faith and health partners. These partners would also influence the partnerships, but no attempt was made to identify these influences.

Partner selection was based on similar missions and the ability of the partners to contribute complimentary resources. The two most influential belief systems were the Christian faith and hospitals. This was also reflected in the background of the key informants who were primarily health care professionals and clergy. Other major health care agency influences were public health departments and physician groups.

In addition to these partners, another influential group was the target population which was primarily the urban, White, African-American, Hispanic, or Asian female of all ages. In creating a practice model, these major belief systems and their differences must be acknowledged and addressed if the partners hope to build a positive working relationship.

The make-up of the Board of Directors also exerted a strong environmental influence on the partnerships. The majority of the partnerships reported clergy, business leaders, nurses, and medical doctors on their Boards. However leadership from the clergy ranked only 14th out of 17 items on the Likert scale and leadership from health care agencies ranked 12th. This may indicate that individuals were valued more for their expertise than their affiliation.

The sample for this study consisted of partnerships with governing bodies that had representation from a faith community and a health care agency. Based on Scott's (1992) organizational theory, this researcher believed that equal decision making power was a crucial difference between collaboration and partnering. The majority of the key informants felt that equal decision making power was important for sustainability and stated that the process of decision making was determined by Board of Director consensus.

Informants felt that equality was important in building positive relationships between partners, and a positive relationship among partners was one of the most important factors for sustainability. These findings confirmed one of the initial assumptions by the researcher that the partnership models would be based on the areal or interorganizational field model (Scott, 1992). In this model the most important factor is the relationship among organizational units or partners. It was also consistent with previous research findings regarding shared decision making (Levine, Becker, Bone, Stillman et al., 1992; W.K.Kellogg, 1995).

The last environmental influence to be discussed is resource mix. The health care agencies and faith communities brought different but complimentary resources to the partnership. The top six resources brought to the partnerships by the health care agencies were: (a) professional skills, (b) technical skills, (c) equipment and materials, (d) economic, (e) human, and (f) facility. The top six resources brought by faith communities were: (a) human, (b) facility, (c) access to the target population, (d) professional skills, (e) norms and values, and (f) economic. These findings reflect what authorities have stated in the literature as an important reason for the two groups to partner, sharing resources (Felix, 1995; Himmelman, 1995; Levine, Becker, Bone, Stillman et al., 1992; Lewis, 1989). The major resources of each group complimented the other partner, and this is consistent with an open system framework in which resources to sustain the partnership must come from the environment (Scott, 1992).

Boundary Setting and Maintenance

Boundary setting was accomplished primarily by completion of a needs assessment. Key informants reported that the selection of partners or recruitment of members was based on partner resources and partners having similar missions which were compatible with the needs and services to be provided. This was consistent with previous work which was reported on in the literature (Scheie et al., 1991; W.K.Kellogg, 1992). The goal of the majority of the partnerships was to meet the health care needs of their target population, to encourage collaboration, to provide holistic health care, and to create healthier communities. These goals were similar to those reported by the Intergenerational Health Center (1995); Lasater, Wells, Carleton, and Elder (1986); Levine, Becker, and Bone (1992); and W.K.Kellogg (1995). For most partnerships their current goal did not differ from the original goal. However, the goals tended to be expansive in nature and lack specificity. This may have added to the frustration expressed by many informants regarding measuring outcomes and goal achievement. The importance of mission or goals also related to the recruitment and retention of staff. Key informants stated that well defined goals were necessary to maintain a staff committed to the partnership.

Boundary maintenance included the continual clarification and understanding of goals and services. In this sample less than one third of the partnerships reported altering their original goal. Scott (1992) stated that one of the best indicators for survival was adaptability regarding the environment. This required change and flexibility related to the needs of the community. This factor, adaptability and flexibility, was rated by all key informants as critical to partnership sustainability. The literature review also revealed that previous

researchers found adaptability and flexibility as critical (Levine, Becker, Bone, Stillman et al., 1992; W. K.Kellogg, 1995).

Setting and redefining attainable goals and objectives was essential for partnership survival and was accomplished through evaluation and redesign. Scott (1992) stated that central to evaluating organizational effectiveness was the setting of standards. The majority of the key informants reported that standards of practice were set by Board of Director consensus based on health care guidelines and faith community guidelines. The evaluation procedures included the use of outcome, process, and structural indicators. Process evaluation, evaluation of efforts not achievement, was the most frequently used indicator of success in this study. Outcome measurement, which is the most difficult because it depends on environmental influences beyond the control of the partnership, was reported by less than half of the partnerships. Some outcome measurements related to objectives, but many relied simply on number of clients served. Structural evaluation looked at the capacity to do work including resource procurement, staffing, and facility and was reported by less than half of the key informants. Although key informants ranked goal achievement as fourth in importance for partnership sustainability, evaluation of partnership objectives was loosely structured. Goal achievement was important in that it served as an incentive to retain staff, attract partners, and maintain credibility in the community. Attention to the setting of attainable goals was essential for partnership survival.

