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An Ecological Perspective of Community Health Partnerships: A Case Study of Collaboration, Empowerment and Effectiveness in Two HIV/AIDS Planning Consortia in Florida

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AN ECOLOGICAL PERSPECTIVE OF COMMUNITY HEALTH PARTNERSHIPS: A CASE STUDY OF COLLABORATION, EMPOWERMENT AND EFFECTIVENESS IN TWO HIV/AIDS PLANNING CONSORTIA IN FLORIDA

by

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABSTRACT

The purpose of this study was to identify and describe from an ecological perspective the characteristics contributing to collaboration, empowerment and effectiveness of federally mandated Ryan White Title I and Title II planning councils and consortia within the State of Florida

A case study approach within two (2) community health planning partnerships, specifically those related to HIV/AIDS consortia, was used to gather data over one and a half years. The methodology included a combination of qualitative and quantitative approaches, utilizing documents, administering several survey instruments, observing meetings, and conducting individual interviews. The interviews and surveys provided the primary sources of data, with the documents and observations providing supportive secondary sources of data. The data were analyzed to develop an ecological perspective of the collaboration, empowerment, and effectiveness of the partnerships.

The findings indicate that both partnerships were collaborative, empowering, and effective in their fulfilling their responsibilities. Significant findings include those related to members' perceptions about the leader and the group, decision making, and conflict as well as the structure, processes, and outcomes of the partnerships.

Suggestions were made for the improvement of each partnership and areas for further research and practical implications were identified.

CHAPTER I

INTRODUCTION AND BACKGROUND TO THE STUDY

For a moment, visualize a disease that could spread each time people engaged in sexual activity. In your mind's eye, imagine a healthy young man or woman, first learning that he or she has a deadly disease. See the look of shock on his or her face. Consider the range of emotions—fear, rage, depression—that they must go through learning that there is a toxic virus living, moving, and growing inside their bodies. This disease is real and can touch everyone. Imagine what your reaction would be if you just found out you or a loved one has human immunodeficiency virus (HIV), or acquired immunodeficiency syndrome (AIDS), the final stage of the HIV disease. What if your insurance does not cover this disease? What if you could not work? What does one do? What will happen to your family? How can you be assured funding is available to care for your disease, sometimes meaning the difference between life and death? Where can you go for assistance and who can help you?

Parts of the answers to these complex questions may lie in the efforts of the community planning partnerships, specifically, the HIV health services planning councils and consortia, that are legislatively mandated to coordinate and plan for health care and support services for those people with HIV/AIDS and their families. These community partnerships are mandated to assure that a continuum of care is available in local communities, filling the gaps where private and public insurance will not pay. Such planning councils and consortia are located in communities of every state and territory in the United States, available to help infected or affected people sort through the perplexing

personal and systemic issues of HIV and AIDS. Collaboration and coordination of HIV/AIDS services can improve the delivery of care, as well as possibly reduce costs.

Acquired immune deficiency syndrome, caused by the human immunodeficiency virus, is a major and complex public health crisis (Feldman & Miller, 1998; Petrow, Franks, & Wolford, 1990). AIDS is currently regarded as a chronic disease that remains fatal, but often can be managed in the home and outpatient clinics. This disease is not only a medical problem, but a social, economic, and political dilemma as well. Because this disease was first associated with gay male sexual behavior, and/or illicit drug use, people have formed prejudicial attitudes towards anyone that has the disease (Myers, Pfeiffle, & Hinsdale, 1994). The irrational fears, homophobia and racial stereotyping have led to discrimination and even violence.

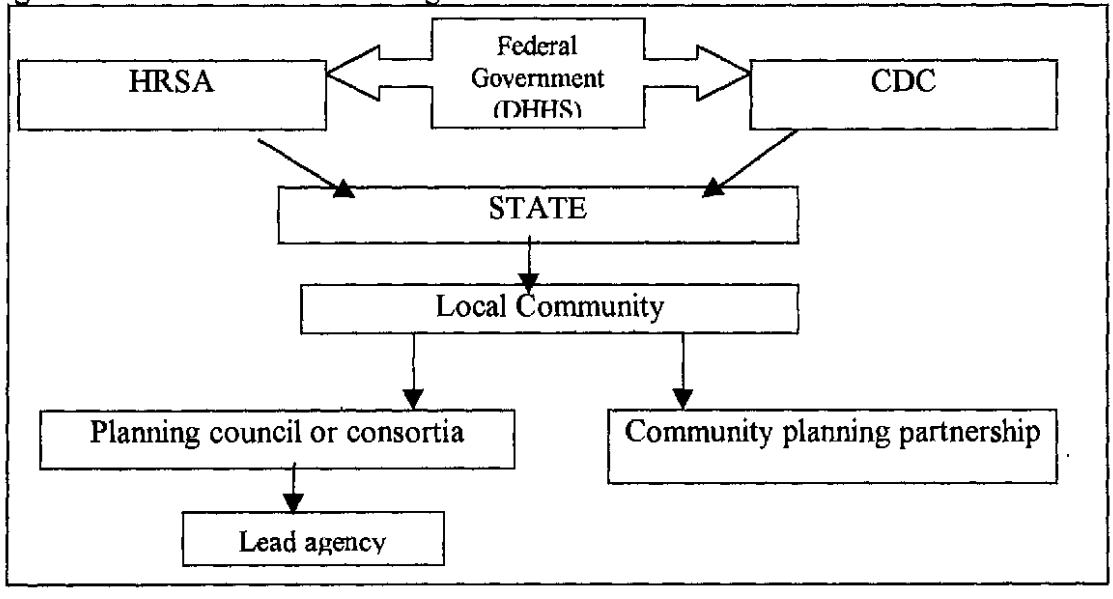
HIV/AIDS often affects minorities, poor, and under served populations disproportionately. In Florida, 59% of cumulative reported HIV cases and 46% of the cumulative number of AIDS cases were among African Americans (Florida Department of Health, 2001). Among women and minorities, HIV infection is associated with preexisting economic distress (Quimby, 1993). Moreover, socioeconomic resources, gender, and race/ethnicity may determine access to medical and non-medical services that affect disease progression. (Loustaunau & Sobo, 1997; Seekins & Fawcett, 1987; Shortell & Reinhardt, 1992; Weissert & Weissert, 1996).

In the early 1980's when this disease was first identified, no one imagined that 21 years later every community would be touched by the epidemic, and that it would strike at people in the prime of their lives, even affecting children. With the growing numbers of people infected with HIV in the United States, the federal government has determined

HIV to be an epidemic. When faced with public health crises, the government has usually stepped in and attempted to control the situation, preventing the spread of infectious diseases to protect the public. Although people have looked to the government to step in during health crises, Chrislip & Larson (1994) report the role of government is often judged to be too "limiting, unjust, and ineffective" (p.27).

Since 1990, the Federal government has been involved in HIV/AIDS crisis in the areas of prevention and patient care (Fleishman, Mor, Piette, & Allen, 1992; Hobfoll, 1998; and Holtgrave & Valdiserri, 1996). Early in the HIV/AIDS epidemic, the government determined that local communities would have to be proactive, to take risks, to determine what works and what doesn't work, and to take control of the planning activities. Congress charged the United States (U.S.) Department of Health and Human Services (DHHS) to administer the programs and funds for both HIV prevention and patient care. A description of the administration and funding of these federal programs follows and is depicted in Figure 1.

Figure 1. Flow of Decision-Making and HIV/AIDS Funds from DHHS



Federal funds for HIV prevention services flow from the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention (CDC) to the states and territories. CDC requires communities, through the public health system, to take charge of HIV prevention efforts through comprehensive community planning and decision-making in a community planning partnership.

Another avenue for federal funds for patient care and treatment of people with HIV/AIDS flows from the federal government to the states and territories. The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990, including the re-authorization amendments of 1996 and 2000, is the mechanism through which federal funds are allocated to the states and local communities (Reauthorization of Ryan White CARE Act, 2000; Ryan White CARE Act Amendments, 2000; U. S. Department of Health and Human Services, 1996, 1999). In patient care coordination and service delivery, community planning is a mandated activity that each state shall follow under the CARE Act. Several descriptive studies have indicated the intent of legislators in the development of the CARE Act was to further the development of partnerships between private practitioners and public sector programs, relationships that should lead to improved access and quality of care for people with HIV infection (Holtgrave & Valdiserri, 1996; Kieler, Rundall & Saporta, et al., 1996; Myers, Pfeiffle, & Hinsdale, 1994; Penner, 1995; Rizakou, Rosenhead & Reddington, 1991).

The focus of this research is on the Ryan White planning councils and consortia that provide oversight of patient care funds. Comprehensive community health planning

partnerships are also mandated for HIV prevention efforts, as previously indicated, but will not be addressed here.

Florida State System: Department of Health, Bureau of HIV/AIDS

The federal agency, Health Resources and Services Administration (HRSA), provides funding, through its Ryan White Title II component, for the Ryan White Title II Consortia. The State of Florida, Department of Health (DOH), Bureau of HIV/AIDS has chosen to establish Title II consortia to plan for and coordinate a comprehensive continuum of care within 14 different regions of the state. The Patient Care Resources Section of the Bureau of HIV/AIDS administers the Ryan White program in Florida and assures the coordination through the regional consortia. During the fiscal year 1999-2000, the total federal and state allocation for HIV/AIDS patient care services in Florida was $102,584,757 (Florida Department of Health, 2001, p. 7). Because the consortia are not private, incorporated entities, the State contracts with a lead, or fiscal, agent, chosen by the local consortia in each of the 14 different areas of the state. The lead agent may be a county health department, a governmental entity, or a private agency. The lead agent then contracts for services with community-based organizations and providers, who in turn delivers direct services to the patients (U.S. Department of Health & Human Services, 1999).

Community Planning in the HIV/AIDS Epidemic

Community health care dilemmas and challenges can be successfully addressed when various disciplines and sectors form effective partnerships (Baker, Melton, Stange, Fields, Koplan, Guerra & Satcher, 1994; Dever, 1991; Dukay, 1995). Community service agencies, public health departments, hospitals, schools, and other organizations form

partnerships (Butterfoss, Goodman, Wandersman,1993). Partnerships organize for many reasons in health care: health promotion; prevention of illness and disability; maximum community participation; accessibility to health and health services; interdisciplinary and inter-organizational collaboration; and use of appropriate technologies such as resources and strategies (Butterfoss et al., 1993; Chrislip & Larson, 1994; Dukay, 1995; Fawcett, Lewis, Paine-Andrews, Francisco, Richter, Williams, & Copple, 1997; Lumsdon, 1993). Attempts at health care reform include the development of community health partnerships, which have emphasized health care that is essential, practical, scientifically sound, coordinated, accessible, appropriately delivered, and affordable (Poole, 1997; Walker & Alderson-Doherty, 1994).

Partnerships strive to accomplish coordination and improve access in the following several ways:

(1) by helping members obtain needed resources;

(2) by providing means of enhancing individual members' self-concepts and lessening the stigma of the perceived disability;

(3) by giving members control and empowering them in the planning council's governance, administration, and service delivery; and

(4) by furthering member involvement in social and health policy-making.

In the public health sector, the trend has been moving away from direct patient care to that of prevention and health promotion through the development of collaborative partnerships (Bazzoli, Stein, Alexander, Conrad, Sofaer & Shortell, 1997). Within the health care realm, Bazzoli et al., (1997) identify two types of collaborative partnerships: (1) "local coalitions of public and private stakeholders that focus on public health and

community planning; and (2) service delivery networks that seek to coordinate and provide collaboratively a continuum of services" (p. 533). Butterfoss et al., (1993) suggest that partnerships may be classified by either membership differentiation, by structure, by initial reason for development, or by function.

Benefits that have been associated with participation in partnerships and collaboration with other members of the group include such characteristics as individual and group empowerment, increased participation, increased coordination of services, access to information, and commitment. Relationships improve between professionals or agencies, costs are more efficient, and creative solutions sometimes emerge (Chinman, Anderson, Imm, Wandersman, & Goodman, 1996; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995). Shaw and Barrett-Power (1998) discuss how diversity has a positive impact on group performance and effectiveness. Jones, Hesterly, and Borgatti (1997) report that social exchanges in an informal network of governance, such as in a coalition or partnership, increase coordination of services and access to information. They further describe how the sharing of values and assumptions in a group guides the actions and promotes cooperative behavior patterns. When people take ownership of the problems as well as responsibility for the solutions, they feel empowered and realize they, together, are capable of changing things.

While the HIV planning councils and consortia in Florida are busy in their planning and coordinating efforts for the care of people with HIV/AIDS, they struggle with issues of turf, competition, governance issues, power and control, accountability, growth and development, membership recruitment and maintenance. Each community is different politically, socially, and economically. Each Florida HIV planning council and consortium

varies in the structure, process, and effectiveness of its activities (Brown, 1998). The bodies wish to maintain their autonomy in the context of abiding by state and federal policy. Many planning partnerships include lay individuals not versed in the language of health care, funding, and federal or state law, causing confusion, misunderstandings, conflict, and misperceptions.

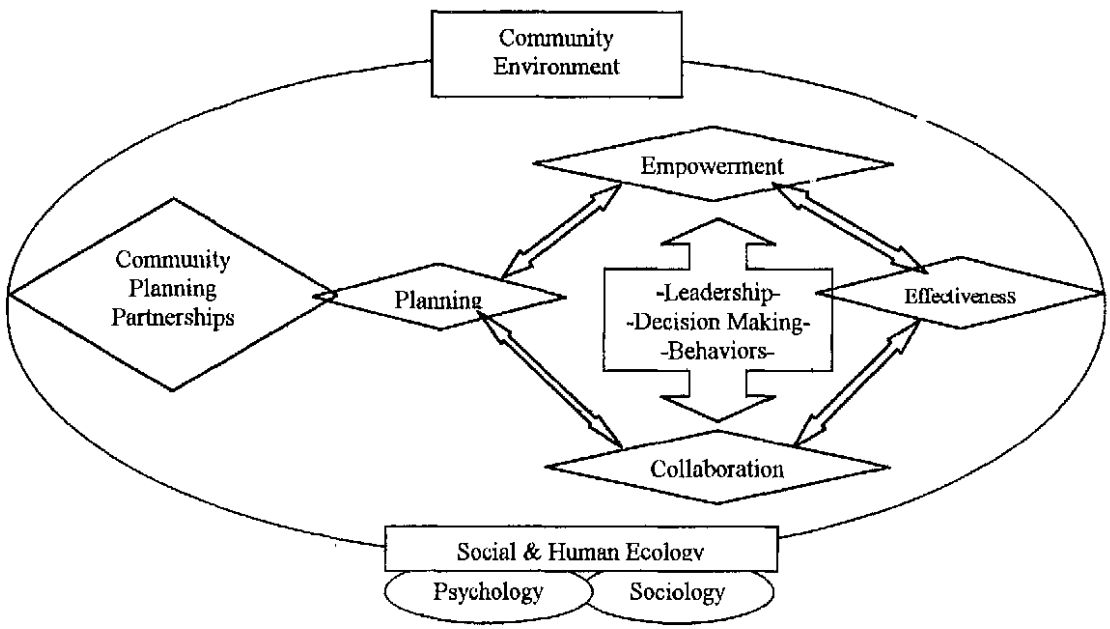
In spite of the many difficulties impeding its effectiveness, positive factors contribute to the successful functioning of HIV/AIDS planning councils or consortia in the State of Florida (Brown, 1998). Little to no research or evaluation has been completed by the planning councils or consortia in Florida, with only a peer review evaluation completed in 1998 and one in 1999 (Brown, 1998, 1999). Research is needed to identify the positive and negative characteristics that emerge from HIV planning councils and consortia under study. This study was an effort to determine such characteristics of effective planning partnerships within the focus of HIV/AIDS community planning for patient care.

Statement of Purpose

The purpose of the study was to identify and describe the characteristics contributing to the collaboration, empowerment, and effectiveness of federally mandated Ryan White Title I and Title II planning councils and consortia within the State of Florida. The characteristics are framed within the major components of a conceptual framework (Figure 2) developed after a review of the literature. The major components for this study include the concepts and theories from the areas of community planning, community coalitions and partnerships, empowerment, collaboration, organizational effectiveness, group and team theories, and social and human ecology.

The researcher's interest in conducting this study evolved from her involvement on a local Ryan White Title II consortium as the HIV/AIDS Program Coordinator in one of the 14 regional areas in Florida. The diversity, competing interests, and involvement of patients, providers, politicians, family members, and other concerned community members on the local consortium led to asking what makes community partnerships effective and why is one planning partnership more effective than others? What is the relationship between leadership control and participation of partnership members? How does this relationship contribute to effectiveness?

Figure 2. Conceptual Framework



This study attempted to answer these questions, and will hopefully allow the Ryan White Title I and II planning council and consortia members and the state and local staff to better understand the contributing factors that influence collaboration, empowerment, and effectiveness in a community planning partnership. The researcher played the role of

participant-observer in this case study which was conducted on-site, in field settings of two (2) local communities in Florida. The research questions were answered in the qualitative and quantitative methods, while the hypotheses posed were answered in the quantitative approach.

Research Questions

Individual and group factors, behaviors; political, social and physical environments; and resources may affect the functioning and effectiveness of community planning partnerships. Therefore, the main research question of the study was as follows: What are the characteristics that contribute to the collaboration, empowerment, and effectiveness of federally mandated Ryan White CARE Act, Title I or II, HIV/AIDS planning councils or consortia?

In order to gain insight into the vast array of factors that ultimately lead to the characteristics of collaboration, empowerment, and effectiveness, many other issues warranted investigation. Secondary questions, as found in Appendix A, were posed and used in both the qualitative and quantitative approaches, i.e., interviews, observations, document reviews, and surveys. Other key secondary questions the researcher sought to answer include the following:

1. What characteristics of the partnership and its environment affect the outcomes of the body?
2. What contributes to collaboration and empowerment within a partnership?
3. How do a partnership's environment, structure and processes influence outcomes and effectiveness? What are the elements within each?

4. What is the relationship between the partnership's members' and leaders' perceptions of their group? How does this relate to the partnership's effectiveness?
5. What are the relationships and behaviors of participants in a partnership and how do they relate to its effectiveness?
6. What is the link between the partnership's planning activities and its outcome of the plan?
7. How are decisions made, conflicts and problems solved?
8. How do the rules, roles and procedures influence and impact on the partnership's effectiveness?

Hypotheses

Over the past several decades, numerous studies have been undertaken to test the assumptions that the presence of a plan with clear goals and objectives is a contributor to a partnership's performance. In order to accomplish the activities and goals set forth, the members of the partnership must work cohesively as a group within the processes of its structure, communicating with and supporting one another. The leader(s) must establish control and encourage participation of the members. The culture, or climate, of the partnership contributes to the satisfaction, interpersonal relationships, level of involvement, and interaction of its members.

Many factors contribute to the collaboration, empowerment and effectiveness of community health planning partnerships. Several factors were addressed in this study through quantitative measures. The following null hypotheses were tested for the quantitative component of this study:

1. There is no difference in the social climate between each of the two community health planning partnerships.
2. Group cohesion does impact the differential outcome of each community health planning partnership. There is no difference in group cohesion between the two partnerships.
3. There is no difference in the perceived support between each partnership.
4. Leader control has an impact on the effectiveness of each community health planning partnership. There is no difference of leader control between the two partnerships.
5. The more positive social climate characteristics evident within a consortium, the more likely that an effective plan will be in place. There is no difference in positive social climate characteristics evident between the community health planning partnerships.
6. The more positive consortium characteristics will be associated with increased member participation and increased member satisfaction. There are no differences in increased member participation and member satisfaction between the two partnerships.
7. There is no difference between the two partnerships' interpersonal relationships.
8. There is no difference in the formality and structure between the two community health planning partnerships.

Significance of the Research

The study is justified by contributions to policy, practice, and theory to the fields of educational leadership and health care in several ways. In the area of policy, health care

policy-makers and legislators can use the findings to help determine which planning councils, consortia, or community planning partnerships may be able to make the best decisions in the allocation of funding for HIV/AIDS patients. For practice, state DOH agencies and/or HIV/AIDS community planning councils and consortia can use findings to shape and/or reorganize the structure and/or processes of the existing consortia and/or partnership(s). Additionally, State DOH agencies, AIDS Education and Training Centers, and planning councils/consortia can use the findings to improve the evaluation process(es) of the planning bodies, to develop training curricula and guides, and to develop training activities and processes to produce more functional and effective planning bodies. In the area of theory, researchers can use the findings to develop new questions, determine relationships between certain variables, and to pursue research in community environments in the areas of community planning, partnerships, empowerment, collaboration, and organizational effectiveness.

Numerous reports and studies have been described in the literature of community partnerships in other fields (Agranoff, 1998; Poole, 1995). These include health care (Fawcett, et al., 1995; Hildebrandt, 1996; Poole, 1997), mental health (Hoagwood, 1996; Johnsen, Morrissey, & Calloway, 1996; Lumsdon, 1993), or the area of health specific to HIV and AIDS (Halloran, Ross, & Huffman, 1996; Holtgrave & Valdiserri, 1996; Taylor, 1994). Literature exists about the effectiveness of teams (Cohen, Ledford, & Spreitzer, 1996; Gladstein, 1984), in youth and family programs (Carter, 1998), in community coalitions or partnerships related to chronic disease, substance abuse (Fawcett et al., 1997), and in AIDS education programs (Thomas & Morgan, 1991). Little evidence is

available, though, about effectiveness of community partnerships related to HIV/AIDS patient care. This study contributes to the research in this area.

Summary

The human immunodeficiency virus (HIV) has been a major disease affecting many individuals since it was first identified. The public health system in this country recognizes HIV as an epidemic and has administered programs and funds for both prevention and patient care. Many financial resources are given to the states and local communities for patient care related to HIV and AIDS. At the present time, the federal legislative mandate, through the oversight of the Health Resources Services Administration (HRSA) within the U. S. Department of Health and Human Services (DHHS), requires that communities play a major role in the allocation and distribution of resources to address the HIV/AIDS epidemic. Therefore, the HRSA requires HIV planning councils and consortia to exist to plan for and coordinate a comprehensive service delivery system. Effective community partnerships will assure that funding is efficiently distributed and accounted for appropriately, that it is being used for quality patient care services, and that those services are organized to assure accessibility for those living with HIV and AIDS. This study focuses on the HIV community planning partnerships from an ecological perspective and addresses the characteristics of collaboration, empowerment and effectiveness.

CHAPTER II

LITERATURE REVIEW

A review of the literature was conducted for several reasons: to validate the need for the study; to identify any conceptual frames, premises, and models related to the purpose of the study; and to identify key research related to the purpose of this study.

Community planning partnerships, sometimes known as collaborative alliances, coalitions, networks, consortia, and planning councils, all basically refer to the same thing--a group of people from a community working together to solve problems. The literature reviewed for this study includes numerous definitions and terms specific to the disease of HIV and AIDS. The definitions and terms are included in Appendix B. In this study, the researcher will interchangeably refer to the generic term of community health partnerships or community planning partnerships, and the specific terms, planning council, consortium or consortia, to follow the language of the Federal CARE Act.

The literature review is organized in six (6) sections. The first section gives a more in-depth description of the Ryan White CARE ACT of 1990. The second section contains an overview of the research that has been conducted on community partnerships and coalitions, including characteristics influencing effectiveness. In the third section, studies related to the concept of planning within the context of community environments are presented, with a discussion of the research on social and human ecology. In the fourth section, collaboration theory is discussed. The fifth section discusses the psychological and sociological theories and models related to the concepts of community partnerships, including a presentation of the factors contributing to group and team theory,

empowerment theory, and organizational effectiveness. Last, a summary and conclusion substantiates the need for the proposed study.

Description of the Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 was passed by Congress and reauthorized in 1996 and in 2000. The purpose of the Act is as follows:

> to provide emergency assistance to localities that are disproportionately affected by the Human Immunodeficiency Virus epidemic and to make financial assistance available to States and other public or private nonprofit entities to provide for the development, organization, coordination and operation of more effective and cost efficient systems for the delivery of essential services to individual and families with HIV disease. (U. S. Department of Health and Human Services, 1996, p. 1).

The Federal Government, through the reauthorization of the CARE Act of 1996, provides direct assistance through Titles I, II, III, IV and Part F. Each Title within the CARE Act mandates different activities for different populations, and, subsequently, funding is appropriated for the specific activities. The CARE Act-appropriated funds are the largest dollar investment for the provision of services for people living with HIV (PLWH) outside of Medicaid (U. S. Department of Health and Human Services, 1996). In the State of Florida, funding has increased from $7.4 million in 1991 to $53.8 million in 1998 (U. S. Department of Health and Human Services, 1996, 1999).

The CARE Act was designed with several purposes in mind (U. S. Department of Health and Human Services, 1996). First, it was planned to provide federal funding for the care and treatment of people with HIV/AIDS disease, assisting the states to lessen the

burden of cost by granting federal funds to develop and maintain essential services. The Act targets those individuals infected with HIV/AIDS who lack financial resources to pay for care. Second, the CARE Act requires a more coordinated approach, through mandating the establishment of community-based HIV planning councils and consortia to jointly plan and provide for delivery of services. Third, the CARE Act empowers community-based organizations, persons living with HIV or AIDS (PLWHs/PLWAs), public entities, and others at the local level through decision making in the planning council and consortium activities.

This study focuses solely on the planning and coordinating functions of two community health planning partnerships, specifically those HIV/AIDS planning councils and consortia in the State of Florida established under Titles I and II. Therefore, this section will include a description of Titles I and II of the Ryan White CARE Act. Descriptions of the remaining titles and parts within the CARE Act will not be discussed in this paper. Several of the regional areas' community planning entities in Florida have combined the Title I planning council and the Title II consortium into a single body. A description of both Title I and Title II of the CARE Act follows.

Title I

Title I, the HIV Emergency Relief Grant Program, provides funds through competitive grants to Eligible Metropolitan Areas (EMAs) identified with reported AIDS cases over 2,000, and with a population of at least 500,000 (U. S. Department of Health and Human Services, 1999). The city or county Chief Elected Official (CEO) that administers the health agency serving the people with HIV/AIDS is eligible to apply for and receive a federal grant. The CEO must establish a HIV health services planning

council that is representative of the local epidemic and includes representatives from specific groups such as health care agencies, social service providers, community-based providers, and other organizations operating in the EMA. At least 25 percent of the voting members must be people living with HIV/AIDS disease. The planning council, in turn, selects an entity to serve as fiscal agent for contracting to community-based organizations, as represented in Figure 3 (U. S. Department of Health and Human Services, 1999).

The main tasks of the Title I HIV planning councils within each EMA, according to the CARE Act of 1996, are as follows:

1. Develop a needs assessment
2. Prioritize for services and the allocation of funds
3. Develop a comprehensive plan
4. Assess the effectiveness of administrative functions and services
5. Participate in the statewide coordinated statement of need initiated by the State of Florida, Bureau of HIV/AIDS
6. Seek public input on community needs and priorities (U. S. Department of Health and Human Services, 1999, p. 3-94).

Title II

Title II, the HIV CARE Grant Program, provides grants to the states awarded on a formula basis to provide for health care and support services for people living with HIV/AIDS. According to the CARE Act of 1996 (U. S. Department of Health and Human Services, 1996), the grants are to be used "to improve the quality, availability and organization" of such services within the States.

While Title II does not require the establishment of a planning council, states are given the flexibility to determine if they shall establish and operate HIV Care consortia. A consortium is a single coordinating entity, usually an association of public and private agencies, as well as individuals, that plans for, develops, and assures the delivery of services to those individuals with HIV/AIDS. The state contracts with a lead or fiscal agency identified by the local consortia to provide subcontracts with local providers of service, as represented in Figure 3, which shows the flow of CARE Act funds (U. S. Department of Health and Human Services, 1999).

The main tasks of the Title II HIV Care consortia within the State, according to the CARE Act of 1996, are as follows:

1. Conduct a needs assessment
2. Develop a comprehensive plan
3. Promote coordination and integration of community resources
4. Assure the provision of comprehensive outpatient health and support services
5. Complete an annual priority-setting process
6. Evaluate the success and cost-effectiveness of the consortium in services
7. Participate in the statewide coordinated statement of need (U. S. Department of Health and Human Services, 1999, p. 3-99).

Figure 3. Flow of CARE ACT Funds in Title I and Title II

Title I	Title II
Federal Grants for Emergency Relief to Eligible Metropolitan Areas	Federal Grants to States and Territories
↓	↓
Chief Elected Official Designates HIV Services planning council	Governor, Administrative Agent (usually the State Health Department)
↓	↓
Governmental Unit (usually Local Health Department	Consortia (in some states)
↓	↓
Lead, or Fiscal, Agent	Lead, or Fiscal, Agent
↓	↓
Community-Based Organizations	Community-Based Organizations and Providers
↓	↓
Services to people living with HIV disease	Services to people living with HIV disease

(U. S. Department of Health and Human Services, 1999, Section I, Chapter 3, page 3)

The Ryan White CARE Act was authorized by Congress to address the HIV epidemic by financially assisting public and private entities to provide for the development and coordination of a comprehensive system of service delivery and care to those individuals infected and affected by the HIV disease. Federal resources are provided for prevention and patient care activities. The federal mandate requires community partnerships (i.e., HIV consortium or consortia and planning councils) to jointly plan for and provide for delivery of services. An overview of Title I and Title II of the CARE Act was provided as background for this study to provide the reader an understanding of the requirements for planning councils and consortia.

Community Partnerships, Coalitions, Alliances, and Networks

Organizations have formed alliances to help solve complex social or economic problems. By involving other people from other organizations, a collaborative and

cooperative effort evolves into solving the problems. Community partnerships, also referred to as coalitions, alliances, networks, and consortia, are defined in several ways. The term "partnership" has been described as an affiliation between two or more individuals, groups, or organizations united together with a common goal that neither can accomplish alone (Chavis, 1995; Poole, 1995). Each partner in an effective partnership commits to working together on a long-term basis, sharing responsibility, openly communicating, and bringing something of value to the partnership. The partnership is also distinguished by a policy, by-laws, or guidelines that outlines its structure, membership rights and privileges, governing rules, and member participation. As each member commits or contributes some type of resource to the partnership (i.e., money, skill, time) either individually or organizationally, it is understood that the benefits reaped by the partnership will be shared by all.

The partnership members "freely negotiate agreements on how to disburse the gains that result from the coordinated efforts" (Kahan and Rapoport, 1984, p. ix). Several other characteristics mentioned by Kahan and Rapoport include such things as coalitional stability, power, worth of the players, and resource exchange. A coalition's structure, process or its outcome has also been suggested as determinants of its effectiveness.

Butterfoss et al. (1993) report several different types of coalitions are "categorized by differences in membership, patterns of formation, types of functions and types of structures that accommodate these functions" (p. 317). Several basic types of coalitions have been referenced in the literature and include mandated, participatory, voluntary, and independent (Hill, 1973; Penner, 1995; Stevens, 1994; Walker & Alderson-Doherty, 1994). A mandated group exists because of its reference in the law,

following bureaucratic guidelines. In a participatory group, members maintain an active role in the process through their involvement and with one another, having influence on policy. A voluntary coalition is founded to politically advocate and exert influence on public policies. An independent group is not controlled by any other entity, but functions independently. The HIV planning councils, or Ryan White Title II consortia, are mandated community planning partnerships, with their existence referenced in the federal legislation, the CARE Act of 1990 (U. S. Department of Health and Human Services, 1996).

Hill (1973) defines a coalition situation as one defined "by the existence of a political decision-making group" (p. 7). He presents the chief theoretical models found in the literature as mathematical, economic and social-psychological. The idea of game theory and how it is related to decision making stems from a mathematical perspective. The outcome of a "game" is determined by its structure, meaning a specification of the idea of either winning or losing. Hill further defines a decision-making group according to the number of decisions they make (p. 8) where a coalition is either terminal or continuing. Decisions are presented as one of two kinds: a simple decision affects allocation of resources only among members of the group, while a "policy decision commits the group to some action or statement intended to affect the behavior of persons who are not members" (p. 8) of the group. For the HIV/AIDS planning councils and consortia, the actions of the group do indeed affect persons who are not members. The persons affected by the consortia's decisions are those clients infected or affected with HIV/AIDS.

A large gain in the development of community partnerships in public health planning and service development (Breckon, Harvey, & Lancaster, 1994; Dever, 1991; Paul, 1955; Shortell & Reinhardt, 1992; Weissert & Weissert, 1996) has occurred during

the past decade. The importance of partnerships between health care organizations, individuals, and community groups to promote collaboration and leverage available resources is recognized. Governmental funding restrictions at the federal, state, and local levels have been one of the biggest factors for public health agencies to seek shared resources and partnerships whenever possible (Baker et al., 1994). The health care system is a huge, bureaucratic, and unwieldy institution that causes confusion and is dis-empowering to individuals (Perkins, 1995). With individuals working together in a partnership at the local community level, empowerment is more likely to occur (Dunevitz, 1997).

Partnerships strengthen communities, individuals, and professionals (Poole, 1995), as well as promote collaboration (Dunevitz, 1997; Lumsdon, 1993). Changes in medical care have forced health care professionals to seek out new ways of tackling patient needs or to create value in the health care system (Petrow et al., 1990; Poole, 1997; Powers, 1997). Health promotion activities have stressed the importance of multiple intervention strategies for chronic health diseases and conditions (Bazzoli et al., 1997; Goeppinger, 1993; Halloran et al., 1996; Hildebrandt, 1996). Butterfoss, Goodman, and Wandersman (1996) and Goeppinger (1993) both state that the development of coalitions is one such intervention activity, but stress the need for them to be effective. Partnerships help to promote value and access (Goeppinger, 1993).

The efforts of health care in the 1990's have revolved around prevention and health promotion activities (Cook, Roehl, Oros, & Trudeau, 1994; Fawcett et al., 1997; Kieler et al., 1996; Mansergh et al., 1996; Paine-Andrews, 1997; Petrow et al., 1990; Poole, 1997; Randolph & Banks, 1993; Walker & Alderson-Doherty, 1994). More efforts

have gone into the development of HIV prevention activities. Approximately a million people have been infected with HIV, but there is no cure or vaccine to prevent this disease (Fishbein, 1996). One of the important principles in community planning is including members of affected communities (Gasch, 1996; Halloran et al., 1996; Holman et al., 1991; Holtgrave & Valdiserri, 1996) . To create value in the health care system, people participating in a partnership must believe the benefits to an activity outweigh the barriers or costs (Fishbein, 1996).