Prior to this study, the researcher assumed that funding would be the major concern of the partnerships. Although funding was not reported to be the most critical factor for survival, the acquisition and maintenance of funding and

all resources was reported to be extremely important. Major funders were foundations, hospitals and health care systems, and faith communities. Many other resources were also brought to the partnerships by the partners and must be valued as well. The site visits and written comments on surveys showed that some partnerships were struggling not because funding was limited but because the target population did not trust the partners. Partners who bring financial resources to the partnership must be prepared to value equally other resources such as access to the target population, facility, and human workers as well as making a long term commitment to stay in the community.

Flow of Communication

Because this study was based on an open system's framework (Scott, 1992), it was expected that the relationship between the partnership and the community would be based on a continual flow of information into and out of the partnership. Consequently, this information would be used for decision making regarding all aspects of the organization.

All of the key informants in this study identified communication as critical to the sustainability of the partnership. The importance placed on communication was consistent with previous research findings (Intergenerational Health Center, 1995; Sofaer, Sparks, & Kenney, 1995; Scheie et al., 1991; W.K.Kellogg, 1995). However, few key informants reported a coordinated or comprehensive effort of effective communication. Media was the most frequently reported avenue for information into the partnerships and ranked second for information flow out of the partnership. Surprisingly, information from referrals and from the clients directly was almost non-existent. The flow of information out of the partnership relied on media as stated above

and from the sharing of minutes, reports and other informal means. Written comments revealed that Board members were the primary source of communication from the partnership to the member organizations. Although all of the key informants recognized the flow of information as critical to the success of the partnership, only half reported having assigned the responsibility to a specific person.

## Conclusions

This research study demonstrated that partnerships between health care agencies and faith communities were accepted models for the delivery of health care services to underserved populations. The major differences between this study and earlier research studies were that the partnerships under study were equal partnerships, not collaborations, and that more hospitals and health care systems were partnering with faith communities than in the past.

The factors identified by the key informants in this study as being critical to the sustainability of partnerships (communication, clearly defined mission, and adaptability and flexibility) had also been identified in earlier research as noted throughout this chapter. However "relationship," which was also a critical factor to the sustainability of partnerships, had not been anticipated. Issues related to relationship were trust, honesty, personal agendas, competitiveness, failure to keep promises, appreciation, openness, respect, understanding, and a shared understanding of belief systems that needed to be addressed continually. The critical importance which these factors play in the sustainability of the partnership require that partners be diligent in nurturing and developing these factors throughout the life cycle of the partnership.

## Scope and Limitations

### Scope

The scope of this research was to provide preliminary research data on the critical factors necessary to sustain partnerships between health care agencies and faith communities. The data adds to the body of nursing knowledge that is important to nurses employed in community partnerships and in the development of community health nursing curriculum at both the undergraduate and advanced practice levels. The data are helpful to community organizers from health care agencies and faith communities working in partnership.

### Limitations

The decision to collect data by a self-administered mailed survey was based primarily on the low cost and ease of application. Choosing this method did not permit determination of causality between variables and also created several limitations to the study. The strengthening behaviors used to improve data collection and reliability were based on suggestions by Bourque and Fielder (Fink, 1995).

The survey tool was developed by the researcher and lacked established validity and reliability. To increase validity and reliability, the survey was reviewed by three expert reviewers and one pilot study was completed. Completion of the survey required approximately 45 minutes. This may have discouraged some from participating. To increase participation all partnerships were contacted in advance. Key informants were identified and the purpose of the study was either explained to the key informant or their representative. It was felt that respondents would be motivated to participate because the study

was relevant to their practice and that they would be eager to receive the results of the study.

The time period for collecting the data was also lengthy, from mid-November until mid-February, spanning three major holidays. This might have deterred key informants from returning the survey. One strengthening behavior to improve the return rate was that of mailing a follow-up post card to all non-respondents after two weeks. The return rate doubled after this second mailing. In addition, all envelopes and the post cards were hand addressed to improve participation.

Data reliability was dependent on key informants completing the survey according to the researcher's instructions. Key informants in each partnership were identified and asked to complete the survey, however the researcher had no control over who actually answered the questionnaire. In addition, the accuracy of the data was dependent on the key informant's ability to recall information. Approximately two-thirds of the questions required short term memory recall, one-third long term memory recall, and ten open-ended questions required a combination of long term memory and analytical skills. The survey format was enhanced by using a combination of questions. Multiple choice and easy answer questions helped to stimulate memory for some of the more complex questions.

Finally, the use of a single key informant and a single researcher created some limitations and risked data contamination. O'Brien and Chaille (1984) have identified one possible difficulty as that of the key informants responding as individuals rather than as representatives of their partnership. Can their responses be interpreted as valid measures of their organization? To safeguard

against such bias, O'Brien and Chaille suggested that the key informants be instructed that they had been chosen because of their expertise and that it was the wish of the investigator that the respondent assumed the role of an expert key informant. Detailed instructions such as these were given in the cover letter accompanying the survey and informants were asked to confine their personal comments to a comment page.

The remaining limitations related to the sample, which was small, heterogeneous, chosen for convenience, and with the researcher's specific inclusion criteria. Therefore, the results of this research cannot be generalized to partnerships other than those in the United States that meet the inclusion criteria. The sample population was chosen based on partnership longevity and partner composition as related to the operational definitions. The operational definitions may have been new to many of the key informants and therefore created confusion. Several key informants required explanation of the terms after receiving the survey and one key respondent stated that he ignored the definitions. The definition of what constituted a partner seemed the most confusing, but it established the difference between collaborating and partnering. No attempt was made to define a "successful" partnership or to compare the results of this study with those of failed partnerships.

## Implications and Recommendations

### Clinical Practice

Nurses were reported to be the largest group of health care professionals employed in the partnerships. Given that the number of partnerships between health care agencies and faith communities appears to be growing in popularity, this service area provides a new employment opportunity for nurses.

Nursing skills required to function in the partnerships related to the services offered through the partnerships: (a) health promotion and health education, (b) referrals, (c) health screenings, (d) support groups, (e) counseling, (f) physical assessments, (g) immunizations, and (h) advocacy. Other skills and knowledge that will be required include the factors which key informants identified as critical to the functioning of partnerships: (a) communication, (b) clearly defined goals, (c) adaptability and flexibility, and (d) building positive relationships among partners. Additional knowledge will be needed regarding: (a) community partnership models, (b) integrating faith and health concepts, (c) resource development, (d) measuring outcomes, (e) respecting belief systems of all partners, and (f) Board development.

Key informants also reported that 63.9% of the partnerships had nurses as members of the Board of Directors. This indicated that nurses were valued for their expertise and leadership. The development of leadership qualities, including those needed in community health nursing, Board leadership and development, and professional commitment to underserved populations must be integrated into the curriculum of nursing schools. Nurses practicing in this field must also begin to publish information that can benefit other practitioners as well as other partners.

Nursing Education

It is the mandate of nursing schools to prepare students to function safely and proficiently in a variety of practice areas. Recognizing this new practice area will require nursing faculty to examine nursing curriculum and clinical experience at both the undergraduate and advanced practice level and to

ensure that the skills and knowledge required to work in community health partnerships are being taught.

The role of nursing faculty in partnerships and faculty presence in the community is extremely important. The faculty of nursing schools need to reach out to their communities, commit to partnerships on a long term basis, and help to develop an effective delivery model that integrates faith and health. This will demonstrate to students the importance of such partnerships (role modeling leadership), provide a community health training site, and demonstrate to the community a commitment to improving their health status. In the current study, 63.9% of the key informants reported that they collaborated with universities. To be most effective, Schools of Nursing should strive to be true partners, not just collaborators, sharing equally in power, decision making, resource allocation, and goal setting. Kaiser (1995) stated that to create healthier communities we must break down barriers and create larger circles. Nursing can do this by escaping organizational domain, thinking outside the circle of nursing, and relinquishing control and joining in community partnerships.

Faith and Health Partners

For health care agencies, including nursing schools, and faith communities to partner effectively a great deal of attention must be given to the planning process to develop the positive relationship that is needed for success. Equality among the partners is critically important, an equality that is not based solely on funding but respects all the different resources that partners bring. Shared decision making is important from initiation to completion, including the interpretation of need, goal setting, identification of services, and evaluating goal achievement.

The key informants in this study ranked as their first priority building positive relationships among partners. To create this positive working relationship, the belief systems of all the partners must be acknowledged. A critical partner in this process is the target population. This requires that the target population be represented on the Board of Directors. Partners need to recognize that building this positive relationship with partners and the community takes time and commitment.

Faith communities and most community health agencies are aware of the need to work slowly and purposefully. However, this creates new challenges for hospitals and health care systems who have been very focused on a cure model, outcome measurement, and have exercised complete authority within their own "walls". Sharing authority and resources without complete control is a challenging, new experience that hospitals will need to recognize and embrace if they hope to be effective partners. However, if faith communities hope to partner with hospitals and other health care agencies, they must also acknowledge the importance of developing outcome criteria that can be measured and which over time can demonstrate cost-effectiveness. To develop a good working relationship, define needs, set mutual goals, define services, and measure outcomes, partnerships will require a long term commitment of time and resources from all of the partners.

Another key factor in building better relationships was the flow of information or communication, identified by all of the key informants as critical to the success of partnerships. The results of this study showed that the majority of partnerships had not developed a well organized system for communication. Communication strategies should be purposefully designed and assigned to

Board members and staff. This is not only important for marketing services but for improving the image of the partnership in the community and involving the target population in planning and implementation.

Further Research

Further research regarding partnerships between health care agencies and faith communities is needed in all areas addressed by this study. Replication of this study should be done with a refined survey and a larger sample to improve generalization. Refinement of the survey will improve reliability and validity. This researcher attempted to collect information regarding emerging partnerships and sustaining partnerships with the same tool. Developing two separate tools would improve the management of data. Adapting the Likert scale to include factors identified in the open-ended questions and eliminating those that elicited low responses are also needed. Open-ended questions that should be added are those which measure action. What are the partnerships actually doing to address the critical factors necessary for sustainability?