Many federal agencies have been active in the development of community planning partnerships. For example, the Center for Disease Control has developed its Planned Approach to Community Health to encourage the formation of local coalitions and the Center for Substance Abuse Prevention has funded community partnerships throughout the U. S. (Butterfoss et al., 1996). The federal and state governments have spent millions of dollars in coalition development and evaluation (Bell, 1983; Dever, 1991; Dittmar & Gresham, 1997; Krathwohl, 1985). The Center for Substance Abuse Prevention has funded between 250-2,000 coalitions throughout the United States to address the disease and death resulting from alcohol, tobacco and other drugs (Butterfoss et al., 1996; Fawcett et al., 1997). Grantees for HIV prevention funds received approximately $175 million in fiscal year 1994 (Holtgrave & Valdiserri, 1996); since that time funding has been significantly increased. The importance of community health partnerships is recognized as a method to improve the community's health by the federal and state governments as indicated by the resources allocated.

While community partnerships develop for various reasons, those relevant to this study focus on health care, and, more specifically to HIV/AIDS. Community health

partnerships have organized and developed to advocate for coordinated and increased services of specific populations from the health care field (Poole, 1995 and 1997), including those for people with disabilities (Dittmar & Gresham, 1997; Fawcett et al., 1994); for those that are vulnerable (Walker & Alderson-Doherty, 1994); or for those living in rural areas and requiring coordinated services (Goeppinger, 1993). Other partnerships have been required or developed for other types of health care services, including mental health services (Nelson, 1994); prevention and health promotion (Butterfoss et al. , 1996; Goodman et al., 1996); prevention of violence and substance abuse (Chavis, 1995; Cook et al., 1994; Fawcett et al., 1997; Lamb, Greenlick, & McCarty, 1998); and chronic disease (Paine-Andrews, 1997).

Little evidence exists from the literature in the area of coalitions or partnerships for HIV/AIDS patient care services. There were only nine (9) studies found in the literature referring to either Title I or Title II community planning councils or consortia (Brown, 1998; Doughty, 1993; Dukay, 1995; Fleishman et al., 1992; Gambrell & Associates, 1996; Halloran et al., 1996; Kieler et al., 1996; Myers et al., 1994; Penner, 1995). The literature reveals more evidence existing of community planning partnerships for the prevention of HIV (Fishbein, 1996; Gasch, 1991; Higgins, 1996; Hobfoll, 1998; Holtgrave & Valdiserri, 1996; Kalichman, 1998; Kieler et al., 1996; Petrow et al., 1990; Quimby, 1993; Rizakou et al., 1991; Scrimshaw et al., 1991; Taylor, 1994).

Community partnerships are a popular method for promoting community-based solutions to health problems. Many granting agencies, private foundations and other organizations have assumed that community participation in the partnerships increases the

likelihood of the success of the partnerships. Several studies have been examined to determine whether certain characteristics of partnerships are related to effectiveness.

The literature reveals studies on partnership effectiveness in the issues of member participation, satisfaction, leadership, team effectiveness, commitment, training, and the quality of the planning efforts. A key study funded by the Center for Substance Abuse Prevention related to a community health partnership in South Carolina (Butterfoss et al., 1996) is described. The partnership consisted of three (3) counties of community members and social service agency representatives. The partnership had convened committees, or work groups, to plan and implement prevention strategies in the communities. Each work group had a specific focus and a diverse membership.

The study design called for several surveys to be administered. The first survey provided information about the committees' level of functioning and effectiveness, as well as about the individual level of interaction, member satisfaction, participation, costs and benefits. It was self-administered and included 129 items developed from several instruments and field tested for the study. Seven scales were tested for reliability, with moderate to high internal consistency among items. A second survey, the "Plan Quality Instrument" (PQI), was developed and field tested to measure the dependent variable of quality of the committee plan, also derived from several sources. The surveys were administered to committee members and chairs after their fourth meetings and after committees completed their plans.

The independent variables include leadership characteristics, staff-committee relationships, decision-making influence, organizational climate, and community linkages. Independent variables were chosen because of their theoretical bases in the literature or

because they were significant predictors of effectiveness in previous studies. The dependent variables were the quality of the community plans that each committee developed, member costs and benefits, member participation, and member satisfaction with the work and plan of the committee. The survey data were analyzed using factor analysis, chi-square, and multiple regression techniques at both the individual and group levels. The results suggested that community leadership, shared decision making, linkages with other organization, and a positive organizational climate were key determinants of member satisfaction and participation. The same factors were not related to the quality of the partnership's plans.

While the study focused on the formation and early maintenance stages of a coalition, Butterfoss et al. (1996) recommended the models should be tested longitudinally over the life of a coalition. The group sample size was limited; and the instrument, the PQI, was a pilot in this study, needing further testing. The approach was to analyze a group of interrelated coalition committees during one phase of their development. Replication with other similar coalitions could be done to see if the same factors that predicted effectiveness can be generalized.

This quantitative approach to studying key characteristics within a community planning partnership has significance on the design of the current study. Administering surveys to groups is an effective method of capturing data on a partnership.

In summary, community health partnerships are important for several reasons. Organizations can become involved in broad issues and can gain external environmental support without sole responsibility. Through joint effort, individuals can maximize their collective strength to influence an issue. From a resource utilization stance, partnerships

can minimize duplication of services and monitor efficiencies. Coalitions should also build community understanding of a particular issue (Stevens, 1994). Researchers have identified different theories of partnerships, ranging from the human and social ecological theory (Goodman et al., 1996), political (Hill, 1973), economics and mathematics (Kahan & Rapoport, 1984), and psychological empowerment theory (Fawcett et al., 1995; McMillan et al., 1995). This section described community partnerships, giving a variety of definitions, types of partnerships, and evidence of partnership effectiveness from a quantitative study (Butterfoss et al., 1996). Each perspective has an important contribution to the notion of partnership or coalition development. The areas of social ecological theory, collaboration theory, empowerment theory, group and team theory, and organizational effectiveness will be briefly presented in the following sections.

Social and Community Ecology

The nature of community planning partnerships cannot be understood in isolation from the larger system of communities, nor can it be understood from the identification of isolated, single characteristics. Community settings have unique personalities, based on local traditions and customs, institutional values, historical perspectives, political structure, economics, and other factors. Community planning partnerships are complex and understanding them requires an awareness of the environment or context in which partnerships function. The community environment, inclusive of its features, forces and influences within and across settings, affects a community planning partnership. The structure and processes of community planning partnerships link its environmental characteristics to its outcomes. Another critical ecological component for consideration is that community planning partnerships must learn how to examine, evaluate and improve to

continue making a positive impact on the community. Discussing the nature of community environment from an ecological framework may assist in the further understanding of these aspects influencing community planning partnerships.

The literature, with respect to local community environment and planning, crosses the fields of sociology, psychology, anthropology, economics, organizational development, and political science. Individuals interact and affect other individuals or organizations (Black, 1997; Komorita, 1995; Langton, 1987; Wageman, 1995). Public organizations and physical environments interact and influence human behaviors and collaborative decision making (Fishbein, 1996; Grell, 1993; Roberts & Bradley, 1991; Smith & Reeves, 1989); member identity (Dutton, 1994); communication (Suzuki, 1998); and group processes and performance (Shaw & Barrett-Power, 1998). The literature focusing on community environment and planning ranges from those discussions on community identity (Puddifoot, 1994), to community organizing (Potapchuk et al., 1997; Seekins & Fawcett, 1987), to community empowerment (Perkins, Brown, & Taylor, 1996; Speer & Hughey, 1995), and to mathematical models and economic theory (Dockens, 1996). Literature is also available on human systems ecology (Smith & Reeves, 1989), organizational ecology (Amburgey & Rao, 1996; Baba, 1995; Brittain & Wholey, 1989; Morgan, 1982; and Wittig, 1996), and population ecology (Langton, 1987; Young, 1988).

Covey (1989) gives a simple definition of ecology as "everything is related to everything else" (p. 283). Trickett (1984) focuses on ecology to mean "the community embeddedness of persons and the nature of communities themselves," (p. 265) suggesting

that the ecological framework is a way to give meaning to the environment's relationship to community social action.

The term *ecology* has its basis in biology, referring to the study of organisms and the relationships to their environment (Bond & Pyle, 1998; Emery & Trist, 1975; Langton, 1987; McC. Netting, 1977). Cultural anthropologists realized that man is grounded in his environment, borrowing the term *ecology* to study the environment and its effect on man, and vice versa (McC.Netting, 1977). Human adaptation derives its meaning in cultural and human ecology. The terms have had many meanings, ranging from the explanation of social systems, to that of urban sub-communities (Smith & Reeves, 1989). Smith and Reeves define human ecology "as the study of the relation of human populations to the biophysical environment, which usually includes other human populations" (p. 2).

The term *social ecology* rather than human ecology, adds the qualities of human culture and human institutions to what Smith and Reeves (1989) had previously defined (Emery & Trist, 1975). Goodman et al. (1996) indicate five (5) levels of the social ecology (i.e., interpersonal, interpersonal, organizational, community, and public policy). Using an ecological approach incorporates identifying the relationships among the structure and processes operating at each level, within each level, and across several or all levels to gain specific outcomes. In the empowerment theoretical model discussed later in this paper, we begin to see the similarities with the ecological framework, as empowerment refers to the process of gaining influence or influencing outcomes within or across the different individual, group or organization, and community levels.

The theory of social ecology may enhance the understanding of how the environment affects human behaviors (Bond & Pyle, 1998). Bond and Pyle believe that

environment refers not only to the physical environment but also to the social norms and customs, rules and policies affecting people's access to available resources. The social ecology definition offers a frame for the study of organizations (Amburgey & Rao, 1996; Brittain & Wholey, 1989; Langton, 1987; Morgan, 1982). Social ecology is an approach into the nature of organizations that addresses the effects of social, political and cultural factors on the effectiveness and efficiencies of an organization (Baba, 1995; Bond & Pyle, 1998; Brittain & Wholey, 1989; Bukoski & Evans, 1998; Graham, 1992; Guzzo, Salas & Associates, 1995; Marram, 1976; Perkins et al., 1996; Smith & Reeves, 1989; Young, 1988).

From an organizational perspective, Heffron (1989) suggests that "organizations can and should be viewed as political systems" (p. 211) complete with their own cultures. From this stance, she describes organizations as complex social entities complete with values, structure, relationships, conflict, power issues, rules, and culture. She reports that one of the greatest challenges in an organization is that "individuals within the organization have accepted" and are "committed to, the dominant values, norms, and culture" (p. 211). Gasch (1991) reports that "the inter-relatedness of biological, psychological, and social factors" (p. 94) helps in the understanding of disease and health. Within the specific realm of HIV disease, a culturally-based, ecological approach is appropriate.

The ecological approach presents a reasonable perspective for understanding the forces that shape organizational structure, process and outcomes. In the study of organizations, literature from research has moved from just a study of one organization, to others studying intra-organizational, population and community organizations (or

associations of community people) (Speer & Hughey, 1995), and social movements (Langton, 1987). Several studies addressed organizational ecology by research on the roles of competition and diversity (Bond & Pyle, 1998), as well as adaptation and resource allocation (Amburgey & Rao, 1996; Brittain & Wholey, 1989; Trickett, 1984; Young, 1988), and interdependence and succession (Speer & Hughey, 1995). The ecological approach is an appropriate approach to addressing change, efficiency and effectiveness across a broad spectrum and various types of organizations: for-profit, non-profit, volunteer associations, grassroots community organizations (Perkins et al, 1996); neighborhoods (Mesch & Schwirian, 1996), and mandated coalitions, to name just a few. In the study of community planning partnerships, researchers need to understand individuals and their interactions in groups, as well as the socio-political forces impacting on the group (Langton, 1987; Morgan, 1982).

Trickett (1984), and later, Speer and Hughey (1995) suggest four ecological processes in the study of communities, including the following:

1. Cycling of resources,
2. Adaptation,
3. Interdependence, and
4. Succession.

Applying these four processes to the study of community planning partnerships allows the reader to develop further understanding of contextual issues.

Regarding the cycling of resources, several task characteristics of community partnerships would be the allocation of resources, the monitoring and adjusting of those resources. The identification and development of resources, including assessment of

human capital, social capital, competencies, strengths and opportunities for development are part of this task (Smith & Reeves, 1989; Speer & Hughey, 1995; Trickett, 1984; Walker & Alderson-Doherty, 1994; Young, 1988).

In order to be responsive to ongoing changes, another vital characteristic for individual members of community partnerships is adaptability. Partnerships need to adapt to the changes in resources, structure and process, as well as constraints placed upon them by political forces. Human systems ecology includes the three qualities of adaptation, a system of communication and information processing, and the ability of humans to be socially differentiated. These three qualities suggest a means to the development of cultural values and norms within a group. Understanding cultural values and norms offers insight into the effectiveness of community planning partnerships. If the members of the partnership share basic beliefs and assumptions, perhaps it eases decision making and achievement. Culture, though, develops gradually over time as a result of shared group experiences.

The principle of interdependence focuses on how persons and organizations are connected (Speer & Hughey, 1995). Variation of social relations and interdependence across communities may enhance or impede prospects for change, and explain the degree to which localized structural change is achieved or not achieved (Ettlinger, 1994). While attempting to remain autonomous, community planning partnerships are dependent upon one another in the areas of communication and interchange between partnership members and other organizations.

Finally, succession in the context of community partnerships refers to the notion that environments change over time, benefiting some populations while being detrimental

to others. The notion of succession for community partnerships lies in the knowledge of local historical factors, political factors, and resource distribution and allocation which may contribute to the decision making process and effectiveness.

With the changes in the global economy and work force, demographics indicate there are many more women, minorities, and immigrants, with expectations of higher numbers in the future.

A key study found in the literature describes the cycling of resources and adaptation in an ecological framework and is reviewed here. Bond and Pyle (1998) present a qualitative case study to understand how diversity in organizational settings affects structure, process and outcomes of the organizational unit. They believe that the arrangement of the environment, along with the distribution of resources, applies powerful forces on people's behavior and that the behavior of people can only be understood when viewed in context. Their study also focused on developing understanding of how interactions between individuals affect the outcomes of an organizational unit. The case study illustrates the complexity of the diversity challenge by highlighting how the organizational context interacts with individual and group characteristics as well as with other social and economic influences to create forces for and against diversity.

The setting of their two-year study was a chemical products company in an industrial, northeastern U.S. city. The city was mostly white working class, but the company was located in an increasingly Hispanic neighborhood. The company had existed for over 30 years and was considered one of the two major employers in the city, employing about 200 people. Turnover was almost nonexistent. The workforce was largely white and male, with clear gender and racial segregation in the jobs. Two thirds of

all the women were in office or lab positions; the majority of male people of color worked in production as operators and technicians; and the leadership team had four (4) white men and one white woman. During a period of conflict over unionization at the plant, there was open discussion of the racial and gender issues within the organization, and the awareness of the subtle ways in which race and gender affected the ability of people to perform their jobs.

The study design called for several qualitative methods to be used, including 36 in-depth interviews, participant observation of meetings, and a series of feedback sessions. The study began with guiding questions that involved relationships and complex interactions among forces at different levels of analysis; a priority on observing events and processes in action; and an interest in describing the events. A Steering Team was formed to guide the project, representing members from a wide range of departments and from all levels of the organization. Initially, the Team reviewed the project goals, clarified a mission statement and piloted the interview schedule. The 36 people interviewed represented folks from all departments and from all levels. Invitational letters were sent to 80 employees initially, and 24 people responded, mostly white. A second call was sent out to seek out additional people of color. After the interviews occurred, feedback sessions were held to check on whether the interpretation of the interview results reflected reality of the interviews.

What emerged from Bond and Pyle's (1998) case study were four (4) themes, or lessons, about the ecology of diversity:

1. The influential role of organizational history and tradition in shaping current diversity dynamics;

2. The importance of understanding how participants' experiences of events may differ;
3. The power of informal organizational processes; and
4. The connections between individual, organizational, and broader cultural values. Organizations need to understand and pay attention to the interactions among varied personal and environmental forces that generate resources and increase the adaptive capacity (p. 589).

The important lesson here is that a case study within an ecological framework was used to fully develop the importance of environmental influences and impact upon the behavior of people. Bond and Pyle (1998) stress the importance of using a social ecological analysis to enlarge the definition of resources. With this, they further describe that organizations must be aware of the interactions among the individual and "environmental forces that generate resources and increase the adaptive capacity of organizations" (p. 619).

In summary, the literature related to ecology emphasized the importance that individuals affect other individuals, organizations, and communities; as well as communities and organizations affecting individuals. Definitions of ecology were stated. There is a relationship between each level of the defined ecological state. A case study was described that supports social ecology as a framework for studying community partnerships. Effective community partnerships can be understood as complex entities with intricate relationships working within social systems in the community environments. This perspective provides a framework for comprehending the characteristics that influence or enhance community planning partnerships to being effective and functional.

Collaboration Theory

One theoretical framework that enhances further understanding of effective community planning partnerships is that of collaboration theory (Wood & Gray, 1991). This framework emphasizes solving organizational and societal problems in a cooperative and collaborative manner, working together in a positive fashion for solutions. Individual organizations have difficulty in today's current environment to solve complex social or economic issues. Understanding the conditions for collaboration, stakeholder involvement, structure, and process, results in knowledge of how collaborative coalitions and partnerships function within their environment (Bartunek, Foster-Fishman & Keys, 1996; Dukay, 1995; Gray & Wood, 1991; Lamb et al., 1998; Paul, 1955). Bazzoli et al. (1997) touch upon the social ecological theory in their discussion of collaboration. They suggest that the environmental context in which partnerships operate will affect collaboration of individuals and organizations, and thus affect the partnership structure and its actions.

Several definitions of collaboration are offered from the literature. Collaboration can be described further as "the process of individuals or organizations sharing resources and responsibilities jointly to plan, implement and evaluate programs to achieve common goals" (Jackson & Maddy, 1997, p. 4). Collaboration is another way of referring to the process of decision making to solve mutual problems (Andranovich, 1995; Gray, 1989). Poole (1995) defines collaboration to mean "joint work with persons or groups that oppose or compete with us" (p. 4). Another concept of collaboration is "a temporary social arrangement in which two or more social actors work together toward a singular common end requiring the transmutation of materials, ideas, and/or social relations to achieve that end" (Roberts & Bradley, 1991, p. 212).

Wood and Gray (1991) present the definitions of collaboration from other authors' work (p. 143):

- "a process through which parties who see different aspects of a problem can constructively explore their differences and search for solutions that are beyond their own limited vision of what is possible" (Westley and Vredenburg);
- "constructive management of differences" and collaboration is equated with societal change (Pasquero);
- "a process of joint decision making among key stakeholders of a problem domain about the future of the domain" (Logsdon; as well as Sharfman, Gray, and Yan); and
- "a group of key stakeholders who work together to make joint decisions about the future of their problem domain" (Nathan and Mitroff).

Two concepts important to collaboration focus on "dependencies among organizations and on their environments as they seek to achieve their own objectives" (Bazzoli et al., 1997, p. 536). The two concepts include "organizational willingness" and "perceived need," representing themes from the resource dependency theory and inter-organizational relations theory. The resource dependence theory discusses the conditions for the collaborative effort and the resulting flow of resources in the allocation effort of collaboration. Stakeholders of partnerships or coalitions are often representatives of community agencies, or they are individuals affected by the social or economic condition that gave rise to the coalition or partnership initially, and thus may be dependent upon the resources under the purview of the partnership.

Embedded within the theoretical framework of collaboration lies an explanation of how an organization functions with respect to the relationships and influences existing in its environment (Rowley, 1997). This is similar to the human and social ecology theory as described previously in this chapter. The study of individuals on the structure and process of organizations results from studies of behaviors and participation within groups, patterns of relationships, group norms and values, as well as member interactions.

The notion of autonomy is important in the discussion of collaboration (Dukay, 1995; Fawcett et al., 1995; Grell, 1993; Logsdon, 1991; Roberts & Bradley, 1991; Sharfman, 1991; Silberg, 1998; Wood & Gray, 1991). Autonomy refers to the level of independence retained by either the individual member of a collaborative group, or the level of independence retained by the group within the community. Individual members represent their own agencies and retain that level of autonomy. The group, or coalition, retains another level of autonomy on a community level. The prior discussion of environmental influence in an ecological framework has impact on the issue of autonomy. The issues of power and influence affect autonomy and decision making; the allocation, use, and access to resources; as well as the rules governing the structure and process of the collaboration. Individual stakeholders of a collaborative group share power in their activities.

Advantages of coalitions include the possibility of more effective and efficient delivery of programs, improved communication, elimination of duplication, identification of service gaps, and improved cost benefits. Disadvantages may include turf protection and mistrust, slow decision making, limited resources, and decreased levels of participation or cooperation from members in times of crisis. Factors contributing to the

ineffectiveness of coalitions may include competitiveness, inflexibility, hidden agendas, and lack of structure or procedures for process.

Obstacles inherent in any group have an effect on successful collaboration. Such obstacles include institutional disincentives; historical and ideological barriers; power disparities; socio-political dynamics; differing perceptions of risk, or task; technical complexity; political and institutional cultures; and individual knowledge, attitudes, and beliefs (Gray, 1989). Obstacles may be temporary barriers to a collaborative group and thus to community outsiders, the group may be perceived as not effective or functional.

Despite the barriers and obstacles to collaboration, success of collaborative groups is found in various communities. Having a shared vision and recognizing the other stakeholders' perspectives help to achieve success (Butterfoss et al., 1996; Ettlinger, 1994). Success is often built on the ability of coalitions to achieve consensus and the exchange of individual needs, psychological factors, and rewards for individual contribution or group attainment of goals (Butterfoss et al., 1996; Dukay, 1995; Graham, 1992; Luft, 1984). Members of successful collaborations exhibit open communication and showing respect for the other person, valuing their input and perspective, as well as their values and culture (Denison, 1990; Kerr et al., 1994; Paul, 1955). Several critical underlying process goals contributing to a successful partnership include the following: intergroup cooperation, group co-empowerment, and member empowerment (Bartunek et al, 1996). The connections between the individual, the organization, and broader cultural values, are identified as a contributing factor to success (Bond & Pyle, 1998).

Five critical preconditions for any collaboration to achieve success include: "stakeholders are interdependent; solutions result from dealing openly and creatively with

differences; joint ownership of decisions exists; stakeholders assume collective responsibility; and collaboration is an emergent process" (Gray, 1989, p. 11). Group effectiveness is important to partnership success and includes three components: "group performance, satisfaction of group-member needs, and the ability of the group to exist over time" (Gladstein, 1984, p. 500).

Gray (1989) indicates that there are common issues that surface in the process of collaboration and can be defined in three (3) phases. Phase 1 is where the problem setting occurs; getting to the table and having face to face dialogue on the issue(s). Phase 2 is for direction setting; organizing, sharing, and exploring the facts and deciding on options. Phase 3 is the actual implementation, where the external environment is involved and monitoring of the activity occurs.

Successful collaboration produces results on different levels: individual, group, and community. Results are often tangible and developmental (Chrislip & Larson, 1994; Mondros & Wilson, 1994). Results are often attained after a lengthy process of meeting, reviewing facts and budgets, and making decisions. Chrislip and Larson (1994) suggest ten factors identified as indicators of whether a collaboration will succeed or fail: credibility and openness of the process; strong leadership of the process; commitment and/or involvement of high-level, visible leaders; broad-based involvement; strong stakeholder groups; good timing and clear need; overcoming mistrust and skepticism; support or acquiescence of "established" authorities or powers; interim successes; and a shift to broader concerns (pp. 52-54).

In summary, collaboration theory (Wood & Gray, 1991) emphasizes solving organizational and societal problems with collaboration and cooperation among people or

organizations. Several authors have described collaboration as a process of joint decision making, sharing resources and responsibilities. The issues of autonomy, power and influence were discussed, as well as benefits and disadvantages, and barriers and obstacles. The next section discusses group and team theory, empowerment theory, and organizational effectiveness.

Psychological and Sociological Theories and Models

Studying a coalition is a complex task. Not only is one attuned to group structure and process, but also to individual and environmental influences. The majority of the studies reviewed related to individual and group behaviors and identity, member participation and interaction, and team effectiveness. Relationships and organizational processes have an influence on the effectiveness of the group (Bartunek & Betters-Reed, 1987; Bartunek et al., 1996). Blau (1954) relates that those members with a broader base of relationships within a group are more integrated as members of the group. A critical element of member participation within a group is the decision-making process (Black, 1997). Factors contributing to empowerment within coalitions include those at the individual and group levels, such as participation, a positive organizational climate, commitment, and a sense of community (McMillan et al., 1995). Factors contributing to individual and group behaviors are evident within a coalition, such as motivation, self-interest, self-efficacy, expectations about others' actions, fear, and greed (Komorita, 1995). Identity of members and group has been an area of heavy research. The reasons for organizing, or the preconditions, of such groups is based on inter-group processes and includes the processes by which individuals form social identities (Brewer, 1993; Burke,

1997; Ellemers, 1997; Jetten, Spears & Manstead, 1998; Simon, Glassner-Bayerl & Stratenwerth, 1991; Suzuki, 1998; Terry & Hogg, 1996; Wittig, 1996).

Several additional theories from a psychological and sociological perspective provide a framework for the understanding of community partnership. These theories are presented to further assist in the understanding the complexity of the community planning partnership. Group and team theory, empowerment theory, and organizational effectiveness will be discussed in the following sections as each relates to community partnerships.

Group and Team Theory.

Teams are often asked to perform difficult and challenging tasks in the business world and in other sectors. Oftentimes, the tasks to be performed require team members to adapt to a rapidly changing environment, especially in the health care arena. Teams working together for a purpose require a wide range of knowledge, skills and attitudes. Teams assembled within a single organization will often receive training to increase their performance. In volunteer community planning partnerships, the members of the team usually do not receive any type of training or orientation, perhaps decreasing the potential performance and effectiveness. While much work has been done in the psychology field of group and team theory, development and practice, group and team research represents a large area within organizational psychology. Group and team theory warrants its own discussion for understanding of its contribution to community planning partnership effectiveness.

Ilgen, Major, Hollenbeck & Sego (in Guzzo et al., 1995, chapter 5) discuss the historical evolution of the work team and the contributions that teams have made to

society. A change in the responsibility of decision making from the individual supervisor to a work team has evolved in many businesses and organizations, so there is a strong need for better understanding of team functioning and decision making in all kinds of situations. The authors believe that teams exist to perform some task, not for social reasons. Decision making is based on how individuals, or individuals within teams, select and process information to make a decision. A discussion is held on the approaches to team decision making--consensus and coalition formation.

Team level interaction appeared to be higher for self-managing groups than for the more traditional work groups. Self-managed teams were found to engage in more reciprocal behavior, experience greater cohesiveness, and participate more in the group decision making. Evidence exists that indicates self-managed groups are more effective than traditional work groups (Brannick, Salas & Prince, 1997; Campion, Medsker & Higgs, 1993; Cohen et al., 1996; Graham, 1992; Guzzo et al., 1995; Lembke & Wilson, 1998; Shea & Guzzo, 1987). Characteristics of the work group may be related to effectiveness. From the view of an organization with employees, Campion et al. (1993) defined work group effectiveness in terms of both productivity and employee satisfaction. The other criteria in their study addressed manager judgment of effectiveness. They identified five (5) major themes and 19 major characteristics related to effectiveness, as indicated in Table 1.

Table 1: Themes and Characteristics Related to Effectiveness

Theme	Characteristics
Job Design	Self Management
	Participation
	Task Variety
	Task Significance
	Task Identity
Interdependence	Task Interdependence
	Goal Interdependence
	Interdependent Feedback and Rewards
Composition	Heterogeneity
	Flexibility
	Relative Size
	Preference for Group Work
Context	Training
	Managerial Support
	Communication/Cooperation between Groups
Process	Potency
	Social Support
	Workload Sharing
	Communication/Cooperation within Groups

(Source: Campion et al., 1993; p. 825)

The themes reflect the components of group structure, process, task and outcomes. The first theme, job design, relates to the individual characteristics of self-management; participation; and the variety, significance and identity of the tasks. The second theme, interdependence, incorporates the task characteristics of interdependence; goal interdependence; interdependent feedback and rewards. The third theme, composition, includes group factors related to heterogeneity; flexibility; size; and preference for doing group work. The fourth theme, context, refers to the environmental support characteristics of training; managerial support; and communication and

cooperation between the groups. The fifth theme, process; includes those factors related to procedures and methods practiced including potency; social support; workload sharing; and again, communication and cooperation within the groups.

In studies related to inter-organizational relationships and member interaction (Erhardt, 1991; Hall, Clark, Giordano, Johnson, & Van Roekel 1977; Wageman, 1995), the results have implications to the design of the groups and their effectiveness. Erhardt (1991) found that groups engaging in more interaction perform better. The use of personality tools, such as the Myers-Briggs Type Indicator, can be a very helpful tool for team building and in developing individuals' awareness of their own style and that of their co-workers. (Erhardt, 1991; Wethayanugoon, 1994). Knowing the various personality types of individuals within a team is useful for group members to understand each other better and to create a language to discuss their similarities and differences. If the group members can better understand and appreciate individual differences and characteristics, then the group can be more effective (Wethayanugoon, 1994).

In reviewing the literature, this researcher found it difficult to separate team interaction and team effectiveness as one was important for the other to occur. Individual and team interaction appeared to be an important factor in team effectiveness and performance. A number of studies have been done of the interdependence and social support in the context of theme-oriented team and group work (Campion et al., 1993; Cohen et al., 1996; Gladstein, 1984; Graham, 1992; Guzzo et al., 1995; Lembke & Wilson, 1998; Shaw & Barrett-Power, 1998; Shea & Guzzo, 1987; Wageman, 1995; Wethayanugoon, 1994). An exploration of what social support means in relation to team effectiveness will be discussed.

Social support has also been identified as a contributing factor to the effectiveness of general process therapy groups. Other literature indicates that social support varies depending upon its sources. Mallinckrodt (1989) refers to a study conducted in 1978 by LaRocco and Jones and gives an example of support from co-workers and supervisors. The purpose of Mallinckrodt's study was twofold: to identify the specific source of social support most closely related to positive changes in specific stress symptoms; and to examine differences in support for members of theme-oriented and general process therapy groups. He measured social support, self-esteem, depression, and psychological symptoms, but found no significant differences. Support from co-workers and supervisors was found to moderate the effects of occupational stress, but support from spouses or friends outside the setting was much less effective. Significant findings from a follow-up study indicated no differences in support from outside sources; but did indicate two types of support from other group members were more available to clients in theme groups:

(a) guidance support: the availability of confidants or authoritative leaders to provide advice, and

(b) reliable alliance support: the assurance that one can count on assistance being available if needed.

A trend was found toward greater attachment support from group members, which included feelings of safety and security in a close emotional bond. These findings have implications for the understanding of social support found within work groups or teams, and to assist leaders or facilitators of groups to maximize the availability of the most helpful types of social support.

Group members are part of a social structure, dependent and interdependent on several factors (Andranovich, 1995; Chinman et al., 1996; Guzzo et al., 1995; Jetten et al., 1998; Lau, 1989; Mallinckrodt, 1989; Rothenberg, 1988; Suzuki, 1998; Wageman, 1995; Yzerbyt, 1998). Whenever members and non-members of a group know who is a member and who is not, Guzzo et al., (1995) indicate that teams and groups are social units within a larger social system, "bounded" (p. 2-3) together when the group has a task to perform. They further report that task-based interdependence is critical among group members, requiring that team members interact by exchanging information and coordination with one another while accomplishing a task. Decision making in a group is important to contributing to the effectiveness of the group. They also report that individual decision making is quite different from decision making in teams. What is interesting is that they discuss decision making as an ongoing, consequential activity, continuous and recurring, with monitoring of past decisions (Guzzo et al., 1995).

Wageman (1995) explained the design of work has been dominated by two contrasting models. Work can be designed to be highly *interdependent*, requiring the input of several people to complete it. An example is a team responsible for creating a new advertising campaign. An example of an interdependent team consists of representatives of different backgrounds and experiences, who are held collectively accountable for the quality of a certain task. Another design is a highly *independent* team whereby work is to be performed by individuals in which each member is given responsibility for a task and is rewarded for his or her individual achievement. A third model of work design is a "hybrid" design that combines elements of interdependent and independent work (Wageman, 1995). An example is a group of researchers in a development laboratory, each pursuing

independent research projects and, collaborating on the larger structure. Members of such a hybrid group sometimes operate entirely independently and sometimes as a team (Wageman, 1995).

Task and outcome have been identified in the literature as important to group effectiveness and its impact on a partnership (Butterfoss et al., 1996; Campion et al., 1993; Cohen et al., 1996; Gladstein, 1984; Graham, 1992; Guzzo et al., 1995; Mallinckrodt, 1989; Marram, 1976; Shaw & Barrett-Power, 1998; Shea & Guzzo, 1987; Wageman, 1995). Wageman (1995), in her very lengthy research study, investigated the separate and joint effects of different levels of task interdependence and outcome interdependence--individual, group, and hybrid--on the effectiveness of work groups in organizations. She describes "task" as the means by which the work is accomplished and "work outcomes" as the ways in which performance is assessed and rewarded (p. 145). She goes on to state that the effects of task and outcome interdependence on group effectiveness may also vary based on the individuals doing the work.

Findings of Wageman's study indicated that work groups performed best when their tasks and outcomes were either pure group or pure individual. The hybrid groups performed poorly, had low-quality interaction processes, and low member satisfaction. Task and outcome interdependence affected different aspects of group functioning: tasks influenced variables related to cooperation, while outcomes influenced variables related to effort. Individuals' autonomy preferences did not moderate the effects of task and reward interdependence but, instead, were themselves influenced by the amount of interdependence in the work. The design of the work had strong effects on cooperation, helping, and learning, regardless of reward system design. Also, group rewards had no

independent influence on cooperative behavior although reward outcomes appeared to affect the motivation of the group members rather than to influence group behavior directly. Findings have implications for the design of work and reward systems for work groups. Additionally, the results of this study may also provide some insight into what happens when the task and rewards are incongruent.

Many situations today and in the future will require people to work in teams and implement decisions that may affect huge amounts of money and people. Therefore, decision- making capabilities of teams need to be understood. The literature indicates that many studies have been done on individual decision making or internal team processes, but little has been done on team decision making or team performance.

Teamwork stress has been mentioned in a variety of studies about how the changes in teamwork behaviors affect the quality and quantity of teamwork behaviors (Baker et al., 1994; Bazzoli et al., 1997; Black, 1997; Butterfoss et al., 1993; Cameron & Whetten, 1983; Fairchild, Frydryk, David & Yutzy, 1995; Grell, 1993; Guzzo et al., 1995; Mayer, Soweid, Dabney, Brownson, Goodman & Brownson, 1998; Penner, 1995; Poole, 1995; Stevens, 1994). The literature regarding the effects of stress on human performances has nearly overlooked the effects on team processes and performance. Therefore, this topic is quite important within the context of community health partnerships.

Morgan and Bowers (cited in Guzzo et al., 1995, chapter 8) describe seven types of stress impacting an individual--psychological, cognitive, environmental, occupational, organizational, physiological, and social. And they note that the stresses have been defined in ways that permit the development of theoretical perspectives and research approaches for researchers. The authors define teamwork stress as being caused by certain conditions

that have an effect on an individual's ability to interact interdependently or that modifies the interactive capacity for obtaining its desired outcomes. Teamwork stress may affect team decision making and thus the effectiveness of the team. Morgan and Bowers (cited in Guzzo et al., 1995) identify and define seven types of teamwork stresses and the effect on decision making: team training load, team workload, team size, team composition, team structure, team cohesion, and goal structure. Implications of the findings indicate a need for further research on the effects of stress on team performance and team processes.

Leadership style affects group effectiveness. The success of a partnership oftentimes is dependent on the leadership style of the partnership's chairperson(s). A leader's role is one of distributing relevant information for the group to make decisions. Another important role as a leader, is to teach the importance of feedback between the group members, and towards the attainment of the goal. Leadership styles are related to engaging member participation in the partnership and in the decision making processes (Carr, 1997). Sharing goals of the task(s) at hand is important for the group to move ahead, as well as trying to help the group members know what their roles are, providing training when necessary. Giving the group enough time to complete a task is also part of facilitating.

Other top variables affecting group effectiveness or performance include the following: (1) communication, if its lacking, the group will not be effective; (2) trust; (3) having shared goals and staying focused, developing a purpose to work together for the future; and (4) giving group members problem solving methods so they can come to a final recommendation or decision. Communicating more effectively is vital to community partnerships as well as learning how not to control the communication (Graham, 1992;

Parker, 1994). Allowing a group to manage conflict themselves and to solve their own problems is also important (Kieler et al., 1996; Weider-Hatfield, 1995; Wondolleck, 1996).

Graham (1992) describes her research on the relationship between effectiveness in self-managed work teams versus traditional work teams. The findings indicated that high team excellence measures were predictive of high effectiveness. Erhardt (1991) found that groups engaging in more interaction perform better. Mallinckrodt (1989) found group interaction to be important in the realm of social support, especially from co-workers and supervisors in an occupational setting. Social support from co-workers and supervisors was more effective than support from spouses or friends outside the setting. Using personality tools, such as the Myers-Brigg Type Indicator, to develop awareness of individual styles, to help group members understand each other better, and to establish a base for communicating similarities and differences in people was recommended by Erhardt (1991) and Wethayanugoon (1994).

The relationship between task and outcome has been identified in the literature as also important to group effectiveness (Cohen et al., 1996; Dittmar & Gresham, 1997; Guzzo et al., 1995; Moos, 1996; Wageman, 1995). Wageman (1995) investigated the separate effects of different levels of task interdependence and outcome interdependence on the effectiveness of work groups in organizations, finding that work groups performed best when their tasks and outcomes were either pure individual or pure group, allowing for higher-quality interaction and higher member satisfaction.

Guzzo et al. (1995) consolidated studies from many authors on the subject of team effectiveness, group interaction and stress, and decision making. Because group members

are individuals within a social structure, task-based interdependence is critical among group members, requiring interaction and decision making. The historical evolution of the work team and the contributions made to society are discussed, while moving the discussion from an individual decision-making model to the team level. As a vital element, stress has contributed to the group interaction and effectiveness. Morgan and Bowers (in Guzzo et al., 1995) describe seven types of individual stress and seven types of teamwork stresses and the effect on decision-making.

Some implications for the current study are acquired from the review of the literature and include the following: (1) the importance that leaders or facilitators of work groups can utilize the knowledge of team excellence to improve or to predict effectiveness; (2) the importance of understanding social support within work groups to maximize the availability of the most helpful types of support; (3) the importance of the design of work groups and reward systems; (4) the importance that decision making capabilities be understood; and (5) the importance of understanding how individual and team stress impact decision making. This researcher found that in order for a group or team to be effective, many factors are involved: setting goals and visions; leadership style; social support; member contributions to the group; participation of members; trust developed and conflict being resolved; shared decision-making; evaluation and feedback. Also contributing to the success of a group are the awareness and knowledge of how to deal with stressors to individuals and to the team. Various instruments may be useful to raise awareness for team members and for the leader to become more effective. The importance of the literature related to groups and teams is further discussed in the next section about empowerment.

Empowerment Theory

An area of research that is important to review in connection with community partnerships is that of empowerment. Empowerment theory falls within the psychological framework. The construct of empowerment is discussed in the literature from an ecological stance, the inter-relatedness of individuals, groups, and environment---whereby everything affects everything else; and relationships are interrelated (Conger & Kanungo, 1988; Gutierrez et al., 1998; McMillan et al., 1995; Perkins, 1995; Perkins & Zimmerman, 1995; Rappaport, 1981, 1995; Zimmerman, 1995). Fawcett, Paine-Andrews, Francisco, et al. (1995) refer to empowerment as the "process of gaining influence over events and outcomes of importance" (p. 678). Some of the factors contributing to the influence of change or to the effectiveness of a group's activities include: individual strengths and competencies, behaviors of individuals within groups, and the political environment (Zimmerman, 1995). Other factors include: person or group factors, environmental factors, and empowerment capacity and outcome (Fawcett et al., 1995). Empowerment processes for community groups may include collective decision making, shared leadership, access to government and other community resources. Community empowerment outcomes might refer to the development of a network, organizational growth, or an increase in funding.

Empowerment has to be discussed within the ecological framework because individuals and organizations are affected by the environment. Rappaport (1981) views people within local communities having the knowledge and resources to offer solutions rather than a centralized controlling organization doing so. He proposes an approach to social problems by offering the empowerment model, suggesting this approach enhances

the possibility for people to gain control over their own lives within their own community. Important aspects of community life are seen as paradoxical for viewing people in trouble, describing a conflict between a "rights" and "needs" model of service delivery. He offers a newer definition of empowerment as "an intentional, ongoing process centered in the local community, involving mutual respect, critical reflection, caring and group participation, through which people lacking an equal share of valued resources gain greater access to and control over those resources" (p. 802).

The issue of power and resources between individuals of a group, or between groups, is important in the discussion of empowerment. Interpersonal power or the ability to share power within a group must be understood. The perceived power of the chairperson has an impact of the partnership's effectiveness. Some of the members may allow the chairperson to assume the power in leading the group, and may lead to effective decisions and outcomes. When members have significant conflict over who should assume the power, there may be associated problems with the activities occurring within the partnership, and may lead to ineffective decisions and outcomes. Within a community planning partnership, the issue of resources is dominant. Individuals may be concerned primarily with the protection of the resources, or in acquiring a majority share of the available resources. Because resource protection and allocation is primary in the partnership, the concepts of power and conflict are prevalent.

Bachrach and Botwinick (1992) reveal the key concept of power and empowerment includes that individuals "have the capacity to develop not only their internal selves but also a potential for expanding their self-interest to encompass an identification with a commitment to the well-being of others" (p. 20). They further report

there are three (3) relational aspects to power: (1) a conflict of interest must exist between two or more individuals, or groups; (2) a power relationship requires that person AA submits to person BB's demands, especially since resources are a key concern; and (3) "the existence of a power relation depends upon the value priorities of those on the receiving end of the power relationship" (pp. 50-51). Hobfoll (1998) further explains and describes empowerment as a notion relating to an interpersonal concept within relationships, between the interactions of individuals based on gender, or as members of an empowered or dis-empowered ethnic group.

Models of community empowerment exist to understand the process of gaining influence over conditions within communities, often giving steps to enhance a collaborative partnership or organization. They appear to be basic guidelines to 'fixing up' an organization within its environment. Influences between personal, group, and environmental factors are part of the empowerment process. Community empowerment must represent those interactions between individuals or groups, as discussed throughout this paper. Individual, group, or environmental factors affect an organization's ability to influence changes in the environment and its related outcome (Fawcett et al., 1995; Gutierrez et al., 1998; Nixon, 1998).

A partnership's ability to influence change results from reciprocal influences between these factors of person or group and the broader environment. For example, a HIV/AIDS partnership may be affected by personal and group factors, such as incompetence of the group's leader, or an uncommitted lead agency. In order to empower the partnership, steps must be taken to teach the members how to improve the empowerment capacity. Fawcett et al. (1995) suggest "four strategies for facilitating the

empowerment process: (1) enhancing experience and competence; (2) enhancing group structure and capacity; (3) removing social and environmental barriers; and (4) enhancing environmental support and resources" (p. 679).

Empowerment is an important construct for understanding and improving the lives of people of marginal status, i.e., those with disabilities, ethnic minorities, older adults, women, and others seen as lacking power. A variety of individuals and groups lack power relative to others in society, and subsequently experience difficulties in access to health care, diminished financial resources and support. Fawcett et al. (1994) report on their collaborative research and case study approach to studying people with physical disabilities. They present eight (8) case studies of collaborative partnerships to illustrate different activities within empowerment, but only one is reported here.

As described earlier, empowerment refers to the process by which people gain some control over valued events, outcomes, and resources (Fawcett et al., 1995). A model is presented in the study of empowerment, with strategies outlined and tactics that flow from the model (p. 679). They describe five (5) interrelated elements of a framework for the process of empowerment in collaborative partnerships: collaborative planning; community action; community change; community capacity and outcomes, and adaptation, renewal, and institutionalization (p. 681-682). Person or group factors are described as being relatively strong or vulnerable in their capacity to influence. Environment factors are described as exerting control at various levels: the micro-level; meso-level; and meta- or systems-level. Stressors and barriers and support and resources are two major factors that contribute to the environment's capacity to facilitate.

Eight (8) cases show the use of different combinations of empowerment tactics within a variety of contexts presented in this study. The eight (8) cases describe 18 intervention tactics that flow from their model. For purposes of this reference, only one referring to coalitions will be described here.

The one case study describes a disability advocacy organization, a grassroots community coalition. Over a three-year period, the researchers collaborated with members of the coalition to study the effects of training on advocacy group members and leaders. Results showed increases in the number of disability-related issues reported during meetings by trained members and consistent improvements in chairperson performance following training. Interviews and review of records, showed that activities and outcomes of the members' actions increased. For the future, if the pattern of behavior related to empowerment is transmitted to new group members, it may strengthen the culture of empowerment. A case study approach is appropriate for the construct of empowerment.

A quantitative approach to studying the empowerment construct is presented here with the McMillan et al. (1995) study. The purpose of the study was to examine three (3) broad areas: What individual characteristics were related to the psychological empowerment of coalition members? What organizational characteristics were related to the collective empowering of members? What characteristics were related to its being organizationally empowered, i.e., successful in influencing its environment? (p. 699). Organizational empowerment was defined to mean the extent to which a coalition was able to effect the policy decisions and resource allocations of other influential community institutions. Coalitions are important for their utility of working on and solving community issues. While many studies have been done to test theories and ideas, the ability and/or

commitment to collaborative problem solving and to local ownership of solutions is different when trying to put theories into practice using concrete terms or notions.

The concept of empowerment at the individual level and at the group level were tested as predictors for organizational effectiveness, i.e., the outcomes, within coalitions. Understanding psychological empowerment is difficult because it is such a nebulous, abstract term. McMillan et al. (1995) report several past researchers in the literature have conceived empowerment to be of a higher order, subsuming all other constructs. These researchers have indicated there are two important themes that run through most of the empowerment literature, each reflecting the emphasis on empowerment as action: first, empowerment is an ongoing social action; and second, empowerment is an intersectional process between the individual with the collective (a group, organization, or community unit) (p. 701). Other researchers reflect that empowerment may refer "to values, processes, or outcomes" or "to activities at the level of the individual, the organization, or the community" (p. 700).

Five constructs were identified as incorporated under psychological empowerment: perceived knowledge and skill development, perceived participatory competence, expectancies for future individual contributions, perceived group/organization accomplishments, and expectancies for future group/organizational accomplishments.

The authors identified four (4) major categories or sets of independent variables that work together to influence psychological empowerment. The four (4) major categories included demographic variables; community perceptions and attitudes; participation; social climate variables; organizational perceptions and participation. The dependent variables included: psychological empowerment, using five scales on the

instrument; and organizational empowerment, derived from two (2) items in the interview. Psychometric information regarding scale construction, response formats, and reliability were discussed in the article.

Rhode Island had community coalitions, termed "task forces," charged with generating comprehensive prevention plans sensitive to the unique combination of risk factors and resources present in each community. There were 35 local task forces. Data were gathered from all 35 task forces, including a mailed survey and telephone interviews with key informants.

The instruments used included a Task Force Member Survey and a Key Informant Telephone Survey. The survey was administered to each of the members of the 35 groups. The purpose was to gather demographics, participation level, prevention knowledge and expectations, perceptions of social climate and more. The interviews included 3 central community figures, president of the town council, chief of police, and the superintendent of schools from each of the communities. The purpose of the interviews was to provide independent confirmation of task force existence, visibility, acceptability, and perceived impact of task force activity in their respective communities.

The data were analyzed in several stages: first, a principal component analysis (PCA) was done on the dependent variables; then to refine the predictor variable set, two (2) PCAs were performed. A hierarchical stepwise multiple regression analysis was performed with the composite psychological empowerment variable as the dependent variable. None of the six variables from the demographic set was significantly associated with empowerment. All six (6) of the independent variables in three of the sets were significantly associated with psychological empowerment with the strongest contributors

identified as organizational climate and participation level. Here we view evidence of how quantitative research has a place within the study of empowerment and collaborative community planning partnerships.

Nixon's (1998) model of empowerment is rather simply stated: "*thinking global; acting local*" (p. xxiii). He believes that in order for people to make a difference, they must understand the whole situation and have as much information available to base their decisions. They also must have shared values, vision and purpose, and work together to achieve the goals and strategies they have developed in their partnerships. Nixon (1998) offers six principles to improving the relationships between the individuals or groups, and the environment:

(1) win the hearts and minds of all stakeholders;

(2) empower and enable;

(3) learn how to both value diversity and unite people in common cause;

(4) be excellent in responding well to uncertainty, complexity and change;

(5) love our work and love ourselves; and

(6) have an attitude of long-term stewardship. (p.14).

Gutierrez et al. (1998) also discuss empowerment as the relationship between individuals, groups, or communities and the ability to gain power. The authors, just as Nixon, reports that as a practice, empowerment "involves a value base, sanctions for intervention, a theory base that guides practice, guidelines for the client-worker relationship, and a framework for organizing the helping activities" (p. 5). She offers several components as particularly significant to empowerment practice, including:

attitudes, values, and beliefs; validation through collective experience; knowledge and skills for critical thinking; and action.

Fetterman, Kaftarian, and Wandersman (1996) also offer similar information in their empowerment model, calling it the principles of empowerment evaluation, which include training, facilitation, advocacy, liberation, and illumination. The authors emphasize that individuals must take responsibility for their actions, must have the environment conducive to sharing successes and failure in a supportive manner, and must be willing to learn.

In summary, the importance of recognizing how individuals are part of a bigger system is the basis for the ecological and empowerment stance. The literature also emphasizes the importance of empowerment to enhancing effectiveness and functioning of community planning groups. Therefore, empowerment theory is relevant to this study. This study will focus on the preconditions, structure, process, and outcomes of community partnerships as well as how individual members perceive their roles and responsibilities to fully understand the characteristics contributing towards effective planning partnerships. The next area for discussion is that of organizational effectiveness and how it relates to this study of community health partnerships.

Organizational Effectiveness

Ample evidence exists in the literature about organizational effectiveness from the business area, but little regarding inter- or intra-organizational effectiveness. Public-private partnerships are relatively in the infant stages as a means to conduct business between governmental and non-governmental, private enterprise (Ettlinger, 1994). Most of the public-private partnerships have been developed between a governmental agency and a

private organization to accomplish a task. The literature contains evidence of studies conducted within private organizations (Campion et al., 1993), but little in the area of community health planning entities. Little evidence exists that shows the relative success of such community planning partnerships and the impact within local communities.

While little is found in the literature on the subject of intra-organizational effectiveness, there is ample evidence of various studies on the subject of organizational effectiveness. Other factors contributing to effectiveness include evidence that having a structural support system in place to support the coalition activities and a favorable political climate suggesting that change is possible (Hoagwood, 1996; Moos, 1996; Nelson, 1994). In the discussion of organizational effectiveness, reference is further made to teams and team performance because of the ample related literature on teams and the contribution towards effectiveness.

A quantitative study on characteristics of groups and teams relates to organizational effectiveness (Campion et al., (1993). The establishment of groups and group behavior is under the psychological realm, but the psychological approaches to work design have been in conflict with traditional business and engineering approaches used to increase efficiencies and effectiveness. Psychological approaches traditionally have not addressed outcomes, efficiency and effectiveness issues for organizations and community planning groups. This study contributes to the literature in three ways. First, it contributes by reviewing a wide range of literature and deriving five (5) common themes of work group characteristics that may be related to effectiveness. The authors reviewed social psychology, socio-technical theory, industrial engineering, and organizational psychology. Second, it contributes by relating the characteristics to effectiveness criteria in

a field setting with natural work groups. Third, it relates by being more methodologically rigorous than previous studies. Therefore, the approach taken in this study is comprehensive and is undertaken with concepts from the organizational theory and development area of research and literature, adopting a work design perspective on groups, and examining relationships between design characteristics and various outcomes.

Effectiveness criteria were derived from the literature on effective work groups, and then characteristics representing the themes were related to the criteria. The themes include job design, interdependence, composition, context, and process. Effectiveness criteria included productivity, employee satisfaction, and manager judgments.

Results indicated that all three effectiveness criteria were predicted by the characteristics and nearly all characteristics predicted some of the effectiveness criteria. The job design and process themes were slightly more predictive than the interdependence, composition, and context themes. Except for task identity, all the characteristics showed positive relationships with most criteria. Self-management and participation were the most predictive. This study has significance on the current research presented in this paper because of the characteristics of effectiveness being a large reason for conducting the study in the first place. This study just relates the importance of effectiveness criteria as a predictor for organizations, and generalizing it to community planning partnerships.

The discussion of team performance measures by Cannon-Bowers and Salas (1997) includes both process measures and outcome measures evaluated both at the team level and at the individual level. They give straightforward definitions of process and outcomes measures (Cannon-Bowers & Salas, 1997). The term *process* is defined as "the

collection of activities, strategies, responses, and behaviors employed in task accomplishment," while the term *outcomes* is defined as "the outcome of the various task processes" (p. 51).

Cannon-Bowers and Salas (1997) describe various measurement tools to assess team performance measures, as represented in Figure 4. While their model suggests measures used in training, it may be applied to other work and practice areas, as well as to community health partnerships. Their discussion begins with their reasons for first assessing individual outcomes to determine if the individuals provide evidence of knowledge, skills, and abilities to be effective. Then they describe the importance of individual process measures that measure how the individuals accomplish their task. Once individual members are assessed, the next step would be to assess team process, showing how the team accomplishes its objectives. The assessment of team outcomes would assess the effectiveness of the team in accomplishing its objectives (p.58). They recommend that measures be sampled from all four quadrants.

Figure 4. Measurement Tools to Assess Team Performance

	TEAM	INDIVIDUAL
PROCESS	▪ Observational scales ▪ Expert ratings ▪ Content analysis ▪ Protocol analysis	▪ Decision analysis ▪ Policy capturing ▪ Protocol analysis ▪ Observational scales
OUTCOME	▪ Observational scales ▪ Expert ratings ▪ Critical incidents ▪ Automated performance recording	▪ Automated performance recording ▪ Critical incident ▪ Expert ratings ▪ Archival records

(Source: Cannon-Bowers & Salas, 1997)

Consortium functioning and effectiveness can also be focused on two other levels: administrative and client (Bazzoli et al., 1997; Fleishman et al., 1992; Goodman & Wandersman, 1994; Goodman et al., 1996; Penner, 1995). The administrative level refers to decision making and fundraising activities. Several indicators of functioning include frequency of meetings and communication, consensus and the degree of trust, cohesion or conflict among members. The client level mechanism refers to case management: the roles, the tasks, and the outcome of solving individual level client problems. Other methods of addressing effectiveness include the review of the consortium's structural characteristics; membership; memorandums of agreement; policies and procedures; by-laws; and lead agency identity and nature (Fleishman et al., 1992; Kieler et al., 1996). A significant awareness has been raised within the literature of the importance of processes' and outcomes' impact on coalition effectiveness (Butterfoss et al., 1996; Cook et al., 1994; Dittmar & Gresham, 1997; Fawcett et al., 1997; Hansen & Kaftarian, 1994; Hoagwood, 1996; Mansergh et al., 1996; Rizakou et al., 1991; Scrimshaw et al., 1991; Thomas & Morgan, 1991).

In the HIV/AIDS health care field, the lead agencies are responsible for the administrative and fiscal duties of the consortia. Lead agencies should have a close relationship with the local consortium, knowing the roles of each, as well as the responsibilities. Often, though, difficulties arise because there is confusion of roles and responsibilities. In a study of lead agency identity and consortium cohesion (Fleishman et al., 1992), the authors report that internal cohesion was related to the identity of the lead agency. There appeared to be greater cohesion if the lead agency was a health department, and less cohesion if the lead agency was a hospital or community-based organization.

They studied the relationship between structural characteristics and consortium cohesion, identifying factors that may enhance or inhibit consortium functioning. While many other articles can possibly be found on organizational effectiveness, a brief view of this perspective was necessary in relationship to health and HIV/AIDS.

A review of the literature within the construct of organizational effectiveness showed several important factors contributing to effectiveness. Important factors consist of the following: having a structural support system in place to support the coalition activities; a favorable political climate; team performance; job design; interdependence; composition; context; and process. Other effectiveness criteria included productivity, employee satisfaction, and manager judgments; having process and outcomes measures; frequency of meetings and communication; consensus and the degree of trust; and cohesion or conflict among members. Additional effectiveness characteristics include structural characteristics; membership; memorandums of agreement; policies and procedures; and by-laws. These factors are important in the ecological understanding of community planning partnerships.

Summary

This literature review provided a comprehensive summary of community health planning in an ecological, or environmental, community context. In addition, the major components of community partnerships and their characteristics; collaboration; group and team work; empowerment; and organizational effectiveness were explored. The role of community health partnerships has developed significantly since its initiation into health care policy and practice and has been used as a means to plan for complex health issues.

The literature review in this chapter focused on community planning partnerships and characteristics contributing to the functioning and effectiveness. Little research has been done to date on the effectiveness of Ryan White consortia and/or planning councils. The literature provided the framework and confirmed the need for this study.

CHAPTER III

METHODOLOGY

This section provides an overview of the procedures and methodology utilized in the study. Included in this section are descriptions of how the population and sample were defined and selected, how the sites were chosen, the procedures undertaken to obtain consent, the study design, how the data were collected and analyzed, limitations, and a statement for managing personal bias in the study. The study design is qualitative, with a quantitative component, using a case study approach with two (2) HIV/AIDS community planning partnerships (i.e., consortia, planning council, care council) in Florida reported to be functional, collaborative, and effective.

The HIV/AIDS consortia and planning councils mandated under the Ryan White CARE Act are composed of individuals from the following groups: public health sector, community-based organizations, providers, governmental entities, and people living with HIV/AIDS disease. The terms consortia and planning councils are specifically used in the health care area of HIV/AIDS to refer community partnerships that provide oversight of patient care funds, but all three (3) terms may be used intermittently.

Setting and Sample

HIV/AIDS planning councils and consortia are responsible for the planning and coordination of HIV/AIDS services within their respective regional areas. Fourteen (14) regional areas within Florida are identified by the State of Florida for purposes of program planning and allocation of funding. A regional area varies in the geographic size, population and number of counties. An area may consist of one (1) large county, such as Dade County, which includes the populous city of Miami; or cover an area consisting of

16 counties, such as the rural counties in North Central Florida, surrounding the cities of Gainesville, Leesburg, and Ocala. For the purpose of this study, the 14 regional consortia are considered to be the population and a sample of two (2) HIV/AIDS planning partnerships from two (2) different regional areas were chosen for this study.

Purposeful sampling (Bogdan & Biklen, 1992; Denzin & Lincoln, 1998) was used in choosing particular sites and consortia. The researcher was interested in knowing why some of the Ryan White planning partnerships were purported to be more effective than others in Florida. In pursuing the selection of specific areas for this study, the researcher contacted key staff at the Bureau of HIV/AIDS within the Florida Department of Health. Because the staff at the State Bureau of HIV/AIDS have had extensive experience working with the consortia throughout Florida, the staff in the Patient Care Resource Section, the Contract Section, and in Administration, were asked to identify consortia which were perceived to be functional and effective. The verbal responses from all the staff contacted at the Bureau of HIV/AIDS were recorded on a chart. Those Ryan White consortia identified as the most effective and cited the most often were then selected as the sample sites. Additional reasons for choosing the two specific sites include comparing different consortia members' views of their particular setting and contrasting the views across the two (2) settings.

The sample of consortia chosen was limited to two (2) regional areas for several reasons. First, the two sites were chosen to keep the scope of the study manageable. Second, the two identified sites had the potential of offering insights into the positive qualities and characteristics of effective community planning partnerships. Third, other consortia were not chosen for the study because many were reported to be refocusing

their efforts or currently had other factors which may have inhibited gathering data necessary for the study of HIV/AIDS community planning partnerships and their effectiveness.

As a result, the two (2) consortia sites selected for the study are located in two regional areas: Area 9, Palm Beach, and Area 4, Jacksonville. The Palm Beach area consists of only one county: Palm Beach. The Jacksonville area consists of five counties: Baker, Clay, Duval, Nassau, and St. Johns.

There are six (6) urban cities in Florida that receive Title I funding directly from the federal government and fourteen (14) regional areas that receive Title II funding passed from the federal government through the State Department of Health. Three (3) of the cities receiving Title I funding have combined their planning activities with the regional area receiving Title II funding. The sample partnership in Area 9 (Palm Beach) has a combined Title I planning council and Title II consortium to address both Title I and Title II planning and coordination. They call themselves the Palm Beach County CARE Council. The sample partnership in Area 4, Jacksonville, consists of a Title II consortium. The Title I planning council and the Title II consortium are still separate entities in Jacksonville, but they partner on several activities such as priority setting and resource allocation. The consortium in the Jacksonville area is named the First Coast CARES Consortium.

Study Approval and Informed Consent

A description of the proposed study was submitted to the Institutional Review Board (IRB) at the University of North Florida for approval. After approval by the IRB (Appendix C), the proposed study was verbally presented to the Executive Committee of

each community partnership, requesting permission to conduct the study. The Executive Committee of the Palm Beach County CARE Council and the First Coast CARES Consortium were provided with information regarding the planned study and how the researcher planned to maintain confidentiality.

An overview of the study was presented at each Executive Committee meeting, as well as the parts of the study in which participation was encouraged. Both Executive Committees agreed unanimously to recommend approval of this study to the full membership of each respective partnership at its next monthly meetings. Informed consent forms, represented by the Consent to Participate in Appendix D, were distributed and signed at each of the meeting presentations. Each of the members from each partnership's Executive Committee signed the Consent to Participate form. A total of 14 members of the Palm Beach County CARE Council Executive Committee agreed to participate in the study on March 21, 2000. The eight (8) members of the First Coast CARES Consortium Executive Committee agreed to participate in the study on April 3, 2000.

The study plan was then presented to each of the partnership's full membership at each partnership's next monthly meeting and approved. The total of 34 members of the Palm Beach County CARE Council agreed to participate in the study at the meeting held on March 27, 2000, inclusive of the 14 members of the Executive Committee and the 20 additional members. In addition to the eight (8) members of the First Coast CARES Consortium, an additional six (6) members of the First Coast CARES Consortium agreed to participate in the interviews only and surveys at the meeting held on April 12, 2000, while everyone else agreed to participate in the observations. A total of 22 agreed to participate in the study from the First Coast CARES Consortium.

Individuals' identities were protected for those electing to participate in the interview process, observation, and survey completion and submission. The study was designed to ensure participants complete anonymity and included the following protections:

1. A confidential name and position listing assigning a coded number was initially developed for each phase and activity of the study.
2. The name list was kept by the researcher and was not revealed to any other persons.
3. All data were coded with no reference to names.
4. During the consortium meetings, the researcher drew a seating chart with a specific number on it, allowing her to identify the individual by number only and record information in observer notes by number only.
5. Interviews were conducted by the use of the same coded number system.
6. The questionnaires were anonymous and were not coded.

Therefore, if an individual agreed to participate in the study, he/she was assigned a number reference used by the researcher in all aspects of their participation: observation, survey, and interview.

Rationale and Basis for Case Study

This study was designed as a qualitative, two-site case study, with a quantitative component, to determine characteristics that contribute to the collaboration, empowerment, and effectiveness of a community planning partnership in the health care arena of services to people with HIV/AIDS. In order to describe the characteristics contributing to the collaboration, empowerment, and effectiveness of community planning

partnerships, understanding the perspectives of the members involved in Ryan White consortia within the context of their local community environments was important, as well as understanding the structure and process of each consortium. The researcher offers two purposes for this type of study (Marshall & Rossman, 1999). The first is exploratory because this particular research focuses on what is happening in the two community partnerships chosen and in identifying relevant themes or categories of meaning. The second is explanatory because this study attempts to identify relationships between individual members, the partnership, and the community environment, as well as relationships between the two sites.

Merriam (1998) indicates that the case study approach would be recommended if the researcher were interested in process. Gray and Wood (1991) indicated the contributions and importance that case study research has made on collaborative partnerships. The interactions of the participants and their perceptions of the functioning and effectiveness of the consortia would provide a frame of reference to the current actions of each consortium studied, providing an awareness of complex health issues, relationships, and decisions. Yin (1989) indicates that compared to single case studies, multiple cases are "often considered more compelling...more robust" (p. 52). Comparing the findings from this study with those of other studies may shed more light of the characteristics contributing to the effectiveness of community planning partnerships.

Several authors defined an action learning rationale for studying community social impact (Meissen & Cipriani, 1984; Morgan & Ramirez, 1983). Morgan and Ramirez (1983) state that action learning offers an approach to "inquiry, learning, and organizational design in terms of minimum critical conditions which seek to enhance

capacities for individual and collective self-organization" (p. 1). Meissen and Cipriani (1984) report that doing research in the natural setting offers the community an opportunity to show governmental agencies that they are ultimately responsible for their individual and collective decisions and actions related to policy and funding of services (p. 372). Therefore, this case study is appropriate as it relates to the ecological approach discussed earlier by utilizing the action learning approach. The researcher actively engaged in learning about the partnerships in its community environment through the use of interviews, documents, surveys, and observations.

A review of the literature on research design and methodology indicated qualitative approaches were appropriate for this study because the research study includes the following conditions:

(1) It was conducted in a natural setting, exploring real situations.

(2) The researcher, as the instrument, attempted to capture and understand the participant's point of view.

(3) The researcher attempted to understand the meaning of interactions and occurrences, through observations, interviews, and reviewing documents.

(4) The research was analyzed through an inductive process rather than a deductive process.

(5) The research findings are descriptive, using words, not statistical data. There is quantitative data, though, embedded within the findings.

(6) The research includes a small sample, and the sample can be described as a unit, such as an individual, a group, or a community planning partnership (Bogdan &

Biklen, 1992; Denzin & Lincoln, 1998; LeCompte & Preissle, 1993; Merriam, 1998).

The study was conducted in the regional areas identified in a previous section to further understand how the interactions of the individuals and occurrences in the natural setting may contribute to the community planning consortium's effectiveness.

When studying the notion of community planning partnerships, and the concepts of empowerment, collaboration, and effectiveness in a community environment, it would be difficult to manipulate specific variables for experimental purposes. While the study itself is a qualitative one, there is a quantitative element embedded within it. In such a case study as this, it was important to participate in and observe many of the variables that may contribute to the collaboration, empowerment, and effectiveness of the community health planning partnerships under study. Huber and Van de Ven (1995) report that the combination of both quantitative and qualitative data can be beneficial in several ways:

a. It can be highly synergistic, as well as offer triangulation.
b. Quantitative evidence can indicate relationships that may not be salient to the researcher in qualitative data.
c. Quantitative evidence may bolster findings when it corroborates findings from qualitative evidence.

The qualitative data are useful for understanding the rationale or theory underlying relationships revealed in the quantitative data or may suggest directly theory that can then be strengthened by quantitative support.

Design

The study was designed to allow for adaptation and modification within a disciplined form and structure. Observations of consortia meetings, participant interactions, questionnaires and interviews, and analysis of documents were the principal methods for gathering the data. Using a variety of analytic tools enabled the researcher to develop a better understanding of what happens in effective and functional consortia. Multiple data-collection methods including quantitative evidence provided "for a stronger substantiation of constructs and hypotheses" (Huber & Van de Ven, 1995, p.73). Two instruments were used in this study as measures of effectiveness of the community partnerships in a quantitative manner to increase objectivity and decrease observer bias.

A timeline is presented in Appendix E describing the course of thestudy during the years 2000 to 2001: what was done, why it was done, and how it was done. A description of such activities follows.

Qualitative Methods

The first phase of the study was to attend the Executive Committee of the planning partnership within each area and to describe the study and gain consent for access and participation. Assurances were sought from several key participants (i.e., consortium chair, lead agency representative(s), and the HIV/AIDS Program Coordinator) prior to the meetings held in each area. The researcher needed cooperation at all levels and to gain access to needed resources, including staff time, materials, documents, and partnership members. Each of the two councils allowed the researcher to speak at their Executive Committee meeting and to present the information about the study. The Executive

Committees within each area approved the study and invited the researcher to attend and present the study to the whole partnership at its next meeting.

The Letter to Participants introduced the proposed study; stimulated interest in the proposed research, stressed the importance of the study, and encouraged participation. A sample letter to participants and consent to participate is presented in Appendix D.

The letter to participants and consent to participate form were distributed to each key participant in each partnership at regularly occurring committee and council meetings. The letter described the study and the form gained consent for access and participation. Other information was distributed to members at the Executive Committee meetings at both sites and included the timeline for the study, the conceptual framework, samples of interview questions, and a brief summary description of the two surveys.

During the second phase, data were gathered in the form of documents to learn about the structure and historical background of each consortium's activities. Eisner (1998) reports that documents are a rich source of information. An initial meeting with the lead agency staff was requested and held and a follow-up email message was sent to acquire the necessary documents to complete the study. The researcher followed the Document Review List, as represented in Appendix F, as a guide to assure the relevant documents were attained. As documents were received, they were checked off on the Document Review List and archived for further analysis. These documents were used to validate other information gathered from the observations, interviews, and surveys.

The third phase began in February 2000. The researcher began preliminary observation visits to each site in February 2000 to learn about the community and context from which each consortium functions and to observe the structure and processes of the

consortium meetings and behaviors of members. An initial observation schedule of dates available was developed in conjunction with the local consortium members, to include the researcher's attendance in six (6) consortia or committee meetings within each area during the study. A total of 17 observations, though, were conducted in the two study areas over a period of 13 months, from February 2000 through March, 2001. Seven (7) meetings of the First Coast CARES Consortium and 10 meetings of the Palm Beach County HIV CARE Council were included. The observations provided first-hand information about key participants report and how meetings and members function.