The site visits were particularly valuable in validating information. Researchers might consider a smaller sample and making site visits to each partnership. An additional study might also include comparing the perceptions of key informants with other staff, volunteers, Board Members, and representatives from the target population. The site visits conducted by this researcher did show considerable differences regarding the perception of how the partnership was functioning among the various groups. These differences were not surprising if one considers the results regarding effort expended for communication strategies.

Another area only briefly examined by this researcher was the measurement of "success." Further research is needed on the evaluation processes used by the partnerships and the measurement of outcomes. It would also be interesting to compare the differences in perception regarding what constitutes success between the faith communities and the health care agencies and compare the results of this study with partnerships that have failed.

Nursing research needs to examine the specific role of the nurse in the partnerships, both staff positions and leadership positions. Identification of needed skills and knowledge necessary to fulfill these roles is important in developing curriculum for undergraduate and advanced practice nurses and for inservice education. Studies looking at the nurse's perception of the critical factors to partnership sustainability and the nurse's role in fostering successful partnerships would also be important.

## Summary

The findings of this study demonstrated that the most important factors contributing to the sustainability of partnerships between health care agencies and faith communities were: (a) communication, (b) clearly defined mission, (c) adaptability and flexibility, and (d) positive relationships among partners. It is imperative that nurses, making up the largest percentage of staff members in the health/faith partnerships, improve their knowledge and skills regarding the organizational factors identified as necessary to sustain the partnerships. Nurses have a unique opportunity and a professional responsibility to take a more active role in the development of this new health care delivery model.

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# APPENDIX A

# HUMAN SUBJECTS APPROVAL

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

Office of the Academic Vice President • Associate Academic Vice President • Graduate Studies and Research
One Washington Square • San José, California 95192-0025 • 408/924-2480

TO: Rebecca Marie Herr
228 Massol Avenue
Los Gatos, CA 95030

FROM: Serena W. Stanford
AAVP, Graduate Studies & Research

DATE: October 30, 1995

The Human Subjects-Institutional Review Board has approved your request to use human subjects in the study entitled:

"Partnerships Between Health Care Agencies and Faith Communities"

This approval is contingent upon the subjects participating in your research project being appropriately protected from risk. This includes the protection of the anonymity of the subjects' identity when they participate in your research project, and with regard to any and all data that may be collected from the subjects. The Board's approval includes continued monitoring of your research by the Board to assure that the subjects are being adequately and properly protected from such risks. If at any time a subject becomes injured or complains of injury, you must notify Serena Stanford, Ph.D., immediately. Injury includes but is not limited to bodily harm, psychological trauma and release of potentially damaging personal information.

Please also be advised that each subject needs to be fully informed and aware that their participation in your research project is voluntary, and that he or she may withdraw from the project at any time. Further, a subject's participation, refusal to participate, or withdrawal will not affect any services the subject is receiving or will receive at the institution in which the research is being conducted.

If you have any questions, please contact me at (408) 924-2480.

# APPENDIX B

# COVER LETTER AND CONSENT

SJSU SAN JOSE STATE UNIVERSITY

A campus of The California State University

College of Applied Sciences and Arts • School of Nursing • Graduate Program
One Washington Square • San José, California 95192-0057 • 408/924-1321

November 17, 1995

Dear

I am a graduate student at San Jose State University, completing my master's thesis in nursing. The research question which I have chosen to investigate is: What are the organizational and structural factors that appear to foster the successful functioning of partnerships between health care agencies and faith communities? Little has been written about this new method of improving the delivery of health care services to at risk populations. As a participant in an existing partnership,
you can provide valuable information for emerging partnerships and provide information which may also be used as a basis for further research. You are the expert!

To collect data on this subject, I have developed the enclosed, self-administered questionnaire. Your partnership was identified, with the help of the Interfaith Health Program at the Carter Center of Emory University and various foundations, as a partnership most likely meeting the criteria for this study. The criteria for the study are that your partnership must have as active partners at least one health care agency and one faith community and have existed for at least one year. An explanation of the terms being used for the study are attached to the survey on a separate card. They should be referred to when answering the questions.

I ask that the questionnaire be completed by two "key informants" in your partnership, individuals in your partnership who are familiar with the organizational structure. They will most likely be the Executive Director or Project Director, the President or Chairperson of the Board, or a long time Board member. Two individuals in your partnership will be receiving questionnaires. The individuals answering the questionnaire should take on the role of the "expert". Although the number of partnerships between health care agencies and faith communities is growing, the number fitting the criteria for this study is quite small. Your response to this questionnaire is extremely important.

The time required to complete the questionnaire during the pilot study was approximately 45 minutes without interruptions. I realize that completing the questionnaire will be an inconvenience, but please attempt to set aside 45 minutes to focus on the questionnaire. Although this packet looks large, the questionnaire has been double spaced to increase readability. Questions are primarily multiple choice and fill in the blank and relate to the partnership history, the partners, the funding sources, the goals, the staffing, the target population, the Board of Directors, the management of the partnership, and key respondent information. There are also six open ended questions about building stronger partnerships. This will be your opportunity to share the lessons you have learned from your experience.

You should understand that your participation in this study is completely voluntary and that choosing not to participate in this study, or in any part of the

study, will not affect your relationship with San Jose State University or the researcher. All questionnaires have been coded to assure anonymity. Questionnaires and lists of those participating will be kept separate and secure in a safety deposit box and will be destroyed five years from the completion of the study. If the results of this study should be published, any information that could result in your identification will be kept confidential. I feel that these safe guards will eliminate any risk to you, if you choose to participate. At the completion of the study, all those who participate will receive a copy of the results.

If you have any questions regarding this study, I can be reached at (408) 354-7256. Please feel free to call collect. If you are willing to participate, please complete the enclosed questionnaire and return it to me in the enclosed self-addressed, stamped envelope. Please try and return the questionnaire by December 5, 1995. **Keep this cover letter** for your records.

If you have questions or complaints about this research project and/or concerns regarding your rights as a research subject, please contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

Thank you for your assistance in this valuable research.

Sincerely,

Rebecca M. Herr, B.S.N., R.N., P.H.N.

# APPENDIX C

# FOLLOW-UP POST CARD

Content of Follow-Up Post Card

December 9, 1995

A few weeks ago you received a questionnaire from Rebecca Herr asking for your participation in a very important study regarding health / faith partnerships. To date I have not received your response. It is very important that I am able to include your opinions in my study. If you have already responded, thank you for your help. If you have not responded please do so as soon as possible. If you require duplicate information or have questions, call Rebecca Herr (408) 354-7256.

# APPENDIX D

# PERMISSION FOR ADAPTATION OF THE SURVEY

Steven E. Mayer, Ph.D
Executive Director
David M. Schaie
Associate Director
Sharon Marie A. Ramirez
Project Associate
Theartrice (T) Williams
Senior Project Associate
Tom Dewar
Senior Project Associate
Becky Swanson Krall
Project Associate

Rainbow Research Inc.
621 West Lake Street
Minneapolis, Minnesota 55408
Tel (612) 824-0724 Fax (612) 824-0429

October 11, 1995

Rebecca Herr
San Jose State University
408-354-[illegible]-(phone) 7216
408-354-5229

Dear Rebecca:

In response to your telephone message of October 5, you hereby have my written permission to adapt or use questions from our evaluation site visit workbook for the "Religious Institutions as Partners in Community-Based Development" project in your own research on partnerships involving religious institutions.

Best wishes to you. Please feel free to contact me should any other questions arise.

Sincerely,

David Schaie
Associate Director

# APPENDIX E

# DATA COLLECTION TOOL

# DEFINITION OF TERMS FOR HEALTH PARTNERSHIPS QUESTIONNAIRE

For purposes of this study, the following **key terms** are to be used when answering the enclosed questionnaire:

A **partnership** will refer to the inter-organizational structure comprised of at least one faith community and one health care agency, formed to meet a community need. It is a vehicle through which individual partners, having an inter-dependent relationship, combine resources to meet a community need.

A **partner** is an individual organization that is actively participating in the partnership by having a formal representative on the Board of Directors of the partnership and by sharing in the planning and in the decision making of the partnership.

A **health care agency** is any public or private organization, whose primary purpose is the delivery of health care services.

A **faith community** is a religious institution which includes congregations, churches, and other religious bodies. It may be a local congregation, an ecumenical coalition, a denominational organization (local, state, or national), a cathedral, a storefront church, a synagogue, or any other system of religious belief.

The **Board of Directors** will refer to the governing body or group of individuals who make management and administration decisions regarding the partnership. In your partnership this group may be referred to as a committee.

CODE_____

## PARTNERSHIPS BETWEEN HEALTH CARE AGENCIES AND FAITH COMMUNITIES

Please refer to the enclosed card, **Definition of Terms for Health Partnerships Questionnaire**, while answering this questionnaire. Please answer **all** the questions to the best of your ability.

### PARTNERSHIP HISTORY

The following nine questions relate to the history of your partnership.

1. How long has your partnership existed? (**Write** in the space provided.)
   _____**YEAR (S)**

2. Who initiated the **establishment** of your partnership? (Circle only **one** response.)

   a. A faith community
   b. A health care agency
   c. An individual, not representing a or b
   d. Other, please specify _____
   e. Unknown

3. What was the **motivation** for the establishment of the partnership? (**Write** in the space provided.)

4. Did the original partners conduct a community needs assessment to determine a need for the services that are offered through the partnership? (Circle only **one** response.)

   a. Yes (Skip to question No. 6)
   b. No
   c. Unknown (Skip to question No. 6)

5. If you did not complete a community needs assessment, how did you determine a need for services? (**Write** in the space provided.)