Observations were conducted with the participants' knowledge and consent. Tape recordings of the full partnership and committee meetings were recorded and comprehensive field notes were written for the purpose of validity, reference and credibility in addition to the forms described below. A comprehensive Observation Record Sheet (Appendix G) was developed by the researcher with the triple aim of avoiding bias, not overlooking important factors during a meeting, and ensuring adequate reporting within the frame of reference of the study.

In addition to the Observation Record Sheet, a three-page Observation Guidelines form was developed, as represented in Appendix H. The Observation Guidelines form was used to record the relevant occurrences at each meeting under the following generalized topical areas: physical environment; human and social environment; program activities and participant behaviors; informal interactions; language of participants; documents being used; and consideration of what is not happening. The Observation Record Sheet and the Observation Guidelines were developed by the researcher from various methods found within the literature about observations (Bogdan & Biklen, 1992; Denzin & Lincoln, 1998;

LeCompte & Preissle, 1993; Merriam, 1998). The forms were used to assure that the many elements and activities occurring during the observation time were captured.

Phase 4 of the study consisted of conducting 12 interviews of key people from both consortia during the months of February 2000 through April 2001. The consent to participate form included a checklist whereby consortium members indicated their willingness to be interviewed. After a review of the consent to participate forms from each partnership, the researcher determined key individuals would be representative of each role including leader, state and lead agency staff, and member. The chairperson or co-chairperson(s), the lead agency representative(s), the HIV/AIDS Program Coordinator, and two (2) other consortium members were then asked to be interviewed at each location. The interviews were conducted individually and audio-taped with the participant's approval. Each interview ranged in time from 30 minutes to 1 hour and 45 minutes. The purpose of the interviews was to meet and gain the perspectives of key participants from each consortium; to verify information gleaned from the literature, documents, or observations; and to seek out new information. The interviews allowed the participants to express their perceptions and feelings about their involvement with the consortium.

A matrix template, the Interview Guide (Appendix I), was developed to assure relevant domains of questions were included in the interview process and to avoid bias in the questioning. The interview guide was based on 12 major domains revealed in the literature as important community health partnerships, including the following: leadership; decision-making; communication; conflict; benefits-costs; organizational climate; staff roles; capacity building; member profile; recruitment pattern; organizational structure; and

community capacity. These domain areas could address the past, present, and future within the scope of the type of question asked of the interviewee. The Interview Guide contains six (6) types of questions: behavior and experience questions; opinion and value questions; feeling questions; knowledge and skill questions; sensory questions; and demographic and background questions.

A semi-structured listing of 40 general interview questions (Appendix A) was developed following the domain areas and types of questions of the Interview Guide. The literature suggests the development of semi-structured interview questions allows for greater flexibility during the interview process (Bogdan & Biklen, 1992; Denzin & Lincoln, 1998; LeCompte & Preissle, 1993; Merriam, 1998). The interview guide and listing of interview questions did not require the researcher to address questions in a particular order, but was designed to be used flexibly to elicit full and undirected accounts from participants and to assure completeness in covering the relevant domains and themes. The interviews covered the majority of the relevant domains under study.

Follow-up activities were accomplished during the period of time from April 2001 to August 2001, including several telephone conversations, communication by email, and the distribution of one of the surveys. These activities were used to clarify any outstanding questions and to validate what was found to date with key participants.

Quantitative Methods

During the months of February through August of 2001, as part of Phase 5 activities, two questionnaires were administered to each community partnership at different times. The two questionnaires offer quantitative measures and evidence to further validate the effectiveness of the community health planning partnerships. The two (2)

instruments utilized include the Application Quality Index (AQI), as indicated in Appendix J, which is a revision of the Plan Quality Index that Butterfoss et al. (1996) had used in their work, and the Group Environment Scale (GES), Second Edition (Moos, 1996).

Application Quality Index (AQI)

Over the period of several months in the summer and fall of 1999, the researcher discussed the development and uses of the Plan Quality Index with the author, Frances Butterfoss. During that time, permission was obtained from Butterfoss by e-mail (Appendix K) for the researcher to use the Plan Quality Index in this study.

As indicated in the literature (Butterfoss et al., 1996), the Plan Quality Index (PQI) instrument was developed and tested to measure the quality of plans developed by committees or groups. As a group develops in performance, and their task is to do needs assessments and develop plans, then a measure of the group's effectiveness will be the quality of the plan. Therefore, an indicator of effectiveness was to determine the relationship between the group and the quality of the plan.

The PQI was originally developed and has been used for several purposes: first, as a quantitative research tool to assess the quality of community plans, which is an indicator of the effectiveness of the community partnership (i.e., consortium, coalition, etc.); and second, as a qualitative consultation tool to communicate back to coalition staff and members on potential areas for improvements to their community-based plans and activities. The review of the literature about community based coalitions revealed many groups were developed and tasked to prepare comprehensive plans, but the literature and data failed to reveal the relationship of planning to outcomes. Health related community based coalitions often have goals that take a long time to achieve. If the goals are

ambitious, then planning is important for goal achievement and for continued satisfaction of the members. If planning is difficult to professional staff, then it is very challenging for community participants. Plans are important intermediate outcomes of the community-based coalition's work.

Butterfoss et al. (1996) indicated the PQI was developed by synthesizing evaluation criteria for judging planning documents from several sources in the literature. The elements of plan quality originally rated included four areas:

1) Clear and realistic objectives and activities. Three items that measure whether objectives and activities are clear, realistic, and reflect the goals and priorities identified in the need and resources assessments of the community;
2) Scope of the plan. Six items that measure the scope of the plan which covers timelines, staff, targeted populations and coordination with existing agencies and program;
3) Community Resources. Three items that measure the identification of resources in the community which would support the activities of the consortium; and
4) Overall impression of the plan quality. Six items that measure overall impression of the plan quality as a whole .

In the revised Application Quality Index, the same number of items in the goals and objectives section and the scope of the plan section remain. The community resources section now includes seven items, while the overall impression of the plan section now includes nine items. The total number of items in the current revision of the PQI includes 25 items.

The independent variables identified in the Butterfoss et al. (1996) study included leadership characteristics, staff-consortium relationships, decision-making influence, organizational climate, and community linkages. The dependent variables included the quality of the community plans for each consortium, member costs and benefits, member participation, and member satisfaction with the work and plan of the consortium. The predictors included organizational predictors and cost and benefit predictors. The hypotheses in the Butterfoss et al. study included the following:

1) the more positive characteristics that a consortium possesses, the more likely that an effective plan will be in place;
2) the more positive consortium characteristics will be associated with decreased member costs, increased member benefits, increased member satisfaction, and increased participation patterns; and,
3) increased member satisfaction and participation patterns would be associated with high-quality plans.

Butterfoss et al. (1996) described the reliability of the PQI (pp.67-68). Interrater reliability was established through Pearson correlations. In the developmental stages, 16 committee plans were rated by three individuals independently rating the plans. They assigned a score of 1 to 5 for each item on the PQI instrument that corresponded to the categories of 1 to 100% adequacy of the plan component. With the 18-item measure, each plan could receive a score ranging from 1 to 90 points. Fisher transformations were done on each correlation value to account for the lack of normal distribution for correlation statistics. Through factor analysis, the instrument was considered to be uni-dimensional and the 18 items were added to provide mean scores for each plan. Interrater reliability for

the 16 plans ranged from .58 to .86 and the final inter-rater reliability statistic was determined to be acceptable at .73. Validity of the instrument was not revealed directly in the literature.

The PQI was determined to be a useful instrument for this study. The original instrument was found to be confusing to a pilot group outside the two areas of study. The PQI was slightly changed, re-worded and restructured to fit the particular language and tasks of the HIV/AIDS consortia in the current study, but the integrity in the design of the items was not compromised as the original questions were used. The revised instrument was pilot tested with a group from a different site location than the two (2) selected study sites. As a result of the pilot test, the PQI instrument was revised two (2) other times and subsequently renamed as the Application Quality Index (AQI) for this study. The purpose of the renaming was to maintain the consistent language used in the Ryan White CARE Act guidelines which state that consortia and planning councils shall submit an annual application for funding, rather than a plan.

Since the staff of each partnership indicated that a small planning committee had developed the application or plan, the chairperson and the lead agency representative of each partnership suggested that the AQI be administered to each of the planning committees of each consortium.

The AQI was then attached to an email (a sample is documented in Appendix L) and sent electronically to each planning committee participant within each area. The email explained the purpose of the AQI and gave directions to completing the questionnaire and returning it to the researcher.

In the Jacksonville area, an email was sent to six (6) planning committee members. Five (5) of the six (6) members responded to the AQI. Three (3) respondents returned the questionnaires electronically and only two (2) people sent them back by U.S. postal service.

In the Palm Beach area, several different attempts were made to administer the AQI. The first attempt was on March 6, 2001, at a Planning Committee meeting, but the chairperson indicated during the meeting that the members of the committee were not knowledgeable of the annual application, so the researcher did not successfully collect the data. After that meeting the researcher discussed the need to accomplish the task of administering the AQI with the lead agency staff, who subsequently recommended her to contact a smaller group of four (4) members that actually had worked on the writing of the application. An email was then sent on June 4 to the smaller group of members that participated in the planning and writing of the annual application. No response was received even after further contact by the researcher. The researcher received a follow-up email message from the lead agency staff identifying six (6) members who participated in the writing of the application. On August 29, a final effort was made by the researcher to seek input from the six (6) members by sending another email message with instruction on how to complete the AQI and return it to the researcher. Three (3) individuals responded and sent their completed AQI survey responses to the researcher via facsimile.

Group Environment Scales (GES)

Social climates are defined as the personality of a setting or environment and have revealed a strong influence on individuals in various settings (Moos, 1996), as previously indicated in the literature review on social and human ecology. To determine the effect

environment has on the individual's behaviors and emotions and its relationship to the consortium's effectiveness, the Group Environment Scale (GES), Second Edition (Form R) was used to measure this relationship (Moos, 1996). The Group Environment Scale, with answer sheets and manual (Moos, 1994) were purchased from the publishing company, Consulting Psychologist's Press, Inc.. The company's policy stated permission was not necessary to use the GES in a study, but permission was necessary if the researcher included the instrument within a dissertation. Because this researcher did not include the instrument within this dissertation, permission was not necessary. The researcher subsequently used computer scored, scannable answer sheets.

The researcher requested 30 minutes on each of the agendas of the two (2) consortia meetings for the administration of the Group Environment Scale. Approximately 60 individuals received these instruments at both groups. The GES questionnaire was administered at the two (2) different sites, given to the members at the regular consortium meeting.

The researcher explained to the consortium members what the GES measured; how to respond on the answer sheets; and then distributed the test questions and the of computer-scannable answer sheets. The researcher then read each statement to the group verbally to assure that any potential illiterate members could succeed in completing the task. A cover letter was available to any individual member at a consortium meeting, along with a set of instructions, and a postage-paid return envelope, in the event that someone did not want to complete the form at the time it was verbally presented to the group.

The Group Environment Scale (GES), Second Edition, one of the ten *Social Climate Scales* developed by Rudolf H. Moos at Stanford University, is designed to

measure a group's social and environmental characteristics in terms of 10 scores. These are: cohesion, leader, support, expressiveness, independence, task orientation, self-discovery, anger and aggression, order and organization, leader control, and innovation. The items are designed to apply to a range of therapeutic, social and task-oriented groups. The scale has been used with sensitivity training groups, church groups, peace action groups, social clubs, and executive training groups. The GES takes approximately 15-20 minutes to complete and is used for adults in groups. The test may be administered orally or by reading and responding. Scoring is done by a template overlay. Raw scores are aggregated by sub-scale and converted to a standard score using tables given in the manual. The GES may be purchased from Consulting Psychologists Press, Inc.

The GES contains 90 items describing the various characteristics of groups, such as in the following examples: "there is a feeling of unity and cohesion in this group"; "this is a planning group"; "members often gripe"; "the leader doesn't expect much of this group"; "angry feelings are rarely expressed in this group"; and "the rules of the group are clearly understood by members." Individuals are directed to indicate whether they believe each statement to be true or false.

According to the Group Environment Scale Manual (Moos, 1994), 10 sub-scales assess three underlying dimensions (p. 1). Within the Relationship domain, three sub-scales (cohesion, leader support, expressiveness) are included; four sub-scales comprise the Personal Growth dimension (independence, task orientation, self-discovery, and anger and aggression); and three sub-scales are contained within the System Maintenance and System Change dimensions (order and organization, leader control, and innovation). Some of the sub-scales and test items may offer support to the hypotheses of this study. Table 2

shows how the researcher matched the GES dimensions, sub-scales, and items that may offer support to the hypotheses stated in Chapter 1. The researcher used the Real Form (Form R), which assesses individuals' perceptions regarding actual group settings.

Table 2. Supportive GES sub-scales and items to Specific Hypotheses

GES Dimension	GES Sub-scale	GES Items	Hypotheses Which May Be Supported
Relationship	Cohesion	1, 11, 21, 31, 41, 51, 61, 71, 81	#2 – There is no difference in group cohesion between the two partnerships. #6 – There are no differences in increased member participation and member satisfaction between the two partnerships.
	Leader Support	2, 12, 22, 32, 42, 52, 62, 72, 82	#3 - There is no difference in the perceived support between each partnership.
	Expressiveness	3, 13, 23, 33, 43, 53, 63, 73, 83	#1 – There is no difference in the social climate between each of the two partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.
Personal Growth	Independence	4, 14, 24, 34, 44, 54, 64, 74, 84	# 3 - There is no difference in the perceived support between each partnership.
	Task Orientation	5, 15, 25, 35, 45, 55, 65, 76, 85	#8 – There is no difference in the formality and structure between the partnerships.
	Self Discovery	6, 16, 26, 36, 46, 56, 66, 76, 86	#1 – There is no difference in the social climate between each of the two partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.
	Anger and Aggression	7, 17, 27, 37, 47, 57, 67, 77, 87	#1 – There is no difference in the social climate between each of the two partnerships. #5 – There is no difference in positive social climate characteristics evident between the partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.
System Maintenance and Change	Order and Organization	8, 18, 28, 38, 48, 58, 68, 78, 88	#8 – There is no difference in the formality and structure between the partnerships.
	Leader Control	9, 19, 29, 39, 49, 59, 69, 79, 89	#4 – There is no difference of leader control between the two partnerships.
	Innovation	10, 20, 30, 40, 50, 60, 70, 80, 90	#8 – There is no difference in the formality and structure between the partnerships.

The normative data are described in the Group Environment Scale Manual (Moos, 1994). The manual describes a sample composed of 130 groups and leaders from 112 groups, a total that includes data from the test development samples. The GES internal consistency for the 10 sub-scales ranges from .62 to .86, with the average in the mid .70s (using coefficient alpha) (pp.13-19). No value is given for the total scale. Test-retest reliability coefficients at a one-month interval range from .65 to .87 for the separate sub-scales, with no value cited for the total scale.

The validity data are different, however. Item-sub-scale correlations are moderate, with the sub-scales appearing to be relatively independent in terms of the reported inter-correlations. The authors do not give the exact number of cases included in the sample, only the number of groups from which scores were obtained; and they do not give the procedures used for sampling nor the social and cultural characteristics of the group.

Analysis and Interpretation of Data

Two sites were chosen for the study to not only glean meaning from each site, but to do a cross-case analysis that may suggest generalizations (Merriam, 1998) about community health planning partnerships and their effectiveness. Each site was initially analyzed as a separate case study, with both the qualitative and quantitative elements; then a cross case analysis occurred offering potential for greater construct and external validity. The literature indicates this may occur through the collection of data from the different settings and perspectives, and corrects for possible setting effects emerging from within the particular groups, or from the geographic or cultural context (LeCompte & Preissle, 1993; Merriam, 1998).

Bogdan and Biklen (1992) as well as Denzin and Lincoln (1998) offered specific suggestions for managing the data. The amount of data collected from each site was enormous, including numerous documents from each site; field notes of interviews and observations; tape recordings and transcripts from the interviews; and responses from the two (2) quantitative instruments. The researcher developed an organizational system to immediately organize each data element upon receipt by completing a "Field Notes Cover Sheet," as found in Appendix M. This cover sheet allowed the researcher to immediately note the date, time, site area, activity, and any materials to be archived and filed for later analysis. The researcher stapled her field notes to the cover sheet, placed it in a colored plastic, see-through folder with any other materials supporting the activity, such as tapes, diskettes, and/or any documents. The plastic folders were color-coded to match each site area: green for Palm Beach, blue for Jacksonville. The researcher also had a 2-inch, 3-ring binder with copies of each form and worksheet that might be used in the field, organized by observation, interview, survey, or document. Included in each binder was also a calendar and schedule identifying each partnership meeting throughout the study period, contact information within each site; and consent to participate forms with contact information of members. Analysis began immediately upon receipt of data to identify and develop categories that needed further investigation or explanation. This analysis was an ongoing iterative process, moving back and forth between the data and the emerging themes and meanings.

Triangulation was employed to overcome any bias inherent in any one method, and to increase validity, by using a 5-page matrix worksheet titled "Analysis Worksheet: categories and terms within theoretical frameworks," which is presented in Appendix N.

Initially, documents, interviews and observations were analyzed through content and a codification process of the materials gathered by using an Observation Guideline and an Interview Guide. This was found to be too restrictive, so the researcher developed the Analysis Worksheet (Appendix N) to assist in the analysis of all the data. The Analysis Worksheet identifies the seven (7) theoretical frames as presented in Chapter 2 of this study and the various characteristics or factors of community health planning partnerships found in the literature. The researcher listed the theoretical frames across the top; and as each characteristic was presented in the literature, it was listed down the left side of the Analysis Worksheet. As the analysis progressed, the worksheet was used to list other characteristics or factors that emerged from the data, but was not identified in the literature. This allowed the researcher to identify those characteristics relevant in one or more of the theoretical structures. The Analysis Worksheet was used in the analysis of the documents, interviews, and observations, and to further validate the findings. The Analysis Worksheet facilitated categorization of major themes that emerged from the data.

Analysis of content was utilized as suggested by Denzin and Lincoln (1998) and Merriam (1998) as a method to analyze documents and transcripts of interviews and observations for a qualitative study. Observations and interviews were transcribed, codified and analyzed for content. By reviewing categories from the data, patterns or themes emerged within each site, as well as across both the sites. Each procedure identified as part of the study was analyzed for each site, then an analysis was conducted on the similarities and differences between the two sites, thus producing further findings. Highlights from the analyses appear in Chapter 4, and a discussion of the findings can be found in Chapter 5.

The analysis of the Group Environment Scale (GES), Second Edition, involved using SPSS 10.0 for non-parametric data, including Pearson's chi-square statistical test. The hypotheses were tested using the GES' sub-scales and related items, as indicated in Table 2. An alpha of .05 was used to determine the statistical significance of the findings. The other quantitative measure, the Application Quality Index (AQI), was analyzed by identifying the frequency and percentage of each response. The quantitative data were hypothesized to further validate the qualitative findings.

Limitations

Several limitations may be offered at this time. First, the study was limited to only two (2) sites. Each of the partnerships chosen operated under the same federal and state guidelines, although each offered its own interpretation of such guidelines. Both sites had been identified as effective and functional. The distance between the sites was a limitation. Access was determined based on each partnership's meetings and the availability of the researcher to attend meetings on specific dates for the observations, the interviews, and the survey administration. Another limitation was not having more time to attend the various committee meetings within each location. Committee meetings often provide more specific and minute detail of relationships and decisions related to partnership business.

The restricted timeline of the study was also a limitation. In order to carefully ascertain the characteristics of the community health planning partnerships under study, additional time was required beyond that initially proposed. While this study could have collected further information over a longer period of time, aspects of the partnership may have changed if such a study were longitudinal. In the year and a half the researcher was involved with each planning partnership, changes occurred in people involved in the

partnership activities and processes within the local area; the chairpersons changed as well as staff members in each of the lead agencies. In addition to time, cost factors related to travel placed a limitation to the completion of this study.

Managing Personal Bias

The researcher currently works in the health care field and had been a regional HIV/AIDS state program coordinator in the past related to HIV/AIDS prevention and patient care administration. She is experienced with community planning partnerships and may have been biased because of her past experience. Another factor for consideration may be that working with colleagues in other parts of the State may have impeded objectivity. On the other hand, the researcher is quite knowledgeable and conscious of the context and nature of HIV/AIDS and the variety of issues surrounding community health planning efforts in this context. This experiential awareness provided the knowledge for the rich interpretation of the data collected and the ability to provide clarity and meaning. In any case, the researcher strove to be as objective as possible given the subjective nature of the study. Also, quantitative data were used to maintain objectivity and to offer triangulation of the qualitative findings. The researcher attempted to be as open, tactful and forthright as possible without harming the integrity and self-respect of another person, hopefully gaining the trust and respect of the participants.

Summary

Community health planning partnerships are complex entities and are often over-looked by those people in positions of power who require or recommend their existence. The literature is very limited in providing empirical evidence of community planning partnerships and their effectiveness, especially in the HIV/AIDS patient care delivery

system. Gray and Wood (1991) report the majority of research had been based on case studies, often providing further questions and impetus for further research. Information that emerged from this current study will fill a gap of knowledge in research and provide needed answers to the questions of collaboration, empowerment, and effectiveness in partnerships. Individuals with HIV/AIDS are often too ill to work through health care systems to access the needed care. If community health planning partnerships, or HIV/AIDS consortia in this case, are effective and functional, they will provide for a quality system of patient care, making it easier for such individuals to access the care they need.

This study of HIV/AIDS consortia in Florida used both qualitative and quantitative data collection and analysis methods. Two (2) sites, purported to be effective, were chosen through consultation with Florida Department of Health staff. Data were collected and analyzed from observations of consortia meetings and member interactions, interviews, survey instruments, and written materials from each site. The findings from this study can be found in Chapter Four and are discussed in Chapter Five.

CHAPTER IV

ANALYSIS OF THE DATA

This chapter describes the findings from the study of two (2) HIV/AIDS community health planning partnerships in the Jacksonville and Palm Beach areas of Florida. This study was designed to identify and describe the possible characteristics of collaborative, empowered, and effective community partnerships (i.e., Ryan White Title I and Title II HIV Planning Councils and Consortia) from an ecological perspective.

The results of the investigation are presented in six (6) sections and organized by the two (2) sites. In the first section, a summary provides a description and comparison of the sites and the participants. The second section discusses the data obtained from selected documents. Then, the findings derived from the observations of the meetings are reported and analyzed. In the fourth section, findings from the interviews are reported and summarized. The fifth section includes a report and analysis of the responses from the two survey instruments. The sixth section addresses the cross case report and analysis between the Jacksonville area partnership and the Palm Beach area partnership. A summary of the methods used to study the two partnerships is reflected in Table 3.

Table 3. Summary of Methods Used to Study the Two Partnerships

Method	Area 4, Jacksonville – First Coast CARES Consortium	Area 9, Palm Beach - Palm Beach County HIV CARE Council
Setting Observations	Participant-observation of four (4) full partnership meetings; three (3) Executive Committee meetings; and one (1) other committee meeting.	Participant-observation of two (2) full partnership meetings; three (3) Executive Committee meetings; and two (2) other committee meetings.
Document collection	Collected numerous documents.	Collected numerous documents.
Interviews	Semi-structured interviews with 6 members at one point in time.	Semi-structured interviews with 6 members at one point in time.
Survey Administrations	Administered two (2) survey instruments:	Administered two (2) survey instruments:
	The Group Environment Scale was administered to the full partnership of 32.	The Group Environment Scale was administered to the full partnership of 38.
	The Application Quality Index was administered to a small group of 6 individuals assisting with the development of the plan.	The Application Quality Index was administered to a small group of 6 individuals assisting with the development of the plan.
Analysis	Occurred within each method, and compared for similarities and differences with other site.	Occurred within each method, and compared for similarities and differences with other site.

The Sites and the Participants

The focus in the present study included two (2) HIV/AIDS community planning partnerships within two (2) separate regional areas of Florida. One of the partnerships, the First Coast Consortium for AIDS Resources, Evaluation and Services (i.e., 1st Coast CARES), is located within the Jacksonville regional area (Appendix O). The other community planning partnership, the Palm Beach County HIV CARE Council, is located

within the Palm Beach County regional area (Appendix P). A discussion of the structure of the planning partnerships is presented in this section.

Area 4, Jacksonville

The First Coast Consortium for AIDS Resources, Evaluation and Services (CARES) is located in the Jacksonville Service Area, consisting of five (5) different counties located in the northeast area of Florida which include Baker, Clay, Duval, Nassau, and St. Johns counties, as found in Appendix Q. The administrative lead agency for the First Coast Consortium for AIDS Resources, Evaluation and Services is the Jewish Family and Community Services, Inc. (JFCS), a non-profit agency. They are located in the city of Jacksonville, Florida.

The Fiscal Year 2000-2001 Title II Application (p. 95) from the First Coast Consortium for AIDS Resources, Evaluation and Services indicates that JFCS received approximately $768,729.00 during the fiscal year 1999/2000 from the State of Florida, Department of Health to serve approximately 1,034 people with HIV/AIDS. A memorandum of understanding is signed annually by the JFCS and the Consortium identifying roles and tasks of each entity. The consortium agrees to follow the guidelines established by the Ryan White CARE Act, and JFCS agrees to sign a contract with the State to act as the lead agency for the consortium for fiscal, administrative and contractual duties. The First Coast CARES Consortium is governed by bylaws created by the consortium members and originally approved in September of 1996. The consortium had undergone a re-structuring in the summer of 2000 and at that time, the bylaws were revised.

The mission of the consortium is to "foster and promote effective communication, inclusion, collaboration, cooperation, advocacy, and education through an open, comprehensive, innovative approach that meets with compassion and dignity the multifaceted needs of persons affected by HIV/AIDS in northeast Florida" (Bylaws of the First Coast CARES Consortium, 2000, p. 1).

The values of the consortium, as listed in the Bylaws, include the following six (6) key principles:

1. Decisions made...must reflect the interest of all members of the HIV/AIDS community;
2. The Consortium must draw its strength from the diversity of its members and clients;
3. Meeting the needs of the HIV/AIDS community will require the utilization of a broad range of community resources;
4. The Consortium must work together with service providers, community-based organizations, agencies, and other planning bodies to provide the needed continuum of services;
5. Services must be provided equitably throughout our service area in Northeast Florida; and
6. All persons in need of and receiving services must be treated in an equitable manner, with dignity and respect. (2000, pp. 1-2)

The purpose of the Consortium is also identified in the Bylaws and includes the following key areas:

1. To serve as a planning body for health and social services for people with HIV/AIDS;
2. To promote greater cooperation among all agencies delivering HIV-related health and human services;
3. To solve problems collaboratively regarding the major issues in health, social service and quality of life for people with HIV disease living in the service area;
4. To assure a comprehensive continuum of care is available to all people in the service area who are infected or at risk for infection with HIV;
5. To provide information to community providers and residents in order to increase accessibility and visibility of HIV-related services; and
6. To monitor implementation plans of service providers and evaluate services provided. (Bylaws, 2000, p.2)

The annual application further indicates there are approximately 214 active and inactive members of the consortium (p. 96), as displayed in Table 3. Of those 214 members, approximately 40 are active members, but the number varies from month to month. The consortium represents a diverse membership.

Table 4. Membership of the First Coast CARES Consortium, Jacksonville

	Female		Male		Total	
Race/Ethnicity	#	%	#	%	#	%
African American	10	25	5	12	15	37
Caucasian/White	8	20	14	34	22	54
Latino/Hispanic	0	0	1	3	1	3
Asian/Pacific Islander	0	0	0	0	0	0
American Indian-Alaskan Native	0	0	1	3	1	3
Other or Unknown	0	0	1	3	1	3
TOTAL	18	45%	22	55%	40	100%

From the Fiscal Year 2000-2001 Application (p. 96-97), there are 15 African Americans, 22 Caucasian/Whites, one (1) Latino/Hispanic, no Asian/Pacific Islanders, one (1) American Indian/Alaskan Native, and one (1) other or unknown. Of the 40 members, 18 are female and 22 are male.

The Bylaws of the First Coast CARES Consortium indicate active voting members are those who have completed orientation and attended at least two of the last three different consortium meetings. Active members have the right to participate in the decision making process of the consortium. The consortium attempts to have various people represented from a variety of agencies and organizations within the communities it serves, as well as recruit persons with HIV/AIDS.

The consortium now meets at least six (6) times per year and conducts the work at the consortium meetings. In the restructuring that occurred in 2000, the consortium did away with the four working committees, including finance, education and recruitment,

planning and linkage, and PLWHIV/AIDS. The consortium now conducts all of its work at the full consortium meetings. Additionally, there are four (4) educational meetings during the year. The consortium also identifies in their bylaws that they follow the consensus decision making process.

Area 9, Palm Beach

The Palm Beach County HIV Comprehensive AIDS Resources Emergency Council (CARE Council) office is located in Riviera Beach, a city within Palm Beach County in the southeast area of Florida. The CARE Council is the community health planning body responsible for the oversight of four (4) different funding sources: Ryan White CARE Act Title I and Title II, Housing Opportunities for People with AIDS (HOPWA), and Patient Care Network/General Revenue. The administrative lead agency for the Palm Beach County HIV CARE Council is the Treasure Coast Health Council, Inc. (TCHC), a non-profit agency located within the West Palm Beach Service Area, as found in Appendix P. The agency also provides staff for the CARE Council through contract with the four (4) funding sources. The County of Palm Beach is the Title I grantee responsible to HRSA for the planning and coordinating of services, receiving approximately $7.9 million during fiscal year 1999-2000. The Fiscal Year 2000-2001 Title II Application (p. 32) indicates TCHC received approximately $604,941.00 during the fiscal year 1999/2000 from the State of Florida, Department of Health, to serve approximately 670 people with HIV/AIDS. The City of Palm Beach is the grantee for the $2.5 million of HOPWA funds; and the county health department is the recipient of approximately $1.2 million for services. The total funding planned for during fiscal year 2000-2001 is approximately $12 million, of which the CARE Council is responsible for the

planning and coordination of service delivery (Palm Beach County Title II Application, Fiscal Year 2000-2001, page 43).The Palm Beach County HIV CARE Council is governed by bylaws created by the consortium members. The most recent bylaws were approved in September of 1998.

The mission of the CARE Council "shall be a collaborative and balanced body of HIV infected and affected individuals, service providers, community leaders and interested individuals whose responsibilities shall be to plan, develop, monitor, evaluate and advocate for a medical and support services system for individuals and families affected by HIV spectrum disease" (Palm Beach County HIV CARE Council Bylaws, 1998, p. 2).

The purpose of the CARE Council follows the duties outlined in the guidelines of the Ryan White CARE Act. The CARE Council functions as both the Ryan White Title I HIV planning council and the Title II AIDS Consortium as mandated under Titles I and II of the CARE Act of 1990, 1996 and 2000, respectively.

The officers of the CARE Council include a chair, vice chair, treasurer and secretary from the membership. The officers and the chairs of each standing committee form the Executive Committee of the CARE Council. The Executive Committee meets on a monthly basis one week prior to the full Council meeting. Meetings of the full CARE Council are held on a regular monthly basis, but the bylaws call for a minimum of only six (6) meetings.

The Council structures its work through committees. The Council has ten (10) committees that meet on a regular basis, usually monthly, depending on the nature of the committee. The ten (10) committees include the following: Planning; Assessment ad hoc; Priorities and allocations; Needs assessment sub-committee; Housing; Medical services;

Membership; Support services; Community awareness; and MIS. Committees make recommendations to the full Council in the form of motions. The full CARE Council will consider motions brought before it and follow the parliamentarian procedures of Roberts Rules of Order during the meeting.

The annual application further indicates there are approximately 37 individuals who are active members of the consortium (p. 33). The Palm Beach County HIV CARE Council represents a diverse membership, with membership evenly distributed from HIV infected and affected individuals, service providers and community leaders. The diversity of the membership of the consortium is displayed in Table 5. Individuals are recruited from a variety of agencies and organizations within Palm Beach County, with a minimum of 25% of the voting membership consisting of individuals who are HIV positive. The CARE Council membership requires a balanced membership of no more than 45 and not less than 21 members.

Table 5. Membership of the Palm Beach County HIV CARE Council

	Female		Male		Total	
Race/Ethnicity	#	%	#	%	#	%
African American	15	41	6	16	21	57
Caucasian/White	7	19	7	19	14	38
Latino/Hispanic	1	2.5	1	2.5	2	5
Asian/Pacific Islander	0	0	0	0	0	0
American Indian-Alaskan Native	0	0	0	0	0	0
Other or Unknown	0	0	0	0	0	0
TOTAL	23	62.5%	14	37.5%	37	100%

From the Fiscal Year 2000-2001 Title II Application (p. 33), there are 21 African Americans, 14 Caucasian/Whites, two (2) Latino/Hispanics, no Asian/Pacific Islanders, no American Indian/Alaskan Natives, and no other or unknown. Of the 37 members, 23 are female and 14 are male. The membership appears to be a diverse one.

Comparison of the Sites and Participants

The Area 4, Jacksonville, site includes an HIV/AIDS community partnership, the First Coast CARES Consortium (FCCC), which is responsible for serving five (5) counties in northeast Florida. The Area 9, Palm Beach, site includes an HIV/AIDS community partnership, the Palm Beach County HIV CARE Council (PBCHCC), which is responsible for serving only one county. The FCCC acts as the consortium responsible for Ryan White Title II funding from the state. The PBCHCC acts as both the planning council for Ryan White Title I funding and as the consortium for Ryan White Title II funding; it is a combined partnership.

Both of the partnerships have a non-profit entity serving as the lead administrative agency, providing oversight for the funding, coordinating partnership activities, and assuring all the requirements are met for the Ryan White CARE Act. The FCCC receives $768,729.00 for Title II. The PBCHCC provides for the planning and evaluation of the $7.9 million for Title I, $604,941 for Title II, $2.5 million for HOPWA, and $1.2 million of general revenue/patient care network funds.

Each of the partnerships has bylaws that set the governing policies and structure. Both the FCCC and the PBCHCC bylaws have 11 articles, each covering the following five (5) similar topics: name, membership, meetings, committees, officers. The FCCC includes sections on the following: policies, planning, contracts and expenditures of funds,

fiscal year, and books and records. The PBCHCC includes the following sections in addition to the five (5) similar ones of FCCC: voting and conflict of interest, grievance procedures, operating procedures, amendments, and effective date. The FCCC has a statement of values, while the PBCHCC does not. Both state their purpose and their mission.