CODE_____

CODE_____

6. What **criteria** are used for the selection of partners? (Circle **all that apply**.)

a. Completely voluntary
b. Bring resources to the partnership
c. Geographic proximity to the service area
d. Expertise with community projects
e. Similar missions
f. Pastor support
g. Support by a key individual, other than pastor, in the organization
h. Unknown
i. Other, please specify_____

7. Referring to No.6, is there **one** criteria that is more important than the others? (Circle only **one** response.)

a. Yes If yes, please specify which criteria_____
b. No

8. In the past, what types of agencies have you collaborated with, who may not be formal members of your partnership? (Circle **all that apply.**)

a. Local School System
b. Police Department
c. Welfare Department
d. Housing Department
e. Mental Health Agency
f. Local prison
g. Youth organization
h. Public Health Department
i. Hospital
j. Recreation Department
k. Employment agency
l. Faith community
m. Home Health agency
n. Physician groups
o. University
p. Clinic
q. Other, please specify_____

9. What is the **total number of partners** who are members of your partnership **at this time**? (**Write** in the space provided.)_____

CODE_____

## FAITH COMMUNITIES

The next five questions refer to the faith communities who have been and are involved with your partnership.

10. How many **faith communities** are **currently** partners? (**Write** in the space provided.) _____

11. How many **faith communities** were **original** partners? (**Write** in the space provided.) _____

12. What resources do **faith communities** bring to your partnership? (Circle **all that apply**.)

    a. Economic
    b. Human
    c. Technical skills
    d. Professional skills
    e. Equipment & Materials
    f. Facility
    g. Administrative
    h. Norms & Values
    i. Access to target population
    j. Clearly defined goals
    k. Organizational structure
    l. Other, please specify_____

13. Please identify the **types of faith communities** who were **original** partners. (Circle **all that apply**.)

    a. Hinduism
    b. Buddhism
    c. Confucianism
    d. Taoism
    e. Judaism
    f. Islam
    g. Native American
    h. Christian (**Check** all the appropriate boxes.)
        [ ] Baptist
        [ ] Catholic
        [ ] Lutheran
        [ ] Methodist
        [ ] Presbyterian
        [ ] Seventh Day Adventist
        [ ] Other, please specify_____

CODE_____

14. Please identify the **types of faith communities** who are **currently** partners. (Circle **all that apply**.)

a. Hinduism
b. Buddhism
c. Confucianism
d. Taoism
e. Judaism
f. Islam
g. Native American
h. Christian (**Check** all the appropriate boxes.)
[ ] Baptist
[ ] Catholic
[ ] Lutheran
[ ] Methodist
[ ] Presbyterian
[ ] Seventh Day Adventist
[ ] Other, please specify_____

**HEALTH CARE AGENCIES**

The next five questions relate to the health care agencies who have been and are involved with your partnership.

15. How many **health care agencies** are **currently** partners? (**Write** in the space provided.) _____

16. How many **health care agencies** were **original** partners? (**Write** in the space provided.) _____

17. Please identify the **types of health care agencies** who were **original** partners. (Circle **all that apply**.)

a. Hospital
b. Public Health Department
c. Home Health Agency
d. Mental Health Agency
e. Physician Group
f. Medical School
g. Nursing School
h. Public Health School
i. Dental School
j. Clinic
k. Other, please specify

CODE_____

18. Please identify the **types of health care agencies** who are **currently** partners. (Circle **all that apply**.)

a. Hospital
b. Public Health Department
c. Home Health Agency
d. Mental Health Agency
e. Physician Group
f. Medical School
g. Nursing School
h. Public Health School
i. Dental School
j. Clinic
k. Other, please specify_____

19. What resources do **health care agencies** bring to your partnership? (Circle **all that apply**.)

a. Economic
b. Human
c. Technical skills
d. Professional skills
e. Equipment & materials
f. Facility
g. Administrative
h. Norms & Values
i. Access to target population
j. Goals
k. Organizational structure
l. Other, please specify_____

CODE_____

## FUNDING RESOURCES

The next four questions relate to the funding of your partnership.

20. Please identify all **current** sources of funding for the partnership. (Circle **all that apply**.)

a. Local faith communities
b. Denominational organizations (State, Regional, or National)
c. Local government
d. State government
e. Federal government
f. Businesses
g. Foundations
h. Community groups
i. Client fees
j. Third party reimbursement
k. Other, please specify_____

21. Choosing from the list in question No. 20, who is **currently** the major source of funding for your partnership? (**Write** your answer here.) _____

22. Please identify the sources of funding for the partnership when it was **originally established.** (Circle **all that apply**.)

a. Local faith communities
b. Denominational organizations (State, Regional, or National)
c. Local government
d. State government
e. Federal government
f. Businesses
g. Foundations
h. Community groups
i. Client fees
j. Third party reimbursement
k. Other, please specify_____

23. Choosing from the list in question No. 22, who provided the major source of funding **originally**? (**Write** your answer here.) _____

CODE_____

## PARTNERSHIP GOALS

The next four questions relate to the goals of your partnership.

24. What is the **goal or mission statement** of your **current** partnership? (**Write** in the space provided.)

25. Was this goal reached by the mutual consensus of all members of the Board of Directors? (Circle only **one** response.)

    a. Yes
    b. No
    c. Unknown

26. Does the current goal of the partnership differ from the **original goal**? (Circle only **one** response.)

    a. Yes
    b. No, Skip to question # 28
    c. Unknown, Skip to question # 28

27. What was the **original** goal of the partnership? (**Write** in the space provided.)

## BUILDING STRONGER PARTNERSHIPS

The next seven questions are your opportunity to express your expert opinion about the lessons you have learned regarding partnership development, management, and sustainability. This information will of course be kept confidential, so please feel free to express your honest opinions.