The age range for the FCCC is 30-39, while the age range for the CARE Council is 30-49. In Jacksonville, 45% of the members are female and 55% male, while in Palm Beach, 63% are female and 38% are male. The majority of the Jacksonville consortium is white (54%), with 37% as African/American and 9% other. In Palm Beach, the majority of the membership is African/American (57%), with 38% white, and 5% other.

The FCCC bylaws do not provide a minimum nor a maximum number of members, while the PBCHCC states their minimum and maximum number of members. FCCC had an active membership of approximately 40 and PBCHCC had an active membership of approximately 37. Each of the partnerships had a small group of officers functioning on either a steering or executive committee. The FCCC originally had four (4) committees that did the work of the consortium, but during 2001 the committee structure was no longer in place. The PBCHCC functions through the work of approximately 10 committees meeting on a regular basis. Both provide education to their members.

The Documents

Written communications and documentation of the partnerships' work were included in the data-gathering stage of the study. The documents gathered from the two (2) sites include a variety of both internal and external means of communication. All documents received were read and sorted through for relevancy and direct applicability to

this study, using the literature as a measure of relevancy and applicability. The documents presented in this chapter include those that may support the structure, processes, and outcomes of the partnership, including those sent to members on a regular monthly basis, such as agendas and minutes of meetings, anything that may support the agenda or minutes, the bylaws and the annual application or plan. The bylaws were reviewed in a prior section. The annual applications/plans are reviewed in this section.

Area 4, Jacksonville

Documents were gathered from the lead agency staff of the First Coast CARES Consortium. These documents are basically communications that are internal to the consortium members, flowing from the lead agency staff or state staff to the members of the consortium for information purposes. Documents received include two years of agendas and minutes of meetings. Thirteen other documents received from the staff include the following:

1. Financial allocation matrix;
2. Conflict of interest disclosure form;
3. Member profile form;
4. Request For Proposal (RFP) rating sheet;
5. First Coast Consortium for AIDS Resources Evaluation & Services Membership Handbook;
6. Lead agency grievance procedures;
7. Client satisfaction survey form;
8. Lead agency work plan;
9. Listing of committees;

10. Monthly expenditure and reimbursement reports;

11. An example of a contract for services used by the lead agency;

12. By-laws of the consortium; and the

13. Fiscal year 2000-2001 Title II application to the state.

Each month the lead agency staff sends out a packet to the members of the consortium which includes the agenda for the next consortium meeting and the minutes of the last consortium meeting. Also included in the packet may be supportive documentation to the agenda or the minutes, such as financial reports, meeting notice changes, handouts from presentations, or information from committees or work groups. The packet contains approximately three (3) to six (6) pieces of paper, size 8-1/2" X 11," with a colored piece of paper used as a cover. The colored piece of paper has space for the addressee and the lead agency's address, along with the postage stamp. The packet is then folded in half, stapled and mailed to the members of the consortium as well as to other interested friends and parties of the consortium.

The agendas include the date, time and location of the meeting. There is also a listing of the officers of the consortium at the top of the agenda, prior to the agenda topics. The agenda topics are listed down the left side of a three-column table, with the person reporting on the topic identified in the center column, and the allotted time period in the right hand column.

There are four (4) main agenda topics used on a consistent basis by the First Coast CARES Consortium. The agenda topics and the allocated time include the following:

1. Welcome and introductions which includes reading of the Mission statement, five (5) minutes;

2. Old business, 25 minutes;

3. New business, 45 minutes; and

4. Community announcements and public comments, 15 minutes.

Minutes are summarized each month and typewritten in table format by the agenda topic. Each topic reported identifies the person who initiated the activity or discussion. In the event of a motion and vote, the persons are identified in the minutes, as well. The minutes are sent to the members prior to the next full consortium meeting along with the agenda.

A review of 13 sets of minutes between February 16, 2000, and August 15, 2001, shows that the total average membership present during the meetings was 24 and the average quorum present for voting purposes was 16. Table 6 shows the average number of members attending the monthly meeting, and the average number of members comprising a quorum during the years 2000 and 2001. A slight increase in membership and quorum is shown during the year 2001.

Table 6. Members Attending and Quorum Present, Jacksonville

Year	Membership	Quorum
	Average #	Average #
2000	24	17
2001	29	19

The minutes report on the activities of the committees, the consortium's business, presentations, and announcements of activities in the community or in various agencies, as

well as upcoming training sessions or conferences. Table 7 shows the frequency of topics discussed at thirteen (13) consortium meetings between 2000 and 2001.

Table 7. Topics discussed at the First Coast CARES Consortium Meetings.

Topic Discussed	#	%
1. General Consortium or Committee Business	42	32%
2. Presentations and/or trainings	23	18%
3. Budget and Finance	13	10%
4. Community Activities	12	9%
5. Services	9	7%
6. Florida Community Planning Group	7	5%
7. Elections/nominations	6	5%
8. Community Agency activities	5	4%
9. Bylaws	5	4%
10. Staff activities	5	4%
11.Application	3	2%
Total	130	100%

A review of the 13 sets of minutes indicates that the majority of the meetings were spent on general consortium and committee business reports with a frequency of 42 times, or 32%. The topic with the second largest amount of topics discussed included that of training and education. There were 23 various presentations conducted, many of which were agencies providing services to individuals in the community. This amounted to 18%

of the meetings given to training. The next ranking topic included budget and finance, with 13 discussions, or 10% of the meeting time. Community activities and discussion about services took up the next largest group of topics discussed at the meetings, 9% and 7% respectively. The topic with the least number of references is the annual application, with it being mentioned only three (3) times, or 2%.

The annual Title II application is written by a small group of members from the consortium. The lead agency coordinates the members and the tasks involved in the writing of the application. There are 16 appendices in the application. The five (5) goals, respective outcomes, and barriers to accomplishment were identified from the 1999-2000 Application. New goals were listed for the current fiscal year, as well as potential barriers to accomplishment with identified alternatives.

The annual Title II application identified three (3) goals in 1999-2000 and include the following: increase recruitment of infected clients and make clients feel more comfortable in participating and making decisions; increase recruitment of minorities; and consolidate the consortium committees with the city's Title I planning council.

The First Coast CARES Consortium identified five (5) accomplishments and included the following:

(1) Developed capacity of consortium members to participate in planning and development activities through training;

(2) Recruited more members from the minority affected community and included them in the committee work;

(3) Developed standards of care, outcome measures and reporting systems;

(4) Increased utilization of cost efficient practices, including seeking third party funding for Ryan White eligible clients and converting to a unit-based system of payment; and

(5) Standardized levels of care for all case management providers to eliminate discrepancies.

The annual application of the First Coast CARES Consortium appears to be very comprehensive and well written. There is clear explanation of each component of the plan. The goals are clear and include specific, measurable objectives; units of clients to be served; and outcome measurement.

Area 9, Palm Beach

Documents were gathered from the lead agency staff of the Palm Beach County HIV CARE Council. These documents are communications that are internal to the consortium members, moving from the lead agency staff or state staff to the members of the consortium for information purposes. The documents also include communications that are external to the consortium, providing information to the community.

Documents received include two years of agendas and minutes of meetings. Other documents received from the staff include the following:

1. Policies
2. Expenditure reports
3. Program evaluation procedures
4. Committee responsibilities
5. Membership recruitment and application packet
6. Roll call sheets for all committees

7. Confidentiality statement
8. Voting conflict of interest form
9. Comprehensive Strategic Plan (1998-2001)
10. Social standards of care
11. Title I application/plan submitted to HRSA, FY 2000
12. Title I, Fiscal Year 2000 grant application guidance
13. Title II, Fiscal year 2000-2001 grant application to state
14. Nominations process
15. HIV Care Needs Assessment, FY 97/98
16. Survey of Housing Needs, June 1999
17. Bylaws of HIV CARE Council
18. Annual retreat agenda and meeting materials
19. *The Redbook*: A Directory of HIV and AIDS Services available in Palm Beach County, April 2000
20. *Positively Palm Beach,* a monthly 8-page newsletter

Each month the lead agency staff sends out a packet to the members of the CARE Council which includes the following: an agenda for the next full council meeting; minutes of the last full council meeting; motions being presented to the council; all committee minutes; and a meeting calendar. Also included in the packet may be supportive documentation to the agenda or the minutes, such as expenditure reports, policies, or information from the committees. The packet contains approximately 18 to 30 pieces of paper. The packet is placed in a large 9" X 12" white envelope and then mailed to the

members of the consortium as well as to other interested friends and parties of the CARE Council.

Minutes of the Palm Beach County HIV CARE Council were reviewed. A review of 14 sets of minutes between April 24, 2000, and August 31, 2001, shows that the total average membership present during the meetings was 29 and the average quorum present for voting purposes was 19. Table 8 shows the average number of members and the average quorum present at the CARE Council meetings during the years 2000 and 2001.

Table 8. Members Attending & Quorum Present, Palm Beach

Year	Membership	Quorum
	Average #	Average #
2000	27	17
2001	31	22

The minutes of the CARE Council included the names of those absent, and the guests and staff. An average of nine (9) members were absent from each full Council meeting between 2000 and 2001. An average of 13 guests attended the meetings, and an average of 11 staff were present at each full partnership meeting as well. The total amount of time the meetings were in session during the 14 meetings under review included 25 hours and 17 minutes.

The minutes report on the CARE Council's activities each month, including a summary of the proceedings of the full Council meeting and attendees. The minutes are summarized each month following the outline of the agenda topics. Each topic within the minutes discusses the issue, the speakers, and any decisions or recommendations made by

the Council. The minutes are sent monthly to the members and friends of the CARE Council prior to the next full Council meeting along with all the items in the monthly mailing packet. Table 9 shows the frequency of topics discussed at the 14 CARE Council meetings between 2000 and 2001.

Table 9. Topics discussed at the CARE Council Meetings, Palm Beach

Topic Discussed	#	%
Committee Business/Reports	82	23%
Budget, Finance, Contracts/RFPs	65	19%
General Consortium Business	48	14%
Services	45	13%
Staff activities	23	7%
Community Activities	21	6%
Presentations and/or trainings	14	4%
Elections/nominations	14	4%
Chairperson's Comments	14	4%
Community Agency activities	7	2%
Appreciation/Recognition	7	2%
Public Comments	5	1%
Evaluation	2	1%
Bylaws	1	0%
Application/Plan	1	0%
Total	352	100%

A review of the 14 sets of minutes indicates that the majority of the meetings' topics were spent on the committees' reports, with a frequency of 82, or 23% of the total meeting time. These included discussions and motions for approval related to the following: community advocacy, membership and nominations activities, service delivery, funding, standards of care, and other miscellaneous business. There were 65 discussions surrounding budget, finance, contracts and requests for proposals, or 19%. This includes expenditure reports by staff, recommendations by the Priorities and Allocation Committee

and a few other committees. General consortium business took up 14% of the meeting time. There were 48 discussions about topics of a general nature to the CARE Council including the meeting opening activities (i.e., call to order, roll call, acceptance of agenda and minutes); old business issues; policy issues; assignment of committee chairs; and nominations and election activity. Meeting time spent on service issues included 45 discussions, or 13%. Reports and announcements about staff and community activities took 7% and 6% of the meeting time, respectively. The topics taking the least amount of meeting time discussions included those of bylaws and application/plan, each only mentioned once.

Committees play a big role at the CARE Council. In fact, the majority of tasks are assigned and completed by the committees, with recommendations for motions and activities brought before the full partnership. Table 10 reflects the number of topics reported by each committee during the 14 meetings reviewed.

Table 10. Topics Reported by Committees, CARE Council, Palm Beach

Committee Reports	#	%
Medical Services	18	22%
Priorities and Allocation	16	20%
Membership	15	18%
Housing	6	7%
Quality Assurance	5	6%
Community Awareness	5	6%
MIS	5	6%
Executive	5	6%
Needs Assessment	3	4%
Support Services	2	2%
Planning	2	2%
Total	82	100%

The committees having the most topics to report on or recommendations to make during the Committee Reports section of the CARE Council meetings include the following: Medical Services, 22%; Priorities and Allocations, 20%; and Membership, 18%. The Housing Committee reported on six (6) different topics, or 7%. The following four (4) committees---Quality Assurance, Community Awareness, MIS, and the Executive Committees---each took 6% of the time to report. The committees taking the least amount of time to report at the Council meetings included Needs Assessment, 4%; Support Services, 2%; and Planning, 2%. During 2001, the process of committees reporting changed during the full Council meetings. Written reports were included in the CARE Council packets, thereby reducing the reporting requirement and resulting in less frequently on other committee activities during the meetings. The committees brought motions verbally to the full Council meeting, though, which occurred during the "New Business" section of the agenda time.

The Palm Beach County HIV CARE Council is a partnership responsible for planning and coordinating services under the mandates of the Ryan White CARE Act, both Title I and Title II. Therefore, there are two (2) separate planning documents submitted by the CARE Council each year. The Title I grantee, the County of Palm Beach, has the responsibility for coordinating and assuring the annual plan is written and submitted to HRSA. The Title II local grantee, the Treasure Coast Health Council, has the responsibility for coordinating and assuring the annual application is written and submitted to the Florida Department of Health. Both the annual Title I plan and Title II application is written by a small group of six (6) staff and members of the Care Council, then submitted

to the appropriate agency. Announcements and reports of staff activities and community activities took up 6% and 5% of the meeting time

The Title I annual 1999-2000 plan is embedded within the 105-page annual grant request for the area. The document follows the federal guidelines and is inclusive of the following four sections: title page; federal forms; formula funding request; and supplemental funding request. The document addresses the local community's epidemiological data; planning council membership and representation; major accomplishments; continuum of care; needs assessment; priority and resource allocation goals and objectives; outcomes; quality assurance; and evaluation activities. The seven (7) appendices include the CARE Council bylaws; formulary; housing standards; medical chart review instrument; nurse care manager job description; prevalence information; and budget allocation. The document appears to be very comprehensive and well written, with clear explanation and supportive documentation.

The Title I plan lists five (5) major accomplishments and includes the following:

(1) A comprehensive annual needs assessment and a comprehensive plan;

(2) The inclusion of affected, infected, and minority community and consumer members on the various committees and in the Council's various activities;

(3) The monitoring of the funding and contracting process had allowed 97% of the funds to be expended;

(4) Priorities of the CARE Council were adhered to in the resource allocation; and

(5) Identified needs were met through the continual review process.

A comprehensive 28-page implementation plan is embedded within the annual grant request for funding. The plan identifies priority areas in an 18-page table format with

specific objectives, outcome measures, resource allocations, and time frames. The priority areas identified in the grant/plan include the specific line-item service categories recognized by HRSA, for example: case management, outpatient primary care, substance abuse treatment, and Care Council support. A 10-page narrative follows the table and summarizes each of the priority areas. The plan appears to be very thorough, comprehensive, and well written.

The Title II annual application (i.e., plan) is the other document coordinated and written by the same small group of staff and members of the Palm Beach County HIV CARE Council. The annual Title II application identified five (5) accomplishments in 1999-2000 and include the following:

1. An increase in the number of primary care provider agencies and service sites;
2. A quality assurance program was undertaken, with a QA workgroup formed and an implementation plan written;
3. Uniform minimum eligibility criteria for all services;
4. Completion of a comprehensive process of prioritizing 25 service categories and allocating to those services among five funding sources; and
5. Coordination in accepting consistent units of service definitions.

The five (5) major goals for fiscal year 2000-2001 include the following:

1. To fully implement a management information system countywide;
2. To implement a continuous quality improvement plan;
3. To develop, adopt and implement standards of care and outcome indicators for each support service category;

4. To implement a strategic planning process to guide better planning and decision making; and
5. To develop and institute a comprehensive member recruitment, retention, and training plan.

New goals were listed for the current fiscal year, as well as potential barriers to accomplishment with identified alternatives. The Palm Beach County HIV CARE Council Title II application is very comprehensive and appears to be well written. There is clear explanation of each component of the plan.

Comparison of Documents between Area 4, Jacksonville, and Area 9, Palm Beach

Five (5) main types of documents were gathered during this study and reviewed in the previous sections. These include the monthly informational packet sent to members; the agendas; the minutes; the annual application/plan; and the bylaws.

A monthly informational packet is sent out to the members from both partnerships. The information included in the packet from the First Coast CARES Consortium always includes the agenda and minutes from the prior month's meeting; and may include financial reports, meeting notices, presentation handouts, or committee information. The CARES Consortium packet usually contains 3-6 pieces of paper. The packet from the Palm Beach County HIV CARE Council always includes the agenda, minutes from the last meeting; a list of motions being presented to the full partnership meeting; all committee minutes; and a meeting calendar; and may also include expenditure reports or other informational materials, as needed. The Care Council packet usually includes from 18-30 pieces of paper.

The agendas offer a structure to meetings and assure that certain topics are discussed. The First Coast CARES Consortium consistently has approximately four (4) main agenda topics, while the Palm Beach County HIV CARE Council consistently has had 16-18 main agenda topics.

Minutes of the full partnership meetings were analyzed within each site. The average members and quorum present during the First Coast CARES Consortium meetings were 24 and 17 in the year 2000, and 29 and 19 during the year 2001, respectively. During the Palm Beach County HIV CARE Council meetings in the year 2000, the average number of members and quorum present was 27 and 17; while in the year 2001, the average number of members and quorum present was 31 and 22, respectively. The members and quorum present at meetings had risen slightly for both of the partnerships during the year 2001. The minutes prepared from the CARE Council included the names of the members, staff, and guests present, as well as those members absent. The minutes prepared from the First Coast CARES Consortium in Jacksonville did not list those present or absent from the meetings.

Both of the partnerships reported on the activities of the partnership and the committees. The five (5) most frequently discussed items at the First Coast CARES Consortium in Jacksonville include general consortium or committee business, 32%; presentations and/or trainings, 18%; budget and finance, 10%; community activities, 9%; and services, 7%. The five (5) most frequently discussed items at the CARE Council in Palm Beach include: committee business/reports, 23%; budget, finance, contracts/RFPs, 19%; general consortium business, 14%, services, 13%, and staff activities, 7%.

The topics receiving the least discussion during the partnership meetings at both sites include bylaws and annual application/plan; with evaluation discussed little in Palm Beach, and staff activities discussed little in Jacksonville.

Committees play a significant role within the CARE Council meetings and structure. The committees reporting most frequently at the CARE Council meetings include Medical Services, 22%; Priorities and Allocation, 20%; and Membership, 18%. All the other committees report less than 10% of the time, with Planning and Support Services being the less frequent to report.

The annual application is completed by a small group of members within each of the two (2) partnerships. The lead agency in Jacksonville coordinates the process for the completion of the Title II application, while several entities coordinate the processes in Palm Beach as the CARE Council oversees the writing of the Title I, Title II, and HOPWA applications/plans.

The Fiscal Year 2000-2001 Title II application of the First Coast CARES Consortium is 148 pages in length, with the body being 106 pages; while the Title II application of the Palm Beach County HIV CARE Council is 111 pages in length, with the body being 43 pages.

The Title II application in Jacksonville identified five (5) accomplishments: developed capacity of members to participate in planning and development activities; recruited more minority affected members; developed standards of care, outcome measures and reporting systems; increased utilization of cost efficient practices; and standardized levels of care for case management providers. The Title II application in Palm Beach identified five (5) accomplishments during 1999-2000: increased the number

of primary care provider agencies and sites; implemented quality assurance; developed uniform minimum eligibility criteria for services; completed a process of prioritization and allocation; and coordinated consistent units of service definitions.

The Jacksonville consortium identified three (3) goals in their plan: (1) increase recruitment of infected clients and make clients feel more comfortable in participating and making decisions; (2) increase recruitment of minorities; and (3) consolidate the consortium committees with the Title I planning council. The Palm Beach County HIV CARE Council identified five major goals and include: (1) implement a county-wide management information system; (2) implement a continuous quality improvement plan; (3) implement standards of care and outcome indicators for support service categories; (4) implement a strategic planning process; and (5) develop and implement a member recruitment, retention, and training plan. The goals in the annual application/plan developed by members in Jacksonville reflect a focus on membership, while the goals developed by members in Palm Beach reflect a focus on systems.

Both of the partnerships developed a comprehensive and well-written application/plan, with clear explanation contained in each of the components.

Observations of Meetings

The researcher observed a total of 14 meetings at the two (2) sites during the year and a half of the study; seven (7) in Jacksonville and seven (7) in Palm Beach. Both of the partnerships considered and discussed a wide variety of topics at their meetings. Topics included agenda clarification, announcements, financial and other administrative matters, committee activities and reports, by-laws, membership, program activities, staff reports, and policy and procedural activities. Many members participated in the discussions at the

meetings. The ecological approach offers a perspective for understanding the environmental impact upon the structure, culture, values, individuals, and the group within community health partnerships. The observation of the meetings offered insight into the structure and processes of each partnership.

The findings are summarized and reported topically within each of the regional areas and by the type of meeting observed, i.e., executive committee or consortium/planning council.

Area 4, Jacksonville

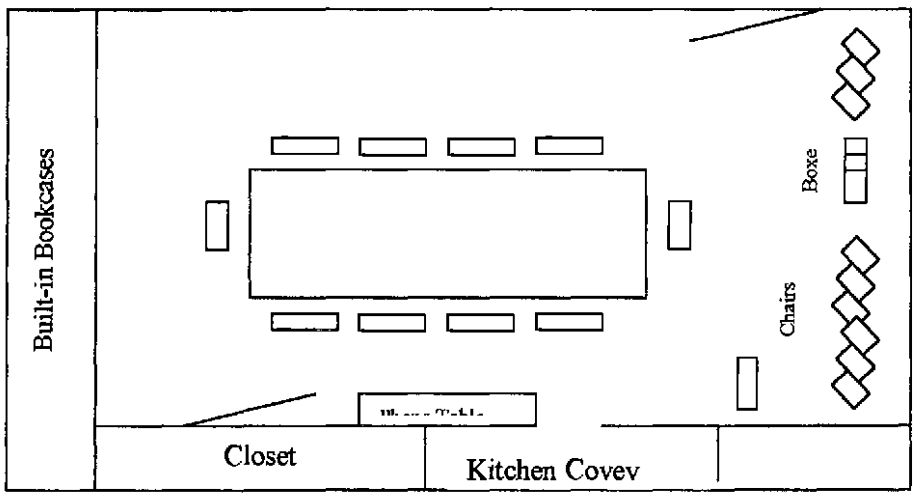
The researcher attended seven (7) meetings of the First Coast CARES Consortium, spanning the period of time between March 6, 2000, and March 21, 2001. She attended three (3) Steering Committee (i.e., executive committee) meetings; one (1) Finance Committee meeting; and three (3) First Coast CARES Consortium meetings. The researcher attended the Steering Committee meetings on March 6, 2000; May 1, 2000; and June 12, 2000; the Finance Committee meeting on May 10, 2000; and the Consortium meetings on March 15, 2000; May 10, 2000; and March 21, 2001.

First Coast CARES Consortium Steering Committee Meetings

The Steering Committee meetings of the First Coast CARES Consortium were held in the AIDS Program Office conference room of the county health department in Jacksonville. The room was small with seating for 10 chairs around a conference table. On one of the walls next to the bulletin board was a poster displaying the ground rules for the consortium meetings. The far end of the room had built-in bookcases lining the whole wall. The wall inside the room entry and to the left had several stacks of chairs and boxes of paper stacked up next to the chairs. The wall opposite the entry to the room had a small

kitchen covey with a sink, refrigerator and microwave. Next to the covey was a doorway entering into a closet with supplies. The researcher sat in a corner outside the kitchen covey and observed the committee activities. A drawing of the conference room is reflected in Figure 5.

Figure 5. Conference Room for Steering Committee Meetings, First Coast CARES



Attendance at the meetings included the lead agency staff, the state HIV/AIDS Coordinator; the co-chairs of the consortium; and the committee chairs. Table 11 indicates the race and gender of the Steering Committee members at each of the three (3) meetings. The demographics of the Steering Committee members reflects the majority as white females.

Table 11. Demographics of the Steering Committee, First Coast CARES, Jacksonville

	Gender		Race	
Meeting	Male	Female	White	African-American
#1	4	6	8	2
#2	3	7	9	1
#3	4	5	9	2

Prior to the meeting, people entered the room, found a seat, and began talking and laughing congenially with one another. There were discussions of gardening, vacations, and family. The meetings began informally with the Chairperson calling the meeting to order, as customary, and reviewing and approving the agenda and minutes. The documents used during each of the meetings were distributed to each of the attendees, and included the agenda, minutes, and budget reports. The agenda included six (6) items: meeting called to order; review/approval of minutes; committee chair reports; old business; new business; and announcements/adjournment.

There was no formality in following a structured meeting process, such as Robert's Rules of Order, but when someone was speaking, everyone gave their full attention to the speaker respectfully. The meeting progressed at an easy, relaxed pace. The lead agency staff and the state HIV/AIDS Coordinator spoke the most frequently during the meeting, presenting information, clarifying issues and responding to questions. The patterns of interactions between the members were informal; everyone appeared to be relaxed and trusting with each other. There was much informal discussion, but very focused on the topic. There was no apparent conflict. Every attendee participated by offering comments

or asking questions during the discussions. The group did appear to follow the agenda, but included many other topics of discussion. The members were jovial, having fun at times. Occasionally one or two of the members would leave the room to answer a page or a phone call, but not disruptive to the group process while leaving or returning. The Steering Committee members felt free to ask others for assistance in their particular committee, and a few offered their help when needed. A brief summary is presented of each of the three (3) meetings observed, presenting an in-depth look into the Steering Committee.

Steering committee meeting #1, March 6, 2000.

The meeting was called to order by one of the co-chairs. One of the members participated in the meeting via telephone conference call; with the phone in the center of the table. .A review of the agenda and the minutes from the previous meeting was presented. The four (4) committee chairpersons presented a brief report. More discussion was held on the finance and budget committee issues, with the lead agency staff member clarifying and explaining several key points of the budget to the members. Everyone was paying attention. The lead agency staff did not have a budget analysis prepared but the members were not concerned about this, trusting the staff member.

From the general budget discussion, the meeting transitioned to the other committee reports. There was a report of three members attending the PLWHIV/AIDS Committee meeting. Another issue discussed was the development and distribution of brochures. The members then discussed concerns about dental services. During the discussions, several people received pages, left the room to respond and returned to the

group. Another discussion was held on the needs assessment process and the need for client satisfaction surveys, focus groups, and survey instruments.

Only one item was presented on the "old business" section of the agenda. A report was given about the consortium restructuring and the move to a new meting location for the consortium meetings. During the "new business" items, the lead agency staff member presented a request to reallocate funds from one budget line item to another. This was recommended and placed on the agenda for the full consortium meeting for approval. Then the state agency staff representative presented information about the state's allocation methodology and discussed each handout, stopping to respond to questions of the members. The last agenda item was presented by this researcher, explaining the research study and methodology, and seeking approval to conduct this study. The Executive Committee recommended approval for the study and the study was placed on the agenda for the full consortium's approval.

The meeting ended pleasantly, with laughter and light joking. The process of the meeting was informal. Everyone participated and gave attention to the speaker. Discussion was free-flowing, moving back and forth very smoothly. No conflict was evident.

Steering committee meeting #2, May 1, 2000.

The meeting began late after one of the lead agency staff members asked the co-chair if he wanted to get started. The meeting was then called to order with the co-chair asking everyone to think of something "light and happy." A brief discussion was held about daylilies. Soon thereafter, the group officially began its work with a review of the agenda and acceptance of the minutes. Several members arrived late. The Committee Chairpersons reported for approximately 40 minutes about committee activities. The lead

agency staff member presented the final budget report during the Finance Committee's report, initiated a discussion of the provider survey and needs assessment. Informal discussions were held continually, but remained focused on the topic of discussions at hand. An issue about clients loss of Medicaid eligibility surfaced and discussion was held about the consequences to clients and to providers.

The topics of restructuring and the bylaws were discussed for approximately 15 minutes. Several reasons for the consortium restructuring efforts surfaced during the discussions: lack of people attending meetings, "wishy-washy" agendas; and lack of people to serve on the committees.

A brief report was given about the hiring process for the lead agency staff member and an update about disease management was given prior to the ending of the meeting. The meeting was not focused solely on the agenda, but included many other topics and side discussions throughout. The meeting was very informal, following no parliamentary procedures. There was no process for recognizing members when they wish to speak; everyone spoke out when they had something to say. The members were respectful of each other during the discussions. The lead agency and state agency staff members spoke the most frequently.

Steering committee meeting # 3, June 12, 2000.

The meeting began late and was opened informally by one of the co-chairs. The members appeared to be subdued. The progression of the meeting was slow and easy-paced. The co-chair reviewed the agenda and recommended approval of the minutes. The committee chairpersons reported about their respective committee activities.

Several service issues were discussed. The issue of transportation services was presented. Apparently, some of the clients did not get picked up and did not attend their medical appointments. During the discussion questions about grievance procedures were asked and the lead agency staff member offered explanation about the procedure. One of the Executive Committee's client members angrily objected to the procedure. The staff member responded to the objection and successfully suppressed further conflict. The discussion got off track with complaints about a past employee. The state agency staff member clarified and explained the employee was disciplined so this should no longer be an issue or concern. The discussion about complaints and grievances ended when there was a suggestion to conduct training. Other service issues discussed during the meeting included clients unable to work because of fear of losing benefits; incentives for clients to attend meetings; and a complaint about clients not being asked to review the HIV directory.

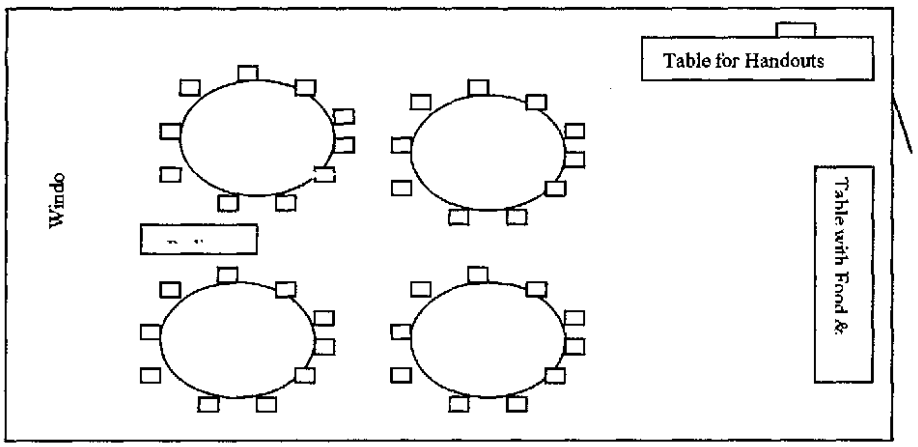
The co-chair kept the meeting progressing forward. The bylaws were discussed briefly. The hiring process for the new lead agency staff member was reported. Announcements were made of several community activities. The meeting adjourned quickly and people seemed to scurry out quietly.

First Coast CARES Consortium Meetings

The First Coast CARES Consortium meetings in 2000 were held in the 10th floor banquet room of the former Methodist Medical Towers, subsequently renamed Shands Hospital Jacksonville. The researcher attended two (2) First Coast CARES Consortium meetings at this location. The room was a large banquet room with round tables located throughout the room. An area of four (4) round tables was set up on the far side of the

entry door, separating them from the other tables. Approximately 8-10 chairs were placed around each table. A podium was located near the windows between two of the round tables. A rectangular folding table was placed inside the entryway and used for all the informational handouts that were subsequently picked up by the members as they entered the room. A lead agency staff member sat at the table to offer the handouts to members and to respond to questions. To the left as one entered the room, a banquet table had food and drinks available for the members. The food and drinks were donated by one of the pharmaceutical companies. Figure 6 presents a graphic display of the meeting area; the room is too large to adequately present a complete drawing of the other areas.

Figure 6. Meeting Area, First Coast CARES, March 15 and May 10, 2000



The consortium meeting of March 21, 2001, was held in the auditorium of the Duval County Health Department. Prior to each of the meetings, members entered the area, placed their belongings at a seat location and either sat down quietly or proceeded to get something to eat and drink while waiting for the meetings to begin. This occurred during each meeting. A summary of each consortium meeting follows.

Consortium meeting #1, March 15, 2000.

The Consortium Chair called the meeting to order, read the mission statement, asked for a moment of silence, and asked for the roll. The members appeared to be quite talkative and congenial to one another, laughing and joking among themselves. The Chair was standing initially at the podium but during the meeting walked about the tables directing the meeting. Initially the committee chairs gave their reports in an informal manner, with little discussion. Members paid attention to the committee chairs. Several members arrived late during the reports; several others left their seats to get food and drinks. Announcements were made during the "old business" agenda item about an open house and a report was heard from the consortia task force regarding re-structuring the consortium's way of conducting business.

Four (4) items in the "new business" agenda section were on the subject of reallocating funds from certain budget line items to others. The lead agency staff member and the state agency staff member distributed a budget report and other budget information about a potential reallocation of funds. More time was spent on the budget issues, with several members asking questions about the budget re-allocation under discussion. The lead agency staff member and the state agency staff member offered clarification to the questions in an objective manner. There was complete attention focused on the staff members from the member audience. The process of voting on the budget reallocations was observed. Members made motions to approve the reallocations in a business-like, orderly fashion.

The meeting was conducted in an informal, business-like manner, with the chairperson friendly, relaxed, and congenial during the proceedings, yet task-oriented. The

researcher perceived the staff members as serious minded about their work and their role within the partnership meeting.

Consortium meeting #2, May 10, 2000.

The Consortium Chair was standing at the podium and began talking, did not officially call the meeting to order, so members kept talking, apparently unsure that the meeting began. The Chair read the mission statement and proceeded to the next agenda item, which were the committee reports. The committee chairs reported for approximately 10 minutes, with discussions surrounding the issues of funding and planning. The group appeared to be more subdued and quiet than the first observation and several members felt free to get up and get some food and drinks during the meeting. The committee chairs discussed the handouts in their respective reports. The handouts were available on the entry table, but several members did not pick them up. Subsequently, there was movement in the group by people getting up, walking to the table, retrieving the materials, and returning to their seats. Several members stopped to speak to someone for a moment or two.

The lead agency staff member and two of the consortium members presented an informational special report and distributed handouts to the others present. The Chair received a cell phone call and left the room during the discussion. Upon the Chair's return, there was a discussion with the lead agency secretary and then returns to the front of the room. There was discussion about the special report for approximately 10 minutes.

The lead agency staff members presented an update about the consortium's by-laws in the "old business" section on the agenda. The update was in response to a question

raised at the previous consortium meeting about restructuring meetings and how it would affect the bylaws. Little discussion was held.

"New business" contained several issues about funding allocations; a motion to recommend the co-chairs participate on the hiring committee for the new lead agency staff coordinator; and a report about disease management. Little discussion was held on these issues during the 10 minutes. Most of the new business was staff giving information to the consortium and offering clarification. The last section on the agenda lasted approximately eight (8) minutes. Four (4) members offered information about various activities occurring within the community that might be of interest to the membership.