28. From your experience, what are the most critical elements necessary for the **establishment** of a successful partnership between faith communities and health care agencies? (**Write** your answer below.)

CODE_____

29. From your experience, what are the biggest **challenges** or **obstacles** facing the **establishment** of partnerships between faith communities and health care agencies? (**Write** your answer below.)

30. What **lessons** have you learned that can make a difference in **establishing** strong partnerships between faith communities and health care agencies? (Some factors to consider are: geographical setting; types of faith communities involved; types of health care agencies involved; local resources to support the partnership; racial, social, economic and political patterns; and attracting funding. (**Write** your answer below.)

CODE_____

31. How is the **flow of information**, both in to your partnership and out of your partnership, managed?
(Some factors to consider are: information to and from the population served; information to and from the Board members; information to and from the members of partner organizations; and information to and from the community at large. (**Write** your answer below.)

32. From your experience, what are the most critical factors that are necessary to **sustain** the partnership? (**Write** your answer below.)

33. What measures have you used to evaluate the **"success"** of the partnership? (**Write** your answer below.)

CODE_____

34. How important do you feel each of these factors is to your **current** partnership? (**Check one response** for each factor.)

| | Unimportant | Neutral | Somewhat important | Important | Extremely important |
|---|---|---|---|---|---|
| a. Leadership from those served | | | | | |
| b. Leadership from clergy | | | | | |
| c. Leadership from health care agencies | | | | | |
| d. Funding availability | | | | | |
| e. Matching programs to community needs | | | | | |
| f. Mutual goal setting | | | | | |
| g. Shared decision making | | | | | |
| h. Clearly defined mission | | | | | |
| i. Sharing of resources | | | | | |
| j. Communication | | | | | |
| k. Salaried staff | | | | | |
| l. Social recognition of staff and volunteers | | | | | |
| m. Religious ties | | | | | |
| n. Kinship ties | | | | | |
| o. Community support | | | | | |
| p. A Board that reflects those served | | | | | |
| q. Adaptability & flexibility | | | | | |

CODE_____

**STAFFING**

The following nine questions relate to the **staffing of your partnership.** When answering these questions please remember that they relate to the partnership and projects related to the partnership and **not** to the parent organizations.
(**Write** your answers in the spaces provided)

35. What is the current size of your total staff? _____

36. How many of the staff are full time? _____

37. How many of the staff are part time? _____

38. How many of your total staff are paid? _____

39. On the average, how many volunteers **donate** time to the partnership on a monthly basis? _____

40. Did any of your current staff have prior experience in a health care partnership?(Circle only **one** response.)

    a. Yes
    b. No
    c. Unknown

41. What is the professional background of your staff, both paid and unpaid? (Circle the letters of **all that apply**.)

    a. Clergy
    b. Church lay leaders
    c. Church volunteers
    d. Nurses
    e. Representatives of the population served
    f. Health Educators
    g. Business leaders
    h. Community volunteers
    i. Chaplains
    j. Medical Doctors
    k. Other, please specify _____

CODE_____

42. To the best of your knowledge, what factors are necessary to maintain a staff that is committed to the partnership? (Circle **all that apply**.)

a. Well defined goals
b. Monetary rewards
c. Social recognition
d. Other, please specify _____

43. Referring to question No. 42, is there one factor which you feel is the most important in maintaining a staff that is committed to the partnership? (Circle only **one** response.)

a. Yes, Please specify _____
b. No

## THOSE YOU SERVE

The following nine questions relate to those you **serve** through the partnership.

44. How would you describe the community that you serve through the partnership?(Circle only **one** response.)

a. Rural
b. Urban
c. Suburban
d. Mixed. Please explain _____

45. At which of these locations do you deliver services that are associated with the partnership? (Circle **all that apply**.)

a. A church building
b. Public Health building
c. Senior Center
d. Youth Center
e. School
f. Community Center
g. Free standing clinic
h. Hospital
i. Other, please specify _____

CODE_____

46. Choosing from the list in question No. 45, what would you say is the **primary** location in which the partnership offers services? ( **Write** in the space provided.)_____

47. What ethnic groups are served by the partnership? (Circle **all that apply**.)

a. White
b. African American
c. Hispanic / Latino
d. Asian
e. Pacific Islander
f. Middle Eastern
g. Native American
h. Other, please specify_____

48. Is there any one ethnic group that the partnership serves which represents 50% or more of your clients? (Circle only **one** response.)

a. Yes. Please specify _____
b. No

49. Which age group does your partnership **primarily** serve? (Circle only **one** response.)

a. Children under 4 years
b. Children 4 to 12 years
c. Youth 13 to 20 years
d. Adults 21 to 40 years
e. Adults 41 to 62 years
f. Seniors 63 years and older
g. All ages
h. Mixed ages, please specify_____