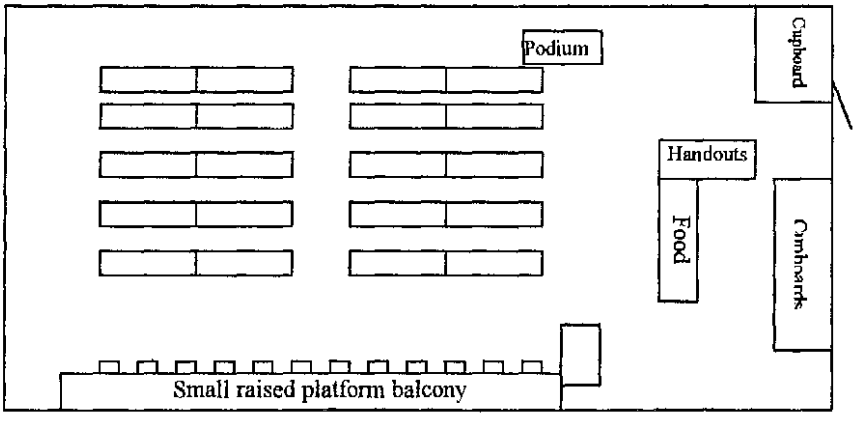
The meeting occurred for approximately an hour and a half, was very informal, and had many disruptions throughout the time. Staff appeared to be serious about their work, as in the previous meeting; and the chairperson appeared to be less focused on the task of running the meeting. Little discussion was held on the various agenda topics, with the membership appearing very quiet, unresponsive and passive.

Consortium meeting #3, March 21, 2001

In the middle of the year 2000, the consortium changed their meeting location from the hospital location. The meetings from June 2000 to present date are held in a large auditorium of the public health department. A graphic display is represented in Figure 7. Five (5) rows of small rectangular tables were arranged classroom style with a center aisle. Two tables with two (2) chairs at each table were placed end-to-end on each side of the aisle. To the immediate left and right of the entry doorway was a set of cupboards; and a small table was placed to hold the information and handout materials. Arranged perpendicular to the small table were two other tables placed end-to-end that held food

and drinks. A row of chairs was placed beneath a small raised balcony in the rear of the room.

Figure 7. Meeting Area, FCC Consortium, March 21, 2001



The meeting began with the two (2) co-chairs at the podium each taking part in the opening exercise. One co-chair welcomed everyone and read the mission statement. The other reviewed the agenda and minutes. The co-chair proceeded to inform everyone that the meeting was basically one of four being offered during the year that would provide education and awareness of the programs available in the area. Representatives from three (3) different agencies presented handouts and discussed their respective programs. This researcher administered the Group Environment Scale to the members at this meeting. There was little discussion during the presentations and very few questions. Members were quiet and passive. Staff members did not participate, but sat in the back and side of the room quietly. The meeting ended with several announcements of community activities and adjournment.

Summary of Observations, First Coast CARES Consortium

In summary, the meetings of the Executive Committee and of the First Coast CARES Consortium were conducted at a relaxed, easy-going pace, with much informal discussion about the agenda topics. The Steering Committee meetings were held in a stable location. The Consortium meetings at the beginning of this study were held at several locations, eventually stabilizing at the same location in the middle of 2000. Everyone participated, members were communicating, offering their opinions with openness and trust. The majority of the members were white female. While the co-chair opened the meeting proceedings, the lead agency and state staff members did most of the talking and appeared to manage the meeting agenda, centering discussions around the budget, needs assessment, bylaws, client services, presentation of committee reports, and announcements of community activities. The members strayed from the agenda during Steering Committee meetings, often going off in a discussion about something unrelated to the topic at hand. The meetings had many disruptions, with people answering pages and phone calls, walking over to speak to others, or leaving their seats to get food. The members appeared to be friendly to one another and accepting of everyone's opinions and contributions.

Area 9, Palm Beach

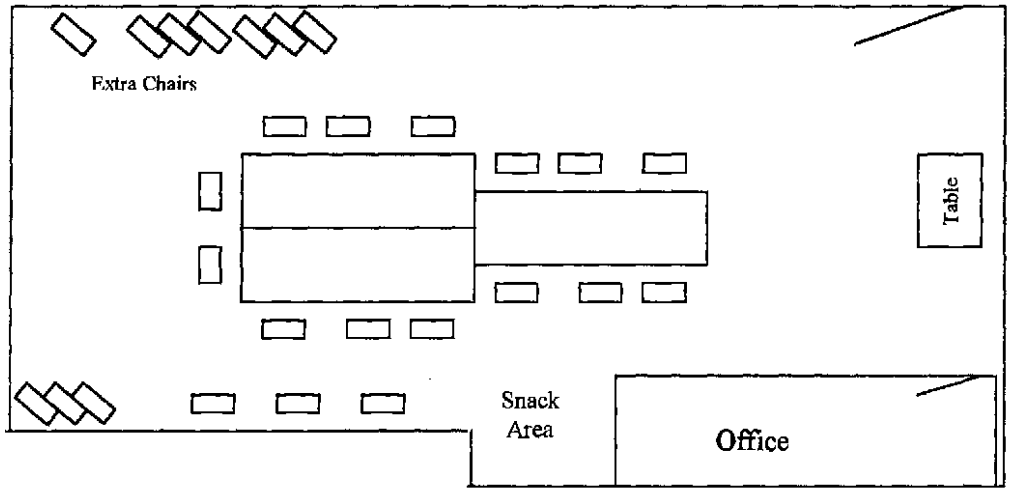
The researcher attended seven (7) meetings of the Palm Beach County HIV CARE Council, spanning the period of time between March 21, 2000 and March 26, 2001. She attended two (2) Executive Committee meetings; three (3) CARE Council meetings; and two (2) other committee meetings. The researcher attended the Executive Committee meetings on March 21, 2000, and May 23, 2000; the Planning Committee meeting on

March 6, 2001; the Community Awareness Committee on March 12, 2001; and the CARE Council meetings on March 27, 2000; April 24, 2000; and March 26, 2001.

Palm Beach County HIV CARE Council Executive Committee Meetings

The Executive Committee meetings of the Palm Beach County HIV CARE Council were held in conference room of the lead agency's offices in Riviera Beach. The room is large with total seating capacity for approximately 40-50 people. There was a small table inside the doorway entry that held the documents for the meetings. The wall opposite the doorway included an office for one of the staff and a small recessed area for the refrigerator and cupboards holding snack items for the members. The researcher sat in a chair surrounding the central meeting tables and observed the committee activities. The conference room as set up for the first observed meeting is reflected in Figure 8.

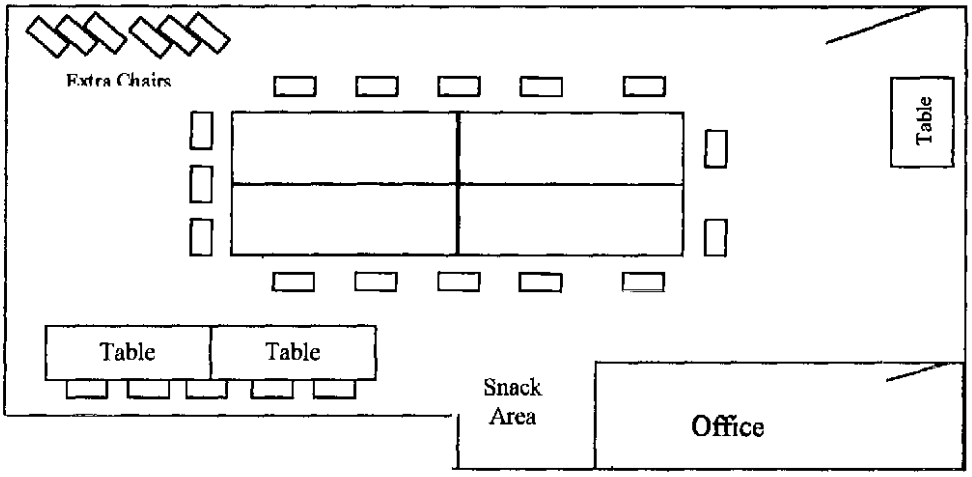
Figure 8. Conference Room for Executive Committee Meeting, March 21, 2000



The tables were arranged differently for each of the two (2) meetings observed. The researcher attended the second Executive Committee meeting two (2) months later and observed a different arrangement; four tables were arranged in a big square to allow

for seating of the 17 people attending. Two tables were placed end-to-end on one of the walls. Figure 9 reflects the arrangement of the room for the second observed meeting.

Figure 9. Conference Room for Executive Committee Meeting, May 23, 2000



Attendance at the meetings included the lead agency staff, the staff of the funding agencies, the chairperson; and the committee chairs. Table 12 indicates the race and gender of the Executive Committee members at each of the two meetings observed. The demographics of the Executive Committee members reflect the majority as white females.

Table 12. Demographics of the Executive Committee, CARE Council

	Gender		Race	
Meeting	Male	Female	White	African-American
#1	5	8	8	5
#2	6	8	9	5

Before the meetings began, people entered the room, found their seats, and talked among themselves while staff placed information on the tables and distributed materials.

Several people walked outside to talk while waiting for the meeting to begin. Several other people felt free to walk about and speak to others.

The documents used for both meetings included the agenda, minutes, and reports of several committees' activities. The agenda varied between the two (2) meetings, and include the following topic areas as presented in Table 13.

Table 13. Agenda topics of the Executive Committee meetings, PBCHCC

Meeting #1	Meeting #2
Call to order, roll, introductions and a Moment of silence	Call to order, roll and introductions
Acceptance of agenda	Moment of reflection
Approval of minutes	Acceptance of agenda
Title I report	Approval of minutes
Title II report	Robert's rules of order moment
HOPWA report	Comments by public
Patient Care/Network report	Old business
Staff report	Staff report
Committee reports	New business
Other business	Adjournment
Adjournment	

The arrangement of the second meeting agenda topics was more structured, including the addition of old business and new business. New agenda topics were added, including time for public comments. The Moment of Reflection was a separate agenda item, stressing the importance of remembering those with HIV and AIDS and the tasks to accomplish.

Both Executive Committee meetings formally began with the chairperson calling the meetings to order, offering opening remarks, review and acceptance of the agenda and minutes, and having a moment of silence and reflection. The agenda provided a formal

meeting structure, while Robert's Rules of Order was used during the meeting process. In fact, during the meeting of May 23, 2000, one of the agenda topics was the discussion of Robert's Rules of Order. The members appeared to be comfortable in the use of the Robert's Rules of Order, making motions to approve, recommend, or accept.

The chairperson was in control of the meetings. When he spoke, everyone paid attention. The chairperson spoke the most frequently during the meeting, presenting information, clarifying issues and responding to questions. When he did not know an answer, he called upon the staff to respond. The patterns of interaction were formal, directing questions to the chairperson and waiting for the chairperson to respond or re-direct to someone else. When other members spoke, the others respectfully listened. There were very few informal discussions between the members and no conflict evident. Every attendee participated during the meeting. The meetings progressed at a quick pace, following the agenda items and straying very little. The culture appeared to be very business-like. A brief summary is presented of each of the meetings observed, relaying a more in-depth look into the Executive Committee.

Executive committee meeting #1, March 21, 2000.

Prior to the meeting, people were talking between themselves, and several were laughing. Staff placed information on the tables, distributing the handout materials. Several people left the room and go outside to talk. The meeting was called to order by the chairperson, roll call was taken, and guests were introduced. There was no quorum present. The agenda was accepted and the minutes were approved.

The staff member from the County who was responsible for the administration of the Title I funding presented a report. All contracts for services had been completed and a

request was submitted to the federal government for carry-over funds. A member raised concern with the staff member not going through the RFP (i.e., request for proposals) process to attain providers for a specific service. Discussions were held between the county staff member and the committee member. Another committee member began to mediate the discussion when the conflict increased. The lead agency staff intervened and clarified what the Council voted on at the previous month's meeting to help dissuade the disagreement. The committee member ended the discussion by summarizing the key points learned and closed his comments by indicating that *"we want to do the right thing and the best thing."* Further discussion was held on the need for an RFP Committee or a process to review RFPs, then the meeting transitioned to the next agenda item.

The lead agency staff member responsible for the oversight of Title II funding presented a report to the Executive Committee. All the contracts for the Title II providers were complete and the monitoring of several agencies had been completed. She offered a handout regarding the budget expenditures and several members had questions. The staff member clarified and explained the budget report more clearly, satisfying the members' questions. Apparently there had been a big surplus at the end of the year and the CARE Council did not appear to like the idea of having a significant surplus. The staff member proceeded to explain about the state's funding allocation methodology. The committee members then picked up on the issue of the RFP process from the earlier discussion.

Another lead agency staff representative gave a brief report on the HOPWA needs assessment and the prioritization and allocation. Everyone expressed their pleasure with this report. The state agency staff representative did not have a printed report for the committee because she indicated she grabbed the wrong one in her haste to arrive on time.

The committee members were not upset at this, but instead re-directed comments to the chair and laughed as reference was made about the chairperson always having everything.

A staff report was verbally presented to the committee. The lead agency coordinator indicated progress was being made on the hiring of three (3) additional staff members. Next on the agenda were the eight (8) committee reports which continued for one hour thirty minutes.

The committee chairpersons presented their reports and discussions were held with great detail. The members questioned each chairperson and appeared to be very interested in what was occurring in the various committees. Staff informed the group of training being offered in Robert's Rules of Order and encouraged members to attend. Motions were presented by certain committees, recommended for approval, and placed on the next agenda for the full CARE Council meeting. A few other committee members arrived and several left during the meeting. Suggestions were made that the bylaws should be translated to other languages in the regional area; training on cultural competence should be offered. The planner and evaluator reported on the needs assessment survey methodology and the analysis procedures she would conduct. Standards of Care were reviewed for social services. The nominations and elections policy was reviewed.

The Executive Committee meeting was very focused, fast paced and busy. Everyone paid attention during the three hour Executive Committee meeting. Whoever was speaking was regarded with respect and interest. Members felt free to speak out during the meetings to ask, clarify or inform others. The meeting progressed in an orderly, business-like manner.

Executive committee meeting #2, May 23, 2000.

Prior to the meeting, members arrived and took their seats. Staff distributed materials and placed named placards at the seat locations. The meeting was called to order by the newly elected CARE Council chairperson. The opening remarks by the chairperson indicated changes were coming. He presented a brief overview of the intricacies of making motions and the importance of these procedures. The committee then discussed the need to place time limits on discussion and agreed to limit individuals to three minutes and no speaking allowed a second time. The chair then suggested a time limit of two hours be placed on the Executive Committee. Further discussion about Robert's Rules of Order was held, with the recommendation to include in the bylaws any changes made to how the CARE Council conducts its business.

During the staff report, the new chairperson gave an overview of the history of the CARE Council, mentioning that now there was an opportunity to do long range planning and the Executive Committee does not need to make financial and committee reports all the time. Discussion was held about the committee reports not being on the agenda and it was agreed to add these back into the committee process only if those committees had action items or motions to bring before the full Council. Chairpersons of committees were encouraged to add other activities into a written report for distribution.

Other items of discussion during the meeting included the needs assessment report and survey information. The chairperson suggested that the members would need to learn how to interpret the data found on the survey analysis. An initial suggestion was made to begin addressing the strategic planning process. The issue of term limits ending was discussed and how to seek nominations for members. The chairperson reviewed the

process of getting members for the Council and indicated that it is "our role and responsibility to get the best membership we can; those who are willing to work in our community." Suggestions were then made to develop a reference book for chairs of committees, including policies, membership lists, procedures, and anything else that could assist the chairs in doing a good job.

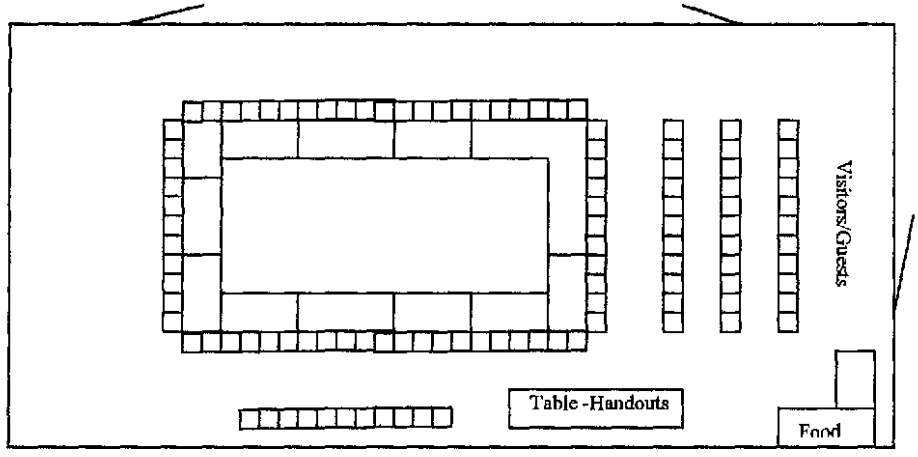
The meeting was adjourned after a discussion about the relationship between committees and expected communications between the committees and individuals and staff. The meeting was more formal than the previous one. People were attentive to the new chair. The chairperson expressed his expectations in moving the CARE Council forward by offering more structure and improved processes.

Palm Beach County HIV CARE Council Meetings

The two (2) CARE Council meetings that the researcher attended in 2000 were held at two (2) different locations. The first one on March 27, 2000, was held at the site location of the Urban League of Palm Beach County, in the auditorium. The auditorium room was a large hall, as shown in Figure 10. People entered the room from one of two (2) doorways from outside the building, or from an inside doorway near the back of the room. Windows lined the whole wall between the two outside doors. Opposite that wall, on the other side of the room, was a row of chairs for guests and visitors. Along that wall near the back of the room was a table with many of the handouts being distributed for the members. Near the inside door were several tables set up for food and drinks. Rectangular folding tables were placed in the center of the room, in the shape of a square, end-to-end, in a seating arrangement large enough for approximately 45 people, 15 people on one length of the large square-shape arrangement, and 15 people on the other side. The "ends"

of the large square-shaped seating arrangement held seats for approximately six (6) to eight (8) people on each end. Along the back of the hall were three rows of chairs arranged for visitors and guests.

Figure 10. Meeting Area, CARE Council Meeting for March 27, 2000



The Council meetings of April 24, 2000, and March 26, 2001, were held in the conference room of the lead agency's offices in Riviera Beach, in the same room as the Executive Committees were held (see Figure 9). The room is large with total seating capacity for approximately 40-50 people. The tables were arranged in classroom style, though, as compared to the arrangement for the Executive Committee meetings. A small table stood inside the doorway entry that held the documents for the meetings. The wall opposite the doorway included an office for one of the staff and a small recessed area for the refrigerator and cupboards holding snack items for the members. Several rows of chairs lined the back of the room. The room was very small for a meeting of this size.

Council meeting #1, March 27, 2000.

The Council Chair called the meeting to order, held a brief moment of reflection, and called for the roll. Committee chairs began giving their committee reports, following the agenda for the day's meeting. The Priorities and Allocations Committee made four motions to approve various recommendations related to housing priorities and funding, and other service categories. The Support Services Committee recommended the Standards of Care document be approved. The Membership Committee recommended the Leave of Absence Policy be approved, but the full council had concern about wording in the document. Other committee chairs indicated that information about their respective committees were in the written reports. The Title I, Title II, HOPWA and Patient Care/Network staff presented their expenditure reports to the members. The staff report was given and the Chair informed the Council the next meeting would be the Annual Meeting, would be held at the new location, and that elections would be held. The meeting was adjourned with no further discussion.

Several members and visitors arrived late throughout the meeting. Many of the members and visitors left their seats throughout the meeting to get food and drinks. The members appeared to be talkative and congenial to one another, getting up and walking about the room during the meeting, even approaching and talking to other members who were seated. The business meeting flowed in an orderly fashion, following Robert's Rules of Order. People raised their hands when they wished to be recognized to speak. All the late arrivals signed in at the table prior to sitting down. The meeting was fast-paced and business-like. Aside from the members leaving their seats, getting food, or speaking to

someone, most people were very attentive to the speaker of the moment, quiet and respectful of other members.

Council meeting #2, April 24, 2000.

The CARE Council meeting was held at the lead agency's home office in a newly furnished conference room. The room was much smaller than at the last meeting's location. This prevented much movement of the members. Prior to the meeting beginning, people were getting snacks, chatting with one another, or quietly waiting at their seats.

The Chair called the meeting to order, but there was no quorum. Therefore, the Council postponed several items on the agenda until a quorum was reached. The committees indicated there was nothing to report as their activities were written in the meeting minutes and copies had been distributed. The representatives from the funding agencies presented their administrative and expenditure reports. One Council member complimented the county staff member for getting the RFPs out in a timely fashion and for spending the funds down in an efficient manner. The CARE Council program director presented an update of staff positions and staff activities. He indicated two positions had been filled. The needs assessment project was in the final stages, focus groups were conducted. The MIS project was progressing. A Council member complimented the program director on having the positions filled quickly and hiring qualified people.

By the end of the staff report, several other members arrived late and there was a quorum. The nominations for the officers were presented and elections were conducted. New officers were elected as presented on the slate by the nominations committee. At that time, the newly elected officers were introduced and the past chair graciously turned the meeting over to the new chairperson. The Council members approved the new chairperson

being elected with clapping and smiles on their faces. The newly elected chair saluted the outgoing chairperson for a good job, presenting a brief overview of her accomplishments. The Council gave her applause. Another council member recognized a client member with AIDS who had been one of the outgoing officers, apparently conducting Council duties and responsibilities while severely ill. The Council membership recognized him with a standing ovation.

Comments by the new chair included "overcoming the challenges of the past two years" and "looking forward to improvements in the 'business of the Council.'" He verbalized pride in the members and in the staff of the Council, complimenting and thanking them for the work they do. He stated his job is "to assure these people get the services they need." The meeting was adjourned.

The meeting was more formal than the previously observed meeting on March 27, following parliamentary procedures. The documents used in the meeting were the agenda, minutes, budget reports, grievance forms, and correspondence. The researcher noticed there was a significant lack of participation by the majority of the members. Most of the people were reviewing the handouts. Not as many people were getting up and down as in the other meetings observed. There seemed to be more graciousness and recognition of fellow members and staff, with compliments and thanks being extended.

Council meeting #3, March 26, 2001.

The CARE Council meeting was held in the conference room of the lead agency. The main purpose for the researcher attending this meeting was to administer one of the surveys to the full Council membership. The meeting progressed as the previous others, following Robert's Rules of Order to accomplish its business. Forty six people were in

attendance. Seating was classroom style with rows of tables facing a table at the front of the room at which the Chair and officers sat. Prior to the meeting beginning, people were reviewing the documents, and quietly talking to their neighbor at their seats. Prior to the end of the meeting, people appeared to become more restless and one could hear sounds of "packing up": zippers being zipped as people put things away in their bags, keys being taken out of pockets and purses, and papers being shuffled more frequently.

The Council meeting opened in their customary fashion: Chair calling the meeting to order, roll taken, guests introduced, and a moment of reflection. Following the opening, the Chair added an "Educational Moment" to the agenda. The members accepted the agenda and minutes of the last meeting. The Educational Moment was a brief reminder of what was learned at the annual conference about being a 'guest or host' at the meetings. The Chair reminded members to greet and welcome unfamiliar people, introduce self to others, help others to feel welcome. He distributed small 3" X 5" cards with this reminder.

The meeting progressed. During the public comments time, one member voiced her concern about the lack of mental health services for HIV infected children. This was referred to the medical and support services committee. New business included motions from three (3) committees for approval of their recommendations and the administration of the survey by this researcher. Only one committee chair reported, as all other committees included their reports in the monthly packet for members. The representative staff members of the funding agencies presented a brief expenditure or administrative report. The CARE Council program director presented a written staff report. The Chair commented about bylaws and nominations for officers. The meeting was adjourned.

The classroom-style room arrangement appeared to control the group better, limiting movement of the members. There appeared to be fewer people leaving their seats than in prior meetings. The documents being used included the agenda, minutes, bylaws, reports, budget reports, correspondence. There was good participation from many of the Council members and from visitors who were in the back of the room. The meeting was fast-paced, but with a 'light' atmosphere, not as intense as in the previous full council meetings. There was some joking and laughing.

Summary of Observations, Palm Beach County HIV CARE Council

In summary, the Executive Committee and the CARE Council meetings were conducted in a formal manner, utilizing Robert's Rules of Order. The discussions moved at a fast pace. The Chairperson was in control of the meeting, speaking the most to conduct the order of business, setting the pace of the meeting, following the agenda topics, and straying very little. The meetings were very business-like, with members using parliamentary procedures to make motions, initiate discussion, and vote. The majority of the members were white female. The participant members were talkative and congenial, openly communicating in an atmosphere of trust and acceptance. The agenda topics included discussions about bylaws; budget; client services; and presentation of committee reports, budget reports, and staff reports. The meetings had many disruptions, with people leaving their seats, getting food, answering pager and cell phone calls. Many members arrived late at each of the meetings. The Chair, staff, and other members offered much recognition to those others during each of the meetings for their hard work on particular tasks, or for doing a good job. The groups had some evident rituals, such as the Educational Moments, and the Moments of Reflection. The officers were perceived to be

role models for members in extending themselves graciously and warmly to one another, taking the time to speak and welcome people.

Comparison of Area 4 and Area 9 Observations

The First Coast CARES Consortium meetings in Jacksonville appeared to be informal, moving at a slower paced than the CARE Council meetings in Palm Beach, which conducted their meetings at a fast pace and using Robert's Rules of Order. Each of the partnerships tended to follow their respective agenda for the most part, but the consortium meetings in Jacksonville appeared to stray more frequently, while the CARE Council meetings strayed very little. Both partnerships are now conducting their respective meetings in a stable location. White females were the majority in each their respective memberships. The perceived *leader* of the First Coast CARES Consortium meetings in Jacksonville was the lead agency staff during the Steering Committee meetings and the Co-Chairs during the full consortium meeting. The Chairperson of the CARE Council in Palm Beach was definitely the *leader* of all the meetings' conducted. The members at each partnership were friendly, congenial, and talkative. Both partnerships appeared to have many disruptions during their meetings. The officers and staff of the CARE Council in Palm Beach offered recognition and praise of their members' participation and work completed, while the officers and staff of the First Coast CARES Consortium in Jacksonville offered little to none. In Palm Beach, there was evidence of rituals from the observations and interviews.

The Interviews

Interviews were conducted with a total of 12 individuals, six (6) members of each consortium. The interviews were based on an initial pool of 40 semi-structured Interview

Questions (Appendix A) and an "Interview Guide" template (Appendix I) which the researcher developed to guide the interview process. Most of the questions were asking for opinions, for a description, or for feelings. The majority of questions asked included those related to structure; communication; community capacity; roles and responsibilities of the consortium members, leaders, and staff; outcomes; planning; and leadership. The individuals consenting to an interview were assured confidentiality of their identity, and thus, their responses are not identified by name. Comments from participants within each partnership have been combined to protect the anonymity of those interviewed.

The results from the interviews are presented in the following manner: first, by the regional site, Area 4, Jacksonville, and Area 9, Palm Beach; then by the research questions guiding this study, which are underlined. Several of the research questions were grouped together because of similarities and for ease of organization. Following each of the research questions are the semi-structured interview questions presented in bold letters. The themes that evolved from the responses of the interviews are presented next, with the supporting quotations from the interviewees. Some of the participants have used the word "consortia" and "consortium" interchangeably; often using "consortia" incorrectly, referring to the "consortium" this way. The researcher reported the results in the manner exactly as the participants stated during the interview.

Area 4, Jacksonville

Interviews were conducted with six (6) different members of the First Coast CARES Consortium. The majority of the interviews were conducted at the members' offices and one was conducted at the consortium meeting location prior to a consortium meeting. The interviews were conducted during the months of March and April of 2000

and in February and March of 2001. The interviews with each consortium member began with the researcher presenting a brief description of the study and definitions of collaboration, empowerment, and effectiveness.

Research Questions: How does a partnership's structure and processes influence the partnership? How are decisions made, conflicts and problems solved? How do the rules, roles and procedures influence and impact on the partnership?

How do you see the consortium as being effective? What contributes to this?

One of the respondents stated,

> I think we're very effective in serving our clients because we have money left over, and we have effectively gotten the contracts fine tuned to the point where everybody is being served and getting the services they need, and still have money left over. From a service delivery standpoint, we are getting it together. We have eliminated as much as possible redundancy between agencies and between funding sources.

An analogy was offered, "As far as the consortium's effectiveness, I think it's kind of like making sausage; it's not a pretty sight in the process but the outcome works." Another member stated, "I see sophistication is increasing year after year after year, which is a good thing."

One respondent stated that trust and communication contributed to effectiveness, "there is that good level of trust and that you do communicate in order to make and process those decisions and that's why the consortia is effective." Another person indicated longevity on the consortium and working together with others as factors

towards effectiveness, "A lot of us have worked together for a long time in a professional way...."

Another member commented at length about what she thought made the consortium collaborative, empowered and effective:

> We don't always all agree but we agree upon that there's a lot of work to do and it has to get done. None of us want to throw a monkey wrench in it and make it not work; but we all want it to work, so we just have to give and take to make it work the best you can with limited resources that you have and recognize that nobody's going to be happy all the time. That's really the bottom line, that none of us gets what we want a hundred percent. But, you split it out and try to give everything enough to where it cannot be crippled. I mean, you wouldn't want to give just a paltry little amount to something that was a token because nothing can happen with a token; you want to give enough to it where it can work.
>
> There's a lot of respect among the different providers that are in the system. Providers that come to the system and stay in the system, that are interested in being part of this are in the system because they care, and because they are committed to doing the work and to this client population. So, if somebody comes and they see dollar signs and then that's what's really behind them, they're not going to say because the money isn't all that great. It's something, but it's not enough to really make you jump and down and want to stay in there. You're not going to get rich doing this. You're just going to have enough to stay afloat.

Another respondent indicated,

> It meets its mandates. The mandates are to assess the prioritized needs and to develop a local plan. The main reason they do that is because they really have very successfully linked to Title I for the needs assessment process or prioritization process or allocation process.

Your current structure helps to contribute toward the collaboration, empowerment and effectiveness of the consortium. Please describe/explain how.

A major change occurred last year in the way the consortium was structured. "Our committees were good, but there were too many of them." Someone else said, "We ended up doing a major change in bylaws." One person stated people were tired and this was one of the main reasons for changing the structure of the consortium meetings:

> People, I think, were comfortable with what was going on...but people were exhausted and really burned out. And, so when you were looking for people to serve on committees, be on Planning and Linkage, be on the Joint Allocation and Prioritization thing. It's the same people over and over again, and it wasn't effective anymore because these people are exhausted.

Another person indicated, "We consolidated the committees into one and started doing what we said we were going to do--have the four meetings a year that are educational." Another member stated, "Getting rid of the committees and having the full consortia do business as a whole" produced the same results."

One person, prior to the new structure took place shared a feeling of insecurity about how the new structure would work without committees:

> The consortium works through committees. The consortium meeting is not really the decision making process. It's a ratifying process. The committees are charged

> with actually doing the work, making recommendations, then carrying the recommendations, supported by whatever evidence they've gathered to the consortium, who then makes the final decision. So, if you're a working member of a committee, and you're working all along, you do have a voice. You can be as involved as you want to be.

What factors contribute to meeting attendance and participation?

Several members reported that food and location does impact meeting attendance. One person said, "That was another thing. It had to be on the bus lines." Upon reflecting about meetings held at the Methodist Hospital in Jacksonville, one person had this to report:

> Yes. And that was another thing that came out . . . . the fact that Methodist Towers used to be a hospital and they [clients] don't want to go to a hospital. . . . it's more administrative offices than hospital, but they still see it as a hospital because it was one for many, many years. So, that's why we moved it to the Cathedral [a different location] so we could have food. . . . . So, Smith Auditorium became it. And, I'm very happy there. I think it's big enough. We can have food; they don't mind. It's not a hospital.

Another member commented about why there may be low attendance at meetings:

> The phenomenon about now nobody comes to the meetings, and we've said a few times maybe because it's not all hot and heavy and debate and craziness and people fighting and you have to whip your people up into coming to the meetings to support your position and all. It's, there's no drama; there's no drama going on. There's very little drama, and that's good for business. It allows you to do the

> actual business of what we are supposed to be doing instead of getting embroiled in all this personal drama stuff.

One respondent talked about member attendance and consistency in attendance:

> So, inclusion and trying to get people to feel free to express and trying to create an environment that they feel they're welcome to come. But, despite these things, we've always had a hard time to get people to actually come and sit down at the table in person on a consistent basis because, you know part of this whole thing is the business of running the consortia. If you come one time and you say a lot of stuff, or whether you do or you don't, but you don't come again for six months or eight months. Maybe you drop in again, how valuable are you to me as a member of the consortia? Not very. You don't do enough; you aren't there enough to participate actively in the process of decision making. You can't come and be there at one meeting and vote without... because you don't know what this is all about.

Describe the decision-making process; and/or describe the voting process.

The consortium's turbulent history contributed to the current decision-making process as reported by one member:

> If you know the history of how the consortia was started and the problems that the community had...prior to the consortia's evolution there was huge issues regarding trust and accountability. And, the people who were most affected by the decisions that were being made felt disenfranchised and didn't feel like they were allowed to participate. So, I think that when the people came together to form the consortia, the passion they had for a process that was inclusive was overwhelming. In fact, if you listen to our mission, ... we talk about decision making that is

> collaborative, inclusive, that advocates for everyone, and that's very important to the members of the consortia who were there from the beginning."

One person commented about the consensus process,

> When I first became involved with the consortia, I was very suspicious of the whole government-by-consensus concept. I thought it was shady and wasn't too impressed. I'm very comfortable with the voting. You know, you vote on everything and every voter has a say. But, over time, watching it work, I think that the consensus process is effective.

Most respondents agreed that consensus was used as a decision-making process.

> It's done by consensus. What we did right near the beginning we had, I forget what her name was, but some lady came and talked about consensus. So, on everything but the finances we do everything by consensus. But anything that deals with money, you know, it's majority vote. I can't remember how, but I think it's majority or two-thirds, but I think it's majority. And, everybody, there is a pretty good trust relationship. Nobody is trying to put anything over on anybody. There isn't any real manipulation going on that I can see. So, it's pretty easygoing. But, I think that's why we don't have many people coming because there's no big issue.

Another person commented about the meetings and voting,

> I think what has happened is the group has just dwindled down and some people just come to the meetings because they have always come to the meetings, because nothing much happens at the meetings. And, I know when we are doing the finance part, people don't understand what's going on. You know, when I'm giving a report, not that I totally understand it some of the time myself, but they

> really don't have any concept of taking some money out of here and putting it over here and what all that means. So, they just vote for it, just rubber stamp it.