50. What percentage of those you serve are female? (Circle only **one** response.)

a. 100%
b. 75-99%
c. 74-50%
d. 49-25%
e. Less than 25%
f. None
g. Unknown

CODE_____

51. What percentage of those you serve are male? (Circle only **one** response.)

a. 100%
b. 75-99%
c. 74-50%
d. 49-25%
e. Less than 25%
f. None
g. Unknown

52. What are the main activities or services of your partnership? (Circle **all that apply**.)

a. Health Screenings
b. Immunizations
c. Physical Assessments
d. Health Promotion / Health Education
e. Counseling
f. Primary Care Services
g. Nutrition / Food Services
h. Referrals
i. Support Groups
j. Advocacy
k. Transportation
l. Other, please specify_____

**BOARD OF DIRECTORS**

The following six questions relate to the **Board of Directors** or governing body of your partnership.

53. How many members are there currently on your Board of Directors? (**Writte** your answer in the space provided.) _____

CODE_____

54. What has been the professional background of the Board members? (Circle **all that apply**.)

a. Clergy
b. Community volunteers
c. Chaplains
d. Medical Doctors
e. Representatives of the target population
f. Business leaders
g. Volunteers from faith communities
h. Nurses
i. Public Health officials
j. Other, please specify_____

55. What ethnic groups have been represented on your Board of Directors? (Circle **all that apply**.)

a. White
b. African American
c. Hispanic / Latino
d. Asian
e. Pacific Islander
f. Middle Eastern
g. Native American
h. Other, please specify_____

56. Where has the **leadership** for the Board of Directors come from? Leadership as indicated by being an officer of the Board of Directors or a committee chairperson. (Circle only **one** response.)

a. Faith communities
b. Health care agencies
c. Business community
d. Population served
e. Mixed, please specify_____
f. Other, please specify_____

CODE_____

57. To the best of your knowledge, have most of the leaders on the Board of Directors had previous experience in **community projects**?.....A community project is defined as one which is designed to benefit a large target population, which may include, but is not limited to the members of the sponsoring organizations. (Circle only **one** response.)

a. Yes
b. No
c. Unknown

58. To the best of your knowledge, what is the average length of service for most of the members of the Board of Directors? (Circle only **one** response.)

a. Less than one year
b. One to three years
c. More than three years to five years
d. More than five years

**MANAGEMENT and ADMINISTRATION**

The following four questions relate to the **management** of your partnership.

59. How have **standards of practice** been set for your partnership? (Circle **all that apply.**)

a. Board of Director consensus
b. Government regulations
c. Professional organizations
d. Faith community guidelines
e. Health agency guidelines
f. Other, please specify_____
g. Unknown

60. How were the **decision making processes established** for your partnership? (Circle only **one** response.)

a. Board of Director consensus
b. Government regulations
c. Faith community guidelines
d. Health care agency guidelines
e. Other, please specify_____
f. Unknown

CODE_____

61. Do all the partners with representation on the Board of Directors of the partnership have **equal** decision making power regarding the operation and management of the partnership? (Circle only **one** response.)

a. Yes
b. No
c. Unknown

62. How are management conflicts resolved within the **current** partnership? (Circle only **one** response.)

a. Board of Director consensus
b. President of the Board of Directors
c. Executive Director
d. Third party liaison
e. Organizational structure redesign
f. Reeducation of partners.
g. Other, please specify_____
h. Unknown

**"KEY RESPONDENT" INFORMATION**

You are almost finished! There are only six questions remaining which are about "you".

63. Which of the following best describes your role in the partnership? (Circle only **one** response.)

a. Executive Director
b. President or Chairperson of the Board of Directors
c. Staff, other than a or b
d. Volunteer
e. Project Director
f. Other, please specify_____

64. Which of the following best describes your professional background? (Circle only **one** response.)

a. Clergy
b. Health Care Professional, please specify_____
c. Business leader
d. Volunteer
e. Other, please specify_____

CODE_____

65. How long have you been with this partnership? (**Write** in the space provided.)_____**MONTHS**

66. What is your age? (Circle only **one** response.)

a. 18-25 years
b. 26-40 years
c. 41-55 years
d. 56-65 years
e. Over 65 years

67. Are you **male** [ ] or **female** [ ] ? (**Check** the appropriate box.)

68. What is your ethnic origin? (Circle only **one** response.)

a. White
b. African American
c. Hispanic / Latino
d. Asian
e. Pacific Islander
f. Middle Eastern
g. Native American
h. Other, please specify_____

**Thank you for completing this questionnaire. Please enclose the completed questionnaire in the enclosed, self-addressed, stamped envelope and return it as quickly as possible. If you have misplaced the return envelope, please mail the questionnaire to:**

**Rebecca M. Herr**
**228 Massol Avenue**
**Los Gatos, CA 95030**

**May I contact you for a site visit? _____**

Your assistance with this research project is greatly appreciated. The information that is obtained from this study will be distributed to all respondents.

If you wish, I invite you to comment on the content of the questionnaire on the attached sheet. Again, **thank you** for taking time to complete the questionnaire.

CODE_____

**COMMENT SHEET**