Further discussion about voting from another member follows:

> I think we've made a conscious decision to vote on things that are fiscal. If it has to do with dollars, you have to vote. Other than that we try to do consensus unless it's just apparent the consensus isn't going to work, we're not going to be able to agree or whatever; then we have to vote.

One member talked about commitment and voting, "The voting requirement is that you can't just vote if it's the first time you came here. You've got to come and show some commitment so that you know what the issues are at least on some level."

Several people commented about how difficult it was to make decisions due to lack of understanding or not having enough information. One person stated:

> There's so much about this process I don't know, and I'm smart. I can read, and I have a computer and I'm in the pipeline for all this information on a daily basis. And, if there's stuff I don't understand and I don't know...I mean, I feel inadequate to make decisions on some things. I feel like I don't have enough information ...the information that you're given, sometimes you have to trust it. You have to make a decision based on the information that you're given, and intuition.

Another person stated,

> So, you just know that no matter what you know, you don't know the whole picture. That's part of it. You just always know that you are laboring under

misinformation or lack of information, and you just have to do the best you can with what you've got at the time.

One other member indicated,

We do not sometimes have all the information that we need. Sometimes I feel like I am making decisions in the dark. We are just guessing. I just go along, and I'm not a big go-alonger, but sometimes it's not an argument or it's not worth making enemies, or whatever. You figure, okay, I'll get on this one and maybe someone else will give them something else. So, it's a give and take.

Describe the membership characteristics important to this consortium, including recruitment efforts, appointment or selection of members?

One member thought the consortium worked hard on recruiting minority members, but still had consistency in its membership.

I think that if we had any disappointments is that we don't have as many African American members as we would like, and we struggled with that for a long time, looking at ways to increase membership. How were we going to go about? What did we need to do to retain members? But, through it all, many things have remained consistent. Some of the people who come are consistent, and they bring new faces with them from time to time.

Another member speaks to the problems of increasing participation from the minority community,

Everybody knew the problem or problems. Nobody knew exactly how to fix the problems. Do you know what I'm saying? I mean, it's like, 'This is what we need to do, but how do we do it?' I mean, what else can we do? How else can we get

> the word out? How else can we, because most of us are white in the consortia, the blacks tend to stay in their own groups and there's the separation there.

The consortium changed the structure of its meetings throughout the year. In the few months since the change, there was an increase in attendance from the minority community. Educational sessions were offered more frequently. Several people commented about these issues. One member stated, "We are attempting to get more people at the educational stuff." Another member talked about the first educational meeting offered:

> Whenever the first educational one [meeting] was, we probably had thirty new faces in there, or more. You know, how people just kind of after a while, they kind of filter out and walk away? Everybody stayed and we started at 4:00. It was 7:00 when we got out of there.

One member commented about the need to attend to the minority community,

> You know, we've concentrated an awful lot on the gays because they were the ones that initially were having the biggest problems. But, I really think that some kind of emphasis needs to be put on minority groups because they are the ones that are suffering right now.

The skills and competencies of the membership is important for several of the consortium's tasks. One member reflected the importance of having a skilled member chosen to represent the consortium at the statewide planning body.

> What we've talked to our membership about is understanding that it's very important when we choose our representative to go to that group, that the representative be someone who is well able to represent the interest of our

consortia, because it's easy to get swallowed up in an organization like that, and it's important that the person who we choose is able to adequately understand our issue, verbalize our issues, is strong enough to advocate for whatever our issues are, and then intelligent and capable enough to come back and report efficiently about what went on.

Describe problems or barriers the consortium is experiencing.

With regard to the question about conflict, one member stated,

> There is an apathy. Apathy is what I see more than anything else, because [staff member] is so efficient that he does all the stuff himself, and he is very quick. He is very, very good and very, very quick. But, I think with the consortium you need to involve people and take a little longer in what you're doing and involve more people. It's kind of like when you raise kids, you know, getting the job done isn't always what you're trying to do, is teaching the kids to get the job done which takes twice as long. But, I think maybe, when [the past lead agency] was doing it, ...but [staff] was one to involve us all.

The respondent thought the consortium was better currently than in the past due partially to less people on the consortium, and stated, "Oh, it's much easier because people have dropped out."

Another member speaks to the issue of including the minority communities,

> The other thing...would be PWA and/or minority inclusion and involvement. Inclusion meaning bringing people to the table that will stay there, that will actually represent and not just be looking to feather their own nest or whatever, either as an agency, as a church.

One respondent discusses membership issues and the difficulty of recruiting HIV-infected clients.

> The work really is fairly heavy duty in terms of time commitment, if you do it. We have a workable service system, that is fairly easy for people to access, and because there are no waiting lists, and because the array of services is rich enough to meet anyone's needs, there is very little impetus for people that otherwise would be involved in planning, to get involved, because their needs are being met. Therefore, they do not participate in the consortium's activities and it has become more difficult to recruit members that are HIV-infected.

Describe the level of independence the members have within the consortium. Do you feel that you're autonomous, independent?

One respondent spoke to the issue of autonomy and independence:

> Well, I think there's some reciprocity. I know that we create our own agenda, we make our own plans about what we're going to do. We pick out our own educational focuses. We survey our members. Like I told you earlier, we were thinking we were falling down on the job of education and we wanted to do better, so we came up with a process where we had, I want to say, eight business meetings a year and four educational meetings a year, and we polled the members on what topics would be of interest to them.

How has the consortium reacted to change? How does the consortium initiate change?

One person commented,

> A lot of our change has been internal change that we initiated, which is a form of being adaptable if you're going to look at yourself and say, 'You know, we're not doing well here. We could do better. Let's try something different or new.' I think we can deal with change. I do.

Another member stated, "Everything changes and change is good. You can't keep things the same. We have to change." Another respondent indicated displeasure to the changes occurring and stated,

> We're in a process, you know, of changing, and I just hate what we're doing because I just think it so...It's going to be chaotic trying to have no executive group and just having the two co-chairs do everything. Everything is decided in a meeting. That just doesn't strike me as a good use of people's time, effort, and energy. But, that is what people voted.

Research Questions: What contributes to collaboration and empowerment within a partnership? What are the relationships and behaviors of participants in a partnership? What is the relationship between the partnership's members' and leaders' perceptions of their group?

There appears to be a congenial atmosphere amongst the members of the consortium; please describe this.

One member stated the history of the consortium led to the current feelings of congeniality. In the past, ". . . . everybody else was sort of there to protect their interests, or to control the group, you see." Another member states, "And, this is, you know, like a little ray of light in the middle of all of that. It seems like it is a family." Another member stated the informality of the consortium led to the congeniality:

> Sometimes we have people trying to enforce Robert's Rules of Order on us and we're just not a Robert's Rules of Order kind of group. We're kind of a let's just go ahead and get to the heart of the matter and get everybody to state their opinions and feelings.

Another respondent stated, "It works well here because people like each other, and have worked together for a long time."

Describe the communication process within the consortium; between members; between staff and members. Is this working well?

One respondent stated,

> I have to say that I don't always say exactly what I think because I don't want to jeopardize our standing in the community and our ability to do things. Sometimes it's easier to work behind the scenes than to say something directly. You have to know when to hold them and when to fold them, and sometimes you just have to just bite your tongue and let something go....

Another member stated,

> There's a lot of communication. There's a lot of interaction and talking. Most of the people that bother to come to the meetings talk. You know, you're not going to go out of your way to come to these meetings just to sit in the corner and be quiet. Why would you do that? So that's one good thing about having smaller meetings is you have active participants in the meetings. Even in the big meeting, which is not all that big, what is it 25 people or something, people mostly talk.

One person talked about communication that goes to people via mailings,

> Communication works well, I guess. The lead agency has a mailing list of about 200 people they send minutes to and committee members they send minutes to and mailing goes out every month. There certainly are not 200 people participating, on average there are 30. As far as internal communication within the consortium, they have, at all meetings, lots of handouts. Financial reports are always made available, and every member gets them at every meeting. New programs that are coming up are always handed out. Statewide brochures or conferences and materials are made available.

Values appear to play a big part in this partnership. Does the consortium have a values statement? Describe the consortium's or your own personal values.

Most of the respondents indicated that people and their opinions are valued:

> . . . because our membership is fluid, people come and people go, and new people are always welcome, and the face of the consortia changes. Every month there's going to be a new face. An old face might disappear, and an old face might reappear. You don't know. And, so, what we try to do is make sure that every person's opinion is valued, and it doesn't matter if this is your first or your fourth year coming every month, you still get the opportunity to voice your opinion.

Another member indicates, "The interest of the clients come first; it's not about building power; that's why power and decision making is decentralized in this consortium." One member states, "I think that people basically want to do the right thing...Everybody has everybody's best interest at heart." Another person commented, "It's trying to do the very best we possibly can with whatever we have and with whatever knowledge we have." With regard to trust, one member commented,

> I think there's enough trust, enough trust. I mean, I wouldn't say it's all copasetic, but I think there's enough trust that, you know, it's not ugly, it's not hard. I think we've all gotten to know each other well enough.

Another member states being a social worker contributes to the importance of values,

> You have to have shared values, because . . . That's all sort of part of that whole thing again. I think that people who have social work as a profession, you know, it's a...we're a community of people who, we don't all think exactly alike, but there are principles and values.

What are the ways that conflict is exhibited? How is conflict managed, minimized, and resolved?

Most of the respondents indicated how the consortium handles conflict of interest if related to funding issues. One person discussed the policy related to conflict of interest:

> We try to avoid conflict of interest, and we do that by when someone is going to speak about an issue, we ask them to say their name and say what agency they represent, if they represent an agency. If they are disclosing what's going on, so you know when they speak you know what point of view they are speaking from, or what might be affecting their decision or opinion about a matter. We don't prohibit someone from sharing their opinion if they represent a provider or if they represent somebody who has a vested interest in the decision. Because everybody has something to say, and we want them to be heard, be understood.

Sometimes conflict occurs for other reasons. Another person stated, "We sometimes we get into nastiness and arguments, but it's not usually the consortia business. It's things on the periphery of the consortia that deeply affect the people who are on the consortia or

who are affected by the decisions that we make." Another person gave the following reasons for conflict:

> Most people now know each other and know where they're from. What we'll sometimes get into is people, I'm thinking about the particular situation, like where a person who is HIV positive, who's in a consortia, who's been an active member for a long time. He didn't come for a while because he was sick, and now he's back. He is a passionate and strongly opinionated person. What will happen sometimes is we will get into extremely heated discussions about issues and you can hear the undertone of the bias against particular agencies.

Another member stated,

> There hasn't been that much conflict in the past year for a couple of reasons: (1) the membership has dropped to the point where there is not enough people to have conflict and the people that are left are the people that created the thing in the first place; and, (2) they were used to working together when they were all fighting [the old lead agency] back in the mid 90's.

Is everyone clear about roles and responsibilities? What is the lead agency role? What is the responsibility of the consortium. What is the role of staff?

The job of the consortium, stated one member, is very basic:

> The reality is the consortium makes decisions about what does the service plan got to look like; where is the money going to go; what are the eligibility requirements that access those services; and how is the needs assessment going to be structured.

One respondent stated the lead agency role:

> They are basically servants. They are the people who do all the work of keeping the meetings going and getting the minutes out to people and making people aware of what the issues are, you know. And, contracting with people and administering the contracts and stuff, but the decisions about those things are done by the consortia or by working groups of the consortia.

Another member confirmed this,

> They really are just, you know, sort of an administrative arm of all of this. They take care of all the business of the consortia without, they are just the minions of the consortia. You know, idle work force. They pay all the bills, and they write all the contracts and administer and monitor, and you know, assist in any kind of meetings. They do all kinds of technical support for the agencies that are the member agencies.

Another respondent indicated,

> They guide us about some things, like when we were talking about like, you were at the meeting where we had to figure out a way to pay for something, I forget what it was. The training or something that was done, and how to move the money around within the thing to make it work so that it actually happen. And they give us guidance about who's overspending, who's underspending.

One person commented about the current lead agency and compared them with the agency from the past.

> They came on the scene afterwards. So, they weren't part of the battle and the anger and the whatever. They weren't screwed by [the old agency] repeatedly, so they were a little bit more objective although they heard from [the state]. They

> heard from me. They heard from anybody who talked about it. So they knew, but they've been very even handed about things. They are not out to crucify anyone. You know, they are not out to take anything away from anyone or whatever. They really do try to work with people and get them up to speed or get them functioning at least within the contractual arrangements and stuff. The lead agency in the past is sort of like "Terminator," you know. It's never really dead, you know, but is that little hand going to start coming towards you, and you know come to... And, they've shown that. They are like that thing that you can't kill.

One member thought the clients "would see staff as the leadership" rather than the elected co-chairs as leaders of the consortium. Another member indicated, "I do not believe they understand the roles that we're supposed to be playing." Someone else thought, " I think there's some confusion on responsibilities where functions are clear." Discussions about roles and responsibilities of the lead agency, the consortium, and the state are held several times a year. One member indicated, "Actually we just went through orientation in January and unfortunately this was addressed."

Describe the role and responsibility of the leader(s). How does the leader contribute to this consortium being effective in its job? Describe the relationship between the members, leader(s) and staff.

One member stated, "We have a good working relationship." One of the leaders stated,

> I find to lead the group you just have to be comfortable as a public speaker, familiar with the agenda, reasonably intelligent to be able to read and reflect what's going on. Normally right before the consortia meeting I'll put my head together

with [staff], because there's almost always an addition, a deletion, or a change to the agenda.

Upon reflection of the end of a co-chair's term, it was stated,

> But, I don't know, maybe it's like hurtful to sit there when you can't be the leader any more. I don't know. It's not like we got voted out of office because we weren't appreciated. It's just the bylaws that we created for good reason limit the term that you can serve. I think that if we could have served again, we would have been chosen.

Describe the costs, benefits of being a member of the consortium. Describe the commitment and/or the participation of the members. What brings or keeps people involved with the consortium?

The respondent talked about the differences of being a member today versus in the past:

> When you look back at the history, people were fighting for their lives. That is a big difference from what's going on today. Apathy, and I think that is a feeling that a lot of the people have who are living with the disease. You know, it's, even if they are on the medication that they can go on with their lives. You know, back before there was such a fear and so people were involved in whatever was going on because they wanted to live as long as they could. Then, I had to deal with what are you doing this for, your own gratification or are you really to be helpful as one of the people? Well, it's really crucial because you can get very, in our case you can get very matriarchal, you know, and want to take care of all these people when they don't want you to.

Another member stated that other community people add something of value to the consortium.

> I always like it when the doctors get involved. They see things from a different perspective, but I think they don't come to the meetings, but by virtue by what they do and the clients they see on a regular basis and the knowledge that they have of the clients that they see on the regular basis and the knowledge that they have of the needs of clients, the unmet needs and stuff, they're very...They're systems people too. They're not just doctors; they're also administrators, so I really like a lot them. I really do like a lot of the people that participate in this process.

One person commented about HIV and AIDS, "I think that's another thing that holds a lot of people in this arena that stay here is that it is fascinating topic, HIV and AIDS and the treatment of it."

Research Question: What is the link between the partnership's planning activities and its outcome of the plan?

Describe your planning activities? How many people and who is involved? How long does it take? Is the application or plan a quality one? Is it reviewed regularly?

One member fully described the consortium's planning process:

> In one way or another, everybody probably is involved in the process, but as the process gets more specific, the people who actually take a role in the writing gets more narrow. For example, when we're writing the application, we always discuss it as a group. And, we talk about the fact that the application process is starting, and we discuss different aspects of it. Of course, this year the consortia has made a

> change, which means that we will be doing it differently in the future. But, I can talk more specifically about what we've done in the past four years. Because what we've done in the past is we have had different committees of the consortia, Planning and Linkage, Membership, Recruitment, the Steering Committee, who each had a specific area of knowledge. So, what we would do with the application is we would break it down into parts. For example, a couple of years back when I was the chairperson of Membership Committee, before I was the Co-Chair, the Membership Committee had part of the responsibility for completing the application regarding the demographics of the membership, and we would do that piece. Planning and Linkage would do their own piece, and then we would pull it all together. The co-chairs would pull it all together along with the contract manager.

Another member validated the process and stated,

> Well, we have to beg people to participate. It's like, I think you were at the meeting the other day when we were talking about how, I jokingly said we should write the application and do the allocation second because people want to be involved in saying how the money is spent, but when the work of writing that horrible document comes into play, and I'm guilty of the same thing. I don't want to do it either. So, we divide it up into pieces and then we get participation. And, we get kind of the same old people participating that come to the meetings and they are the workhorses. The people that you can guilt into doing it. The same old core group does it, the old stand-bys. It's probably a dozen people, you know, and the lead agency takes the lead in putting it all together. You know, what we do is

we sit around and get the committee assembled, whoever is going to volunteer to work on this. And, what we do, say Planning and Linkage has to participate and Steering Committee. And, a lot of the same members are on, I mean there are a couple committees that have to absolutely, and then you ask for volunteers, and then we have a meeting and we divvy it up. We go through last year's and we look at stuff. [One person] takes pieces of it, [another person] takes pieces, and [lead agency staff] takes pieces, and then we fill in. They are really, [state and lead agency staff] take a lot of it, and then the rest of us, we go through line by line, page by page, and we figure what people can do, who has the oversight and knowledge to do what sections. Because, there again, even with my level of involvement there's a lot of that stuff that's just totally Greek to me. Where I would get that information and how I would, from my little limited vantage point, say what needs to be said in that, that represents the viewpoint of this district. That's it.

I think our plan is realistic. I think it represents who we are and what we are about and what we do and what we plan to do. It's no masterpiece. I don't think anybody would say that it's a masterpiece. I'm sure there are better ones. I'm sure there's a lot worse ones, though. At least it's real; it's based on reality and not on fantasy. I'd say it's okay. I wouldn't give it an A, you know, if I was grading them, but I don't know. I think it's realistic and it's well...it's not crap...it's well written. It's a collaborative effort.

Another respondent reflected on what occurred with planning in the past structure and what may possibly happen with the new current structure and acknowledged:

> In the coming years what's going to be different is that rather than rely on committees, what we've done is the full body of the consortia functions as the committee. And, rather than having us break into individual groups to discuss things separately and come back together with committee reports, what we're doing instead is we have the full consortia, business meeting is a little longer, and we go through each of the responsibilities, whatever needs to be discussed and decided, is discussed and decided as a group."

With regard to the regular review of the application/plan, one member stated,

> Things come up because they're, when you're putting things down, you're saying, What did we say we were going to do? We're always going to have to refer back to that. Well, we said we were going to do this, so we better, when we are making the decision about what services and what we're going to target, keep that in mind. That's always sort of in the back of your mind. It's sort of like your contract, What did I say I was going to do. I said I was going to serve this many people and I was going to try this ... and this demographic group I'm going to target. But, there are numerous times within the year we say, 'Now what did we say we were going to do?' And, there are enough people who are intimately aware of that document.

What is your process for conducting needs assessment?

One member speaks about the importance of HIV infected clients having a voice, using case management services, and the needs of clients.

> There was a lot people not wanting to trust what case managers said because they figure you work for an agency and you're not HIV infected. You know, a lot of

> people think you've got to be HIV infected in order to speak for the HIV infected. Otherwise, you're just trying to fetter your own master. If you're not HIV infected, your opinion doesn't count as much. I've been to meetings, statewide meetings, where if you were an HIV positive you felt like an outsider, like you don't matter. Your opinion doesn't matter. I heard [staff] say that too in meetings. That you're just basically crucified and you know, my point is when you get sick where are you going to be because you're not going to be well enough to run these programs? The well people have to...There's a partnership here, you know.

In conducting needs assessments and surveys, another respondent stated,

> A lot PWA's are not really objective about things. Not all; there are some people who do a very good job. By and large, people who have been out in the professional world or whatever, maybe their needs are being met now. Maybe at one time they were in crisis or whatever, but now, you know, they're able to be more objective. I think objectivity is a real important part of, when you survey. I keep saying what we need instead of spinning our wheels doing surveys and surveys and surveys of people; and trying to get people to fill out these surveys and tell us what they need; and trying to do focus groups---that if they would capture the information that case managers do every six months on every single one of their clients which is a needs assessment and put that in the computer and say, This was an identified need.

Another person stated,

> The process has been fairly standardized. They always use focus groups. They've used focus groups for about the last four years. They do interviews. They do

written surveys. They have public hearings. They do a review of the utilization data. They do a review of epidemiology, and all that is clashed into the 'Needs Assessment.'

Does your consortium have an evaluation process? Is there achievement towards completing the goals and objectives of the plan? Is there a quality improvement process?

Several of the members indicated they evaluate themselves through a yearly retreat process. One respondent stated, "I don't know that it's written in any book that you should do a 'State of the Union Address' every year and grade yourselves and focus your efforts the following on your assessment of yourself that year." Another member stated,

> We would do a yearly meeting in January. And it was like the consortia evaluating the consortia. And, it was, at one time, all the committee chair people. We did it in January 2000, on a Saturday. And, we evaluated how effective we were being. We sort of did okay.

Another respondent stated about the how they evaluated themselves, "It was a grading, a strategic type meeting, and we graded our selves." Another member confirmed the purpose of the annual meeting,

> Well, we just did that one Saturday morning whenever we had that Saturday meeting. I guess we do it about once a year just to check where we are, rate ourselves, and that kind of thing; find out are we doing a good job?

Further discussion with one of the members about "grading" brought this response on one topic,

> And, then we took like committees. Well, burnout. We got Title I committees. We got Title II committees, and all month long you've got committee meetings. People don't have time to do work because they're at committee meetings, so we gave ourselves like a B-.

The self-evaluation became a method for improving the consortium. One member stated,

> We ended up doing a major change in bylaws in 2000 on what to reflect that self–evaluation." Another member stated, "And from that 2000 planning meeting was when it was decided to bring it before the consortia to consolidate and make the consortia the committee.

Describe the prioritization and allocation methods/processes your consortium follows?

One member stated, "I guess what we try to have happen is inclusion and people around the table that represent different disciplines and different points of view, different organizations." Another person said, "This is not a popularity contest; this is about meeting people's needs, meeting the broadest number of needs, and not just looking at who comes to the table if you are looking at inclusion of PWA's." Another respondent clearly described the process followed by the consortium.

> Title I created a coordination committee that links to Title 2's planning and linkage committee and together they created a Joint Allocation Committee that does planning for the consortium. The members of that committee are members of the Joint Allocation Committee. There is a written agreement between the Title I Planning Council and the Title II Consortium that clearly defines how the joint

> allocation and needs assessment process will be conducted. The agreement clearly defines conflict of interest, manages conflict of interest. It actually manages the ability of large agencies to overpower individual voices or small agencies by limiting voting by members of one organization to one vote per organization. Every person present and wants to be a voting member of the committee will be a voting member of the consortium.

How does the consortium assure funding is adequate to meet the needs of the clients? How is the budget monitored by the consortium? What is the impact of the consortium to the client and the community?

One member worried about funding going to small, inexperienced agencies, and declared,

> I worry about other agencies, I know within our agency how structured our fiscal department, how there's checks and balances and how the money... I know that whatever money that comes into our agency, I'm not spending it for purposes for other than Aids work and what goes on in this department. When you have little mom and pops and you have people who aren't as sophisticated as larger agencies or whatever, or maybe when you are so large like if they are part of a hospital conglomerate, does it get lost?

How is the satisfaction of the clients determined?

One respondent stated about the satisfaction of clients, "You know, they're satisfied. It think that's it. The whole thing is I think they are being taken care of, and as I've said before, they don't feel like anybody's trying to pull anything over on them." Another member indicated, "They are being taken care of and they really feel like...I think

transportation was one of the icky areas and dentistry, but aside from those two...."

Another respondent indicated the satisfaction of the clients is done by survey once a year.

Research Question: What characteristics of the partnership and its environment affect the outcomes of the body?

What kind of training and team-building activities does the consortium provide to help the members?

The consortium holds several educational workshops throughout the year. One member stated training is over most members' heads, giving an example about a budget workshop recently held,

> I think it helped the people who really wanted to know. The ones that were there that aren't really sure why they're there, I don't think they really understood what [the lead agency] is. They're there for the food. And, because somebody told them to be there. Literally. Like, 'Get your butt there.' And they were going like, 'What do you do? Where does this money come from?' You could see the look on their faces. Yeah, 'the deer in the headlights look' in all of them. And there were some things like 'Well, I didn't know it paid for that. I didn't know it paid for this.' It's kind of like, 'Ryan White may not pay for it, but you know, somebody will.'

One member spoke about the effectiveness of training or educational workshops,

> It's like trying to explain how the companies blend together to do things and this is a total universe of services available through a funding stream somewhere. But, it was tough to teach people, to make them aware. Because they don't want to be, some of them, you know. The few that do, it's like don't come back and ask questions. So, yes, in effect we did it, but the effectiveness probably isn't right.

> How much of it was actually absorbed. I bet if we did a pre and post test, they'd be identical or worse than the post test.

What kind of support do the leaders, staff and members provide to each other?

One member stated,

> Sometimes, even when the people don't get it, they still get support from the members because they are coming with a problem that's affecting them personally and it may not be appropriate for the consortia to deal with it, but we have a lot of experts in our audience with providers, with the people living with the disease, with the people from the health department. So, we can usually take that person in the corner and help them out later.

Another respondent indicated the members actually help the chairperson and the staff,

> There are some key individuals in the group, either the natural leaders, I will say, who will step and they will ask leading questions to get the [staff or chair] to say what they know what the rest of the consortia wants to hear. I don't want to say wants to hear, but what they need to hear. There are four, five that know enough about the system, been around the system enough, two or three of them will ask in a gentle, open ended type question way, and the other one will always do it in an acquisition, aggressive way.

Most of the respondents feel that staff support is available, adequate and information is accessible when needed, "Every piece of paper we've ever needed is ready when you want it." Staff were also helpful indicating they were "able to summarize for us what the big picture is; ... letting us know what the trends are and what's going on in the state."

Do the political and bureaucratic systems have an impact upon your consortium? If so, how? Please describe.

One member described stigma in the environment and how it relates to the consortium members,

> In this transient age, it's just, you know, clients just don't have the larger family, especially with Aids and with the gay issue. Both of them, you know, families have rejected these people... So, we have taken over, you know, and that was what it was like at the beginning. You were there. I would get phone calls from people--their church has rejected them. You know, their family has rejected them. Some people from Georgia would call because they lived in a small town and they would want to do a support group in Jacksonville because then the family, and nobody, would know in their hometown so they wouldn't be ostracized. You know, you hear, heard all that kind of stuff. It's probably the same now in a small town than it ever was. But, in the bigger city, you know, its not quite as bad as it was. I think it's bad in black communities because they don't think the clergy, the clergy in black communities has really taken to heart the problems.

If you were to say anything about what makes your consortium the most effective in the State of Florida, what are the top three (3) to five (5) characteristics you think would contribute to that effectiveness?

One of the members stated several characteristics would include collaboration, a strong lead agency, open-mindedness, and people are valued:

> Well, the first thing that comes to mind is the collaboration. Everyone who participates is able to participate fully and give their opinion about anything. So,

> that collaborative process presents an opportunity to hear things you might not otherwise hear if you had a more closed process. I don't think the consortia could get the job done without a strong lead agency, because it's effortless for me. I show up with an agenda that I didn't type, you know, maybe I brain stormed some the agenda items with the group of people at the meeting, but I didn't type it. I didn't print it, I didn't mail it, I didn't organize it. I got 97 handouts that are just waiting for me. It makes it look like all this hard work was done. I didn't do any of it. The consortia, the lead agency, did all of it. We are open minded and I think that we welcome opinions from a diverse population. I think when you get providers and clients together in a room and you all leave shaking hands and coming to agreement, that there's a strong value and respect for the individuals who participate. Your opinion is heard and given whatever weight it merits, not because of who said, but just because it's an idea out there.

Another member stated, "I think a good sense of collegiality; honesty, openness. Yeah, we're very open. And, you have the opportunity to avail yourself of all that information, and I think that's it. I think there's a real sharing that goes on." One respondent commented,

> We have stable leadership. I think we have stability of people. And professionality in the ethics of the leadership. I think those are real important. If you don't have that it doesn't matter what else you have. And I think we have the support of...Jacksonville, the health department, there's a core group of people that are in power in these different agencies that are supportive of AIDS. There are people in high enough places that are supportive. There are people who also have a lot of

integrity. That's really the core reason why things work is that the people who have come and stayed at the table are there because they are committed.

Summary of Interviews, Area 4, Jacksonville

In summary, the themes revealed through the interviews indicated that the participants thought the consortium was effective in its work, the members to be collaborative and empowered. The administrative work was completed by the lead agency in an efficient manner, completing and monitoring the contracts for services, managing the budget, and assisting the agencies under contract. Most of the members felt they were open, congenial, trusting and communicative in the meetings. Most of the participants indicated they liked each other, valuing one another's input and respecting their feelings. Most of the people perceived the members were committed, the lead agency was committed and dedicated, and the officers were committed to the client population.

Several of the participants indicated the consortium had worked hard on recruiting minority members and those who were HIV infected, but still had difficulty. In an attempt to get more people involved, the consortium had undergone a major restructuring during the past year, realizing that it was important to have people involved in the process. They also desired to have less committees and meetings, and to make time to do education and training with members. The members interviewed perceived that people did not come to the meetings as frequently as in the past because things were running smoothly, clients were being served and people did not have major complaints. Several people felt there was an apathy among the people.

The participants stated they believed the meetings were conducted by consensus, but majority vote on budget issues. Several people commented about the difficulty of

making decisions due to lack of understanding and feelings of inadequacy. They attempt to make decisions on the information provided by the staff. Most of the participants believed they were empowered to create their own agenda, make their own plans, and choose their direction.

One of the major themes that people discussed during the interviews was that of communication. Most of the members felt that communication was good, with much interaction and talking about issues. They believed that operating informally, without Robert's Rules of Order was better for their group and they perceived it to be working well. They believe they are collaborative, everyone who participates is able to participate fully.

It was the perception that individual and collective values were important to the success of the consortium. The people interviewed perceived that they all shared similar values: every person's opinion is valued and had the opportunity to voice their opinions, the interest of the clients come first, and honesty and trust was important. They perceived themselves to be supportive of one another. Most of the people indicated their reasons for being involved in the consortium and that was to help people.

With regard to conflict, the participants indicated they had a procedure in place to reduce conflict of interest in the voting process. Occasionally, they perceived that conflict occurred with heated discussions about certain issues, sometimes getting into "nastiness and arguments." Most of the members did not think conflict has occurred much in the past year or two.

It was perceived by the interviewees that most members, agencies, and participants in the consortium were clear about roles and responsibilities. While they indicated the lead

agency understood its role, several thought there was confusion about their leadership role. Several people thought that the lead agency was "leadership" of the consortium, rather than the elected officers inclusive of the co-chairs. The people thought the lead agency staff was superb in its work. It was perceived most members understood their role and the state agency understood its role.

The planning function and process of the consortium was perceived by most of the interviewees to be effective, especially in working with representatives from the Title I planning council. This included the needs assessment process. The majority of the people thought that "the same old core group" was involved in the open process, continually reporting and involving the members of the consortium, encouraging more participation by its members. The members believed their plan to be realistic and a quality one, but thought it was not reviewed during the consortium meetings.

Several members indicated they have an evaluation process in place through their annual retreat, whereby they "grade" themselves and seek opportunities for improvement. The emphasis on education and training has been perceived by most people to be effective in that there are more people coming to meetings and involved.

Area 9, Palm Beach

Interviews were conducted individually with six (6) different members of the Palm Beach County CARE Council. The interviews were conducted either in the members' offices or at the location of the CARE Council meetings prior to or after a meeting. The interviews were conducted in February and March of 2001.

Research Questions: How does a partnership's structure and processes influence the partnership? How are decisions made, conflicts and problems solved? How do the rules and procedures influence and impact on the partnership?

Your current structure helps to contribute toward the collaboration, empowerment and effectiveness of the consortium. Please describe/explain how.

One participant described the Council's structure and processes:

> We conduct our business by Robert's rules, major event. Because it promotes debate, and discussion and sound decision making. We've been able to limit the great majority of our meetings to 2 hours for the full council. And in general, the committees are holding to that too. The CARE Council starts at 3 and is officially over at 5, unless the membership votes to extend the meeting time, according to Robert's Rules. The meeting is set: it starts at this time and ends at that time, unless somebody decides. The other thing that's important to Robert's Rules is that when there is a motion on the floor, you may speak to it once and may not speak to it again, until everyone else has had the opportunity to speak. If nobody wants to speak, you may speak again, if the chair recognizes you.

One respondent stated, "We are very organized because our meetings are well planned; the agendas are followed. The chair of the Council, the chairs of the committees are very organized to where they can keep people on track in their meetings." Another person described the physical location and staff as factors,

> We used to meet over in the Urban League Building, in that big room there. Then we came over here because we got more staff, but we got more cramped. I shouldn't say cramped; we became more intimate. We have lots of staff to help us

> now. When we were meeting over at the Urban League there were people getting up all the time, and it appeared that, you know, who was paying attention and who wasn't. Of course you can't stand up and walk around all the time the way it's configured here.

With regards to change and improvement, one member thought that change was good and, in fact, had made the council more positive through the changes. "The environment is much more conducive to, 'Okay, let's think about that idea, and we'll come back to it.'"

How does the past structure contribute toward the current Council activities?

The history of the CARE Council has an impact on the current structure and processes. One member gave a brief historical review and how the integration has been more efficient in coordinating services and funding:

> This really talks about what we did to integrate the council. At the beginning, this was the fund sources that we were incorporating in integration. We really, with this project where people will say, 'I go to so many meetings,' you know. I almost say to the people that go to the Title I Planning body and the same people go to the Title II Consortia, and there are some differences, but a core group was the same in both, and they both seem to be doing sort of the same thing. But, the consortia was focused on just the Title II program which, in those days, was pretty much was just medical care, and the planning body was focused on a full range of services, including medical care because they were picking up some aspects of medical care like the lab tests and the mental services.

So they said, 'Let's do something about this,' and formed one group and called it the County HIV Care Council. Initially they just said, 'Okay, we will do a common needs assessment and determine what the need is out there, and then both funding sources we'll look when they get back.' That year they issued, each group, issued its own RFP so those of us who were caught just had to write two RFPs among the card member thing. People started grumbling because the, we would have contracts with both Title I and II to do like medical care or something. So, people said that if you are going to do the needs assessment, let's just go the next step and let's subtract the needs assessment, what's available where, to get who's going to fund what kind of more clearly coordinated. And, what they discovered is that they could make decisions, like where we would use this fund source for this one because it fits nicely within its guidelines. And, we can get rid of these couple of little pieces and move them back on the other source because we've freed up that little bit of money that was used for, let's say, housing.

So it was particularly good for us, the patient care network, because we had some contracts at the food bank. So, they were having contracts with us for half of their food bank and with Title I for the other half. By moving the first half from patient care or network funding, or to be funded, over to Title I, we could then pick up more medical care and freeing up the Title I money. And, all of a sudden, the provider had one less contract, and the grantee had one less contract. So, everybody began to gain. Someone said, 'Hey, you know, let's do this.' The usual sheet [referring to a budget sheet] that we all do that shows how much you spent at Title I, Title II Patient Care Network, etc., we do up front as part of the

plan rather than at the back end saying, 'Here's how it fell out,' which we did the first couple of years I was here. We could look back and see how it fell out. Now we're up front making the decisions on how we want it to fall out. So, this is the usual sheet, but this is done going into the year and what we're able to see when you do this is why do we have case management contracts in both patient care and Title I.

Another member responded, confirming the historical perspective that was stated above:

We've come a very long way. From when it was Health and Human Services Planning Association, that was when we were just the planning council. It was just Title I, and then it took a long time and a lot of work from a lot of different people, and then we merged with Title II. And, then got Patient Care and Network. They are two different state revenue. So, we have five funding streams, and that's when we called ourselves the Care Council. And, that resolution was approved by the Board of County Commission who is our CEO, and I think it functioned so well, because, first the funders.

They worked together like when, it's not like we're playing with the money, but the fiscal site, the fiscal year for each funding stream is different so if we know that this one is going to run out of money at this time or they are going to have extra money they need to spend, like Title II. When they, at the end of their year, if they have extra money, they'll put it toward some of our services and then when they run out after a while, ours will go back to theirs. So, we can like

play with the fiscal year so that we can cover each other's butt so that the clients don't go without services.

How do the bylaws and/or policies of the consortium contribute to the effectiveness?

One of the respondents clearly stated the importance of the law and how it impacted on his understanding of the purpose of the Council,

> With all that diversity of opinion and motivation, the best way to steer a course is to stay within the confines of the law, and that's where the emphasis of the council is. Can we do this? Can we do that? We debate that from time to time. I was frustrated by that process, I must tell you, when I first came and I wanted to all kinds of things. 'Why ain't we doing this? Why ain't we doing that?' Well, now I understand, and I didn't have that understanding when I first started.

With regard to the formality of the meetings, one participant stated,

> We've had to make it much more formal. First of all, the size. The limitation of time, and things that have to be done, like the things that have been drafted have to be voted on. You try to make them come first. I think that the Roberts Rules, cause I've been around here a long time, I think that it really helps to the whole council meeting run better. The formality is basically following the Roberts Rules.

Another respondent indicated,

> We're working on new bylaws; we have been, and also policies and procedures. And, I really think it is going to define everything. In the past it was enough. It was good for then, but we need more now. We're up to 22 policies already. We're almost done, but we want to make sure we cover everything. They are not approved yet. They all have draft on it. We have our, we're following our

adopted bylaws until these other ones are adopted. They have to go to the Board of County Commission. Well, actually they go to the Executive and Full Council and then the Board of County Commission. But, we've been almost done for about three months now. We keep thinking of more stuff to add. They [Board of County Commissioners] meet twice a month I think it is. They're our chief elected official. Now, the CEO appointed the grantee, which is the Department of Community Services, to do all the contracting and everything else. If anything goes wrong, they are the ones accountable. So we have drafts.

Describe the decision-making process; and/or describe the voting process.

One respondent explained the decision-making and voting process.

All the work, the work is done in committee. The committees are the ones that do the work. Now, the committees work together. I mean, the Needs Assessment Committee provides the needs assessment for the P & A to see what the needs are and how to define what bet meets the need. The Housing Committee tells, you know, they are all entwined. But, the work is done in committee. When it goes to the Executive, the only one that doesn't have to go to the Executive, is the Priority and Allocations Committee. They might report for 'FYI purposes,' but the recommendations go straight to the full council. Everything else has to go through the Executive Committee. So, if the Executive Committee has a problem with it, they send it back to committee; if not, it goes on to the full council.

Now, when it gets to the full council, if you're not involved in these committees, a lot of times there are a lot of people who don't understand what it is, but you have appointed these people; the chair was appointed, these members

have been appointed as members, you have to trust that they did their work, and if this is their recommendation and you don't know one way or the other. They did their work, so it's up to you. But if you have a real problem, of course, you voice it. But, usually when it gets to the full council level it's approved because the committee has done its work, and its homework, and its research to back up.

One respondent stated decisions are based on good information provided by staff:

I like to think that the decision making process is one of consensus. It's based on sound reasoning and back-up information. Again, that's where the staff comes in. People cannot make good rational decisions without good rational input. So, we try to do the grunt work, if you will so they will have something to base their decisions on.

Further explanations by the member revealed the process if something needed to go back to the committee.

You send it back to committee. You need to just tweak it. You say this is not very understandable or this needs to be more specific. It goes back to the committee. No big deal. Okay. They can, if a committee does not have a quorum, they can make a recommendation only on consensus, so they have to state that they do not have a quorum at the time. So, then it's the decision of the full council and Executive Committee. Sometimes it priorities and allocations maybe; something will happen after that meeting and [County staff] needs to reallocate some money somewhere. So, it can go, things can go straight to the full council that hasn't gone to committee if you're under time restraints.

Describe the membership characteristics important to this consortium, including recruitment efforts, appointment or selection of members, its impact?

One member described membership of the CARE Council as, "... a collection of different types. We have one third of our CARE Council made up of providers; one third are people impacted by the virus, and then one third are community activists who are concerned about HIV." With regards to the membership committee, one respondent stated,

> The membership committee has, it doesn't just meet and that's it. We do interviews on prospective members, and also guiding them through the process, the manual. Then we have to meet as a membership committee to approve the people, you know, it takes two or three people at interviews. It has to go to the Membership Committee for full approval. From the Membership then to the Executive Committee, and then to the full council. After the full council it goes to the Palm Beach County Commission. Also, membership committee involves keeping track of attendance. You know, there are many people that are on committees but are not on the council, but everybody on the council must be a member of at least one committee.

The person indicated that the committee had staff support, "A good staff member reports to us and works with us." He further described the diversity of the Council's membership. "The balance of the membership is between affected community, demographics, what percentages, why you report percentage--Black or Latino, and then there's male and female, infected and not infected, their health care providers."

One person commented more specifically about the members having specific expertise needed by the Council.

> We have a very diverse membership. We have the expertise that we need. I mean, people that are on our council are not, like the providers that are there, they are not there to represent their agency. They are there because of their expertise in whether it be case management, dental, medical, housing. They are there for their expertise; and I think just having them there and trained staff that gives training to the consumer, the consumer is more, becomes more of an advocate for themselves and more aware and understands how things work, and learns how to better take care of themselves in what they are. They have a voice, and they come to these meetings and they make a difference to where before they were just, 'It doesn't matter. They're just moving where ever...' So, we have such a diverse different population on our council along with the expertise we need, along with, I mean the expertise of the consumers too, because they know what they need.

Another member described the recruitment of members for their expertise and gave an example.

> Actually the priorities and allocations committee probably is the one committee that does not have a lot of care council members on it because of the expertise we need. We have basically recruited a guy for the P & A committee because of several reasons, but we do want the chair of that particular committee, due to a job change and some other things, we knew that person would no longer be able to serve. So, we went out and recruited a guy who's a fiscal person for another local tax supported organization, but he deals with numbers daily, and asked him if he

would serve and, actually I was kind of shocked when he said yes without venting. He said yes, and he's one of those new people. But, he has attended a couple of P & A Committee meetings, and, you know, the wonderful questions like, and nobody else knows it but him, like 'Why, the fiscal year from this funding source is this, and why is it over here? Why don't you have one fiscal year?' Of course the answer is very, very simple. We can't because it's established by somebody else, not us. But, we deal with five different funding sources and three of them have different fiscal years. So, that means we have two with the same fiscal year.

Another person discussed the membership requirements and stated,

Our resolution is one-third consumers, one-third providers, and one-third non-elected community leaders. Not to say that a provider wouldn't fall into one of those slots, but I haven't heard that term provider-driven in years, which is good, yes. Our recruitment is a lot better.

Describe the empowerment or level of independence of membership of the consortium. Do you feel that you're autonomous, independent, or empowered?

One person described empowerment within the consortium:

Members are more empowered than before. By having a voice empowers people. By thinking that what you're saying matters and makes a difference, and could sway something one way or the other. I mean, you're making a difference and the Community Awareness Committee put together that forum out in Belle Glade which was so great. How empowering is that? 500 people that don't know where to get services or what or how to use a condom or whatever. You're helping these people. What's more empowering than that?"

Another member described the voting process in response to this question.

> The leaders and staff do not sway voting, they explain. I mean, the chair does not say, 'This is how we're going to vote.' Or, when a motion is brought is forward, it has to have a second for discussion. Now the person that seconds the motion doesn't have to agree with the motion. Just need a second to discuss it. Now, when [the chair] feels that everybody's done with their opinions or they keep saying the same things over and over again, he'll ask, 'Is there any more discussion or anything we haven't discussed as of yet?' No. Call the Question. So, usually it's YEAS. I've heard a few NAYS. Then we take a hand vote, and you know, if its 13,4 and 2 against, motion carried. So, no the chair cannot tell the committee this is what we're going to do or this is how we're going to vote.

Research Questions: What contributes to collaboration and empowerment within a partnership? What are the relationships and behaviors of participants in a partnership? What is the relationship between the partnership's members' and leaders' perceptions of their group?

There appears to be a congenial atmosphere; please describe this.

One member stated the atmosphere changes,

> It is tense, it is amenable, everybody is happy. All of these things. It depends what the issues are. I mean, we can get hot and heavy. We can be laughing the whole meeting. We could..., it depends, it changes. We value and respect each other, so we can be flexible in our feelings.

Describe the communication process within the consortium; between members; between staff and members. Is this working well?

One participant described communication in the [consortium] as "semi-chaotic."

> You can imagine an organization of almost 70 people with 7 staff. First of all, Florida Sunshine Law precludes us from talking with on another so that adds an element of difficulty to communication. Communication is impacted by each staff member having assignments to committees. If I have an MIS question, I know I have to deal with [MIS coordinator] on it. If I have a membership committee question, I deal with [membership coordinator]. We're not relying on staff to communicate business about various committees between one another other than when there is something that says medical committee ought to talk to the P and A committee, or something like that. Then we expect that staff to see to it that communiqué goes from one committee to another.
>
> The other is that minutes are done within a month of the meeting. We tend to meet monthly. The committee is responsible for the review and approval of their minutes. Every member gets a packet about Wednesday or Thursday prior to our monthly meeting. That packet contains the latest versions of the drafts of committee minutes, the last meeting minutes, copies of drafts of motions that are probably going to be made at the meeting; we know of in advance. So that's all communication, respect.

One staff member stated having specific staff members assigned to respond to committee chairs was important for both staff and consortium members, and it provides increased member satisfaction, "They see me as somebody that's been here a long time, if they have questions, they'll call me. I used to be more involved; my phone rang off the hook. Now, more staff to help with the committees." Another person stated, "We don't

have any trouble calling another member of our committee or vice versa. They usually don't care. Everybody is calling the office, just to talk to the different people or [staff]. Good communications back and forth."

With respect to all the information sent to the membership, one respondent commented: "We have good communication, but all the materials and information sent out is a little much for anybody to read. Committees can't give reports at a meeting; not enough time to do it within the two hours." One member spoke of written and verbal communications and gave examples of how they communicate and encourage members to attend meetings:

> There's a lot of communication, like in the package that [staff] sends out every month, and all the minutes, and everything else. Continually, information is on the web site. By telephone is another way. For instance, we have a problem with that committee (P & A). The attendance in the last few months has not been good because it's not an important time of the year. Once we allocate those funds for the next contractual year, which just started last week, once we are basically finished with that in November, prior to us sending off the grant, then people think they've got a second bite at the apple after the grant award we get.
>
> So once all of that is completed, it's kind of difficult to pique people's interest, but what they don't know, from a staff perspective, is we have pushed the process up almost two months. Rather than going to the Board of County Commission with recommendations at the end of September, we want to be finished in August. So, [staff members] are going to be singing the song all next week, okay. It's got nine people on that committee, but each of them will get four

telephone calls, two from me, two from her, and the people who are on the committee who also represent the infected and affected community will also get calls from [staff]. Some of them will get three calls from us. 'We want you to come to the meeting. Is there any reason why you cannot come? If there is a reason why, can we alleviate that reason for you? What can we do to keep you coming to this meeting because this is a very important meeting.' Because we are getting ready to go in to looking in the P & A committee before, well two meetings, ask staff to come back with a two year work plan rather than a one year work plan. Because, what they are contemplating recommending to the Board of County Commission is letting contracts for two year. So, we won't go through this same old, same old every year. It makes sense.

Values appear to play a big part in this partnership. Describe the consortium's or your own personal values and the importance to the consortium.

One respondent discusses how values are made evident through behaviors:

We take time, and the Chair is wonderful. He explains everything, and if you don't understand something, ask. We don't want, we try not to make anybody feel inferior to anybody else because even the people that are there for their expertise that are maybe the executive director of somewhere, they are no better than somebody coming down from Belle Glade to join us in the meeting. So, we try to make everybody feel at home, and we try to play the host and not make them feel like they are just sitting there and not even, like we don't even know they are there. Everybody is introduced and everybody, it's getting a lot better. We're getting a lot better with parliamentary procedure.

One member describes his values, the reason for being a member of the consortium, and how he thinks making an impact on individuals is important:

> It's like you live your whole life and you can't look at one single thing, point to one thing that you've accomplished about which you are proud and that sort or stuff gives you hope. So, while I lived in that depression and self-deprecation, I became homeless and was an alcoholic and drug addict. It took a lot of work, and still does take a lot of work on my part, to try to remember that we don't live for ourselves, we live for one another.
>
> In spite of everything that each of us can have an impact on the next and we try to balance the scale of wrong and right with something right, doing as much right as I can and instilling hope in others that they can do the same thing. You don't have to be Moses; you can be just be somebody willing to help the next person. If you keep it little and not grandiose, keep it small, each person that you make contact with walks away with a little something, a little piece of something that they can hold on to. That's the low life I've learned to accept and it's okay. It's okay for me. I am not looking for a statue of me for pigeons to shit on. I think, you know, I'm not looking for that at all. I don't want my name on anything. I am more interested on the impact that I have on an individual because they'll remember that longer than the statue.

Another member speaks of impact upon individuals: "it's really about the day to day impact that you can have on one or two individuals." One person speaks about the value of helping other people beyond self and of spiritual connection:

> You know, I was not a person with a lot of values. You know, values are something that people remember, and usually my values were related to my need more than anything else. Well, I value that because I need that. Today, I think I have the value of trying to care about the next person as much as I care about myself, and to try to have a genuine relationship with each and every person that I share my story with and that I talk about HIV with. And, not just eye contact, but spiritual contact with that person. Very important for me to have that. Because, that comes back and you get that back and people respond, and you get smiles. And, when they laugh at your jokes, it's a genuine laughter; it's not politeness. Do you know what I'm saying? They are laughing because they are with me.

One person commented that members of the consortium were there to do a job, but to do it with respect, compassion, care and love. "You know, it's like, 'God, I'm here to learn,' which helps me to be a better giver. And, also the respect for other people as human beings. We are all here as one people." Another member discusses the partnership between staff and members:

> There's the partnership with staff person or the other folks that are willing to give to you or to the other folks involved. I see that, I see that as a key thing as one of the things that makes this council so special--the staff and the members. Well, the respect in treating people with respect and care, love and compassion, and that we're all in the same boat. We care about people. You know, and we are here to do a job.

Another respondent commented about learning to trust and respect others,

> I was always the kid who thought he had to answer, and so I have to be careful and allow others and trust the others are just as committed to problem solving and the goal of preventing the spread of HIV as I am. And, sometimes as a soldier in this war, I think that others aren't as capable, not if they don't have the same motivation. There's politics involved in what they're saying, and so I've learned to respect, to trust others and I came into the process with difficulty trusting people as a result of life's experiences, but now I'm more able to trust and to be more part of the collaborative. To contribute and not feel that my answer was the answer just to make my contribution, have people hear that and then move on. And, I'm learning it.

One member discussed the value of having a vision for the future, preparing the next group of leaders.

> We have to make room for people coming behind them. That's my message. Be thinking about the next group. Think about the future. What about the group behind you? How are they going to get theirs? How are they going to get the support that they need and the services they need? As long as we are blocking all the slots, okay, maybe you can't get a massage, but if you can get your medications and have a job to pay your own rent, I mean you can kind of make it from there.

One person stated the reason many are part of the consortium to help others, "That is why we are here. To help the consumer. That's the only reason we're here. Many of us have compassion, respect, admiration for each other, for the client." Values were a part of another respondent's discussions with the researcher:

What has happened, people have wonderful values, and the only problem that we have had has been from sort of the community care council members toward some of the staff. In other words, not that it's the staff's respect for council members, and the council members' respect for the staff, but most of the council members have. I have the greatest respect for the staff. The staff is wonderful.

Whether as a member or staff representative, the tone reflected passion. One member described the value of passion and responsibility.

If I am going to be here, first of all, I'm responsible, Okay. I don't care what screws up, I don't care whose fault it is, even if it's the chair, I am responsible because I get paid the bucks to be responsible. So, from that perspective, I guess that's where the passion comes because I was taught if you're responsible, you've don't accept second rate anything.

Passion--I think that's there where the values are. They're in the passion that people have for what they do because we are talking about people who are spending a lot of time volunteering their time. Some of them directly infected, that is, affected. Some of them indirectly affected, and some of them simply because they realize this is a disease that could destroy us all if, in fact, we don't get a handle on it. Especially in my community, we're going to lose a whole damn generation of little black boys and a generation of black women. So, I don't think people, when they see HIV stuff and AIDS stuff on the television, most of the times they are showing atrocities in Africa, and that's too far away. My next door neighbor last Friday night died of AIDS. That's when it's close. That's when it's close. He participated here. This is a guy 41 years old that moved where I live. He

was a little boy; his father and I became very good friends, and dad was older. He died maybe two years ago, but the son was there. His mom, who is pretty close to over 80, typical elderly woman. He was her 24-hour care giver. He's dead. Okay. Well, it's not like. He has another sister and a brother who lives here in town, but he lived there and, so, you know. I don't think people really grasp the enormity of what's happening.

What are the ways that conflict is exhibited? How is conflict managed, minimized, and resolved?

A very clear process is in place to manage and dissuade conflict, as one member discussed.

We've had trainings on the Sunshine Law done by the Assistant County Attorney. We make it quite clear that council members know you do not even talk between two people, you do not discuss anything that's going, that may be voted on at the [consortium] meeting. They can discuss how this does work, because we've assigned mentors now for the new people which is working very well. So, we have a mentoring system in place, but how does this work? Questions. No consortium business that might be voted on is discussed. If you have a question, you call staff.

Other conflicts of interest, when something is being voted on, and maybe it has to do with housing funding, for example, anybody there from any housing agency abstains from voting so there is no conflict of interest. They have to sign a little form and put it in there so they are not counted in that vote.

One person commented about conflict and anger and how staff may intercede to resolve the conflict. "Sometimes you're the one that's involved in a particular case, and

very angry and mad given that you want things done your way; and your mind is all made up. Very simply put, the staff person gets involved then." Another respondent spoke about 'anger moments' and gave an example.

> We have some anger moments, sometimes about personal agendas. There was, I won't say anger, but I'll say teary-eyed moment when we did our allocations for next year's fiscal year. A lot of people were here. They need housing and the Pahokee thing [a local news event], we had nothing to do with that. That doesn't come from Title I, and they came to us thinking we could help them.
>
> It was heartbreaking. They're telling us their stories. It did end up, at the end of the meeting, we were allocating more money toward housing, but they didn't let us get there. But they were blaming, the Pahokee thing had nothing to do with Title I. I mean, we didn't take that funding away. It was kind of heartbreaking. We had like 70 people at that meeting and I felt bad. That was two months ago, in our conference room; it was standing room. As far as anger, yes sometimes, but then mostly it's from, I mean not often, but from the consumer when...'Well, I know somebody that gets this and this, and how come I can't get this and this?'"

Another member indicated the Roberts Rules of Order were responsible for reducing conflict.

> I got a chance to see basically tumultuous meetings from the previous chair. Not anything against the previous chair, but rather the group as a whole. We had not had parliamentary procedure training. We had not had anything even remotely looking like Roberts Rules of Order, okay. So, we had a parliamentarian, a

recognized parliamentarian to come here and do the thing for about four hours. Then, the chair, followed it up with what he called an 'Educational Moment.' Before each meeting, depending upon what he had seen at the previous meetings, he would emphasize a rule through example, 'You don't talk to another member; you talk to the subject through a chair.' He kept emphasizing stuff like that, and pretty much meetings are civil, shorter, significantly shorter, and taking care of more business.

Another method used to reduce conflict is described by one of the members.

I think we have gotten over the major obstacle called mistrust. People didn't trust each other because it got to a point where, I mean, when you have providers, consumers, and interested people, if nothing else, providers are going to become pushy. They think that what they do is best since sliced bread, etc. But, what has happened is, and it didn't happen overnight, but you could constantly hear this refrain in committee meetings and council meetings. 'We're not talking providers. We don't talk providers. We talk service categories.' And, I heard these statements in council meetings: 'What hat are you wearing? Are you, it sounds to me like your provider hat.' I've heard people say that. 'I think you're wearing your provider hat, and we don't talk provider. We talk service.'

I think that has changed a lot. Not only that, even though that some providers are here for purely self-protection reasons, and I don't blame them, they really, really do participate because now they realize things that are happening directly impact them. Quality Assurance--we have had so much cooperation from providers on quality assurance, putting together the standards of care, because

> they want to make sure, if nothing else, they could meet the standards. Okay. So, it's been excellent metamorphosis if you will.

Describe the relationship between the members, leader(s) and staff. How does the consortium help members to learn and grow?

One respondent stated,

> The thing that was interesting was that individuals who had been on the council since the beginning were very, very patient and some of them were extremely impatient. It's like, look, you don't know what you're talking about, so shut up. Others were like, I think you're right about your point, but we can't do that or here's a gray area over here. So, I had to learn how to be more part of the team than I was when I first came here. I thought coming here and just being one of those wild brand, kind of person, full of ideas... Yeah, but you know, not a clue how to do it. Now, I know a lot of things that I didn't know. So as a result the council educated me and refined me in a way.

A respondent talked about the little rituals evident in the consortium and how they help members to feel part of the group, "I like the 'moments' we have: Informational Moment, Cake Moment. Lots of good moments. We have a Moment of Silence every meeting. [The chair] reads a little thing of why we're here. We have Educational Moments during the meetings."

Is everyone clear about roles and responsibilities? What is the lead agency role? What is the responsibility of the consortium. What is the role of staff?

One member described the role of the consortium, but also discussed the difficulty in being a new member and in understanding the role as a member:

> ...because the council is limited to an advisory role primarily, as it relates to the distribution of Title II money anyway, it took me a while to understand the difference between Title I and Title II, and that Title II, by law in the county, has to prioritize money the way we suggest, and that, the function of the consortium is basically to try to educate the public at large about services that are available. That prevention was not of our thing. It took the first couple of years to learn, and the concern I had was that if it was that difficult for me, and I'm relatively knowledgeable, then people with less knowledge and experience would have an even greater difficulty understanding what was going on.

One person suggested that new members may not understand their role:

> I am quite sure that there are some people who are a little fuzzy simply because we have just gone from, when I first got here care council had 21 members. Care council was very difficult to get quorums, well, basically because of we are approved to have at least 45 members. We were at the minimum. That is, our bylaws say between 21 and 45. To go back to your original question, when I say some of the members are fuzzy, because 13 of them, we're up to 34 now, thirteen of them have been on board about a month.

Another member stated the Council does understand its role, but the chairperson has contributed to this understanding:

> It really does [understand] and I have to tell you that the chairperson, his leadership has been much, much appreciated by me. We have philosophical differences but what he has been successful at doing, at least in my case, is getting us to discuss those differences without being uncivil.

One staff member indicated, "I'm staff. I help when I can. I try to be professional as well as compassionate and friendly." Another staff member reported,

> My role is to make sure, from leader on down throughout the council, that they, one, do what's federally mandated and in an acceptable federally mandated way. I look at my job as saying to the [consortium], if they are gong astray, we should be approaching this from a different direction because the rules and regs say thus and so. Like this morning we talked about the jail linkage program. That was the first time I had brought that subject matter up because it appropriately should be at the membership committee and it is on their next agenda. But, the question was asked, so I answered it. But, what we normally do, we, you know, I sit here and I hard copy stuff they send. I sit here and make sure we are on track as far as HRSA is concerned.

Another member discussed learning about the roles and responsibilities of everyone:

> The council members are learning their roles and responsibilities. They are doing a lot better, because we never had the staff we have now. We didn't have the health planner and the program director and the quality assurance coordinator. So, it's a lot to learn, as far roles and responsibility of staff or of committees.

With further regard to staffing, another member stated,

> The one thing that makes us function and effective is spending money on staff. We used to do it with 2-3 people. Now we've got a program director, an evaluator/researcher type, a committee coordinator, an administrative assistant, an MIS director, a QA coordinator, a membership coordinator, and another person that works with those who are clients.

Who is/are the leader(s)? Describe the role and responsibility of the leader(s). How does the leader contribute to this consortium being effective in its job?

One member described the officers as leaders of the CARE Council.

> The officers are leaders, the vice chair. Officers, staff, program directors, of course. As far as, those are like the people kind of in charge, but I don't look at one person and think a leader. I look at them as people, so I really don't, I mean I work as well with [officer] as I do with [member], you know, or the chairs of the committees. The chairs of committees are leaders. It depends on what you're considering. I think everybody on the council is a leader. I really do. They are there by choice and, you know, sometimes it's really hard to speak your mind or hard to go against what other people are going 'Yeah, let's do this. Well no, let's not.' So, to me they all are leaders.

In response to being asked who the leaders of the Council were, another person stated, "You mean the Executive Committee? That's the leadership of the Care Council." Another person stated, "The chair."

One respondent was a chairperson of a committee and discussed the effects of his leadership.

> I believe that under my leadership we've made it more people friendly in the sense that what we try to do is to educate people; use it as an entry point for new people with little experience working in a consortium environment or a meeting environment where Roberts Rules are employed and other complexities. So, we have tried to use it as an entryway for people to educate themselves about issues,

as well as trying to encourage them to learn Roberts Rules, and to not be intimated so much by the process.

The member further discusses the skill necessary in being an effective leader.

> It requires a little bit of skill. The skill involved is trying to encourage people to participate without making them feel inferior. Part of that is to allow them the freedom to make mistakes and to do things, not to be so strict in the application of Roberts Rules, and, not to, although you encourage people to use Roberts Rules, I don't strictly enforce that. People feel comfortable. We've always had a family environment in this committee, and so people coming here and sharing and talking, and once they achieve that comfort level then they can move to another committee and branch out and learn more. They are less inhibited. I try to instill confidence in folks, and one of the ways that we have done that is to take on projects that are easily achieved.

One person stated that feelings of mistrust due to racial prejudice was "baggage brought to the council with me that related to issues that had nothing to do with the council." He commends the chairperson for helping members to overcome the feelings of mistrust and for making people feel part of a team, "I give credit to the chairperson. His leadership has been very, very effective in making all of us part of a team through his own unofficious way. And that team spirit hasn't always been there."

Describe the level of commitment and participation of the Council members? What are barriers to participation and commitment of members? What does the consortium do in planning for the future leaders and members?

One respondent stated his feeling about each member's commitment.

> You know, there's no doubt in my mind that the whole council, that at the whole council level, there is an intense level of commitment, but what motivates that commitment is very, very different depending on what group of council members you've got together. If I am a provider and I'm at the table, then I am concerned about the programs and services that I provide and how they are impacted by the priorities and allocations process. And, so to that end, my focus on committees might relate directly to influencing that process. Whereas, I'm on the other end of the spectrum only because it's safer. I don't want to get in the way.

Another person commented about a general sense of apathy.

> I want to be involved in educating the leaders of the future because, for me, there are so many people who are being infected by the virus who don't seem to have the same sense of fear or concern about being infected as I do. It's almost, there's almost a nonchalant attitude about HIV that I still haven't really understood myself. It's sort of like when you take people who are confronted with so many threats to their existence, and you add another one. It's like, so what? As long as I don't do this or as long as I don't do that, I'll be safe. Now, nine times out of ten, they're wrong, but the attitude is not one of concern. Not urgency. No sense of urgency, and I'm concerned about the rate of infection among young people.

Another person discussed how mentoring and training has helped new members,

> A lot of new members, not the ones that were just brought on because we started our mentor program. Every one of them has mentors, so they sit at meetings. If they don't understand something, they can find out. But, there was a period when people were, consumers were coming to meetings and they would just sit there and

> that was it. 'We're glad you came; we want your participation. We want to hear your voice.' And, now that we've had different training and they've gotten to know people on the council and know the staff, they're actually participating at the meetings, not just being there.

One respondent discussed how the Council's value of respect contributes to member participation.

> Nobody's better than anybody else. You know, just because you don't understand something and somebody who is a Ph.D. doesn't mean, you know, we'll take time and explain it to you. They're not better than you. We've gotten that through. I mean, [member] never has Ph.D. on his name plate. He wants to keep it an even level because, just because you're a Ph.D. or because you're unemployed, live in Belle Glade doesn't mean what you have to say is less important than the other person.

What contributes to the satisfaction of the members on the partnership? What are the costs, the benefits? Is it worth all the time and effort?

One person gave an intense description of the sense of hopelessness in the African American communities and part of his job, or others like himself, or perhaps on the partnership, is to have an impact on the people.

> There is a malaise that I'm just aware of and I can't really, I haven't been thinking about it long enough to determine how long I've been aware of it. The thing that seems to be evident to me is that African Americans as a whole, we have distinctions, but we have classes within that category. You have people who are extremely educated and very sophisticated and very successful who are

knowledgeable about not only HIV, but other issues that threaten their life. And then you have a middle class sort of that is also knowledgeable and somewhat sophisticated and are more protective of their health say than the poor people if you will of that ethnic group.

And, it seems that there is a depth of hopelessness that seems to pervade that poor part of the African American community that makes it---it's like a blanket; it's like heat. When you go from one environment to the other you know that you're in that environment. You can sense it and feel it and know that people, they just don't want to talk about it. They don't want to hear it because it's just one more problem that they can't have any impact on sometimes they feel. So, part of the job that people like myself and others have is stirring that up and encouraging people and infusing them with a sense of, 'Hey, maybe I can have an impact on this problem. Maybe I can do something. If nothing else, as a relation to me and mine, me and my children, maybe I can educate my kids.' In the process of educating their kids they find that the task is not that difficult, is not that daunting, and then soon they start feeling like maybe I can educate my neighbor's kids, and it's a step by process.

It sort, it puts me in mind of the civil rights. I'm old enough to remember the Civil Rights Movement and there was a time in this country when civil rights, there were people who were very sophisticated and educated who knew what the issues were and understood and could articulate what they were. And, the people who mostly, who were impacted the most, were the poor and the disenfranchised. And, there were people whose lifestyles didn't nobody else identify with or

> associate with, and so they, I refer to them as disposable people. It's like this aluminum can. We used to throw these on the ground until we realized the value of recycling. And, I think until we realize the value of recycling people in the same way that we recycle plastic, aluminum, and other materials that they understand that they are disposable.

Another person stated, "I think the majority of the members are satisfied with the way things are happening."

One member gave his reason for working so hard on the Council, "I was still living in [the north] and there was a big coverage of Mother Teresa and her nuns opening like a hope house in Greenwich Village. Actually, it's mostly homosexuals that were dying of AIDS, and the church teaches against homosexuality, and I was thinking how could she be there? It's like. That was the big problem in the beginning. It was treated as a political football. That's why I'm here. That's it."

One of the respondents stated the Council assists those members with funding to allow their attendance at Council activities.

> We pay for transportation and do some reimbursements for child care if necessary, and we happened to have two guys fall into the group where we reimbursed for job wages, loss of wages. We do that too. We have some other positive people who are professional people who don't request reimbursement because they don't lose wages when they come and participate as opposed to some of the guys with hourly jobs. If they are gone two or three hours, they lose the money. So, we reimburse them here based on check stubs, and we've gotten letters from employers that say how much they make an hour. But, it's not something that, it's

rare, actually. Most of the people have served some time on at least one or two committees.

One respondent described his feelings about member satisfaction.

> If they were not satisfied, they would let [lead agency staff] know. And, when you say satisfied, well I can answer it in one of two ways. One, answer in relation to staff. I like to think that they are satisfied. Certainly we have not been without complaints but the complaints outweigh the compliments you heard this morning. They don't outweigh the compliments because, you know, we've made some turn-arounds here. And, they are not lost on me and I like to brag about them. Like I said, look at our role as being the catalysts to make those things happen. But, I think that when I first came here there were a lot of frustrated people. I don't see the frustration any more, not that it is totally resolved, but I think it's been a whole lot more happy than what they used to be. Because there are some changes. There are more bodies and if you look at our organizational structure, having to have to have at least one HIV person on ten committees, eleven committees, you have to have recruiting base and have to have people in place ready to go with knowledge. So, that's why we have come up with that, basically it's about like a baseball training camp, if you will. 'Hey, you want to serve on a CARE Council? Come sit on my so-and-so committee.'"

Research Question: <u>What is the link between the partnership's planning activities and its outcome of the plan?</u>

Describe the consortium's/council's planning activities? How many people and who is involved? How long does it take? Is the application or plan a quality one?

One member stated he was a member of the planning committee and described the involvement, "I am on the planning committee. We're now putting together the overall two year plan, three year plan, whatever it is. Strategic Plan, that's it; what we're going to do. The Planning Committee has responsibility of developing the plan."

Another person described the involvement of staff on the application/plan. With regards to the Title I plan, it was stated,

> It is a combined effort between members of the Council, including lead agency staff, county staff, and a consultant that they hired. But, the consultant was not hired to just do things like Title I. It is a consulting grant writing service that the county retains for all of their grants. Other than the priority and allocations process, Council member involvement is minimal. Because of the work, you know what the grant application is all about. The grant application is nothing but a review of your previous year, so the care council's input is there. They ask about processes. How did, first they want the P &A processes described.

With regards to the Title II application, the respondent stated,

> We have no input, but the same answer goes. The Council does get stuff during the year and gives input into the grant application like that. With respect to Title II, I can't answer that because I don't know what Title II's application even looks like. But as far as the grant is concerned, [staff] tells me the final amount so we can have that input for the Council. What the Council blesses are actually the funding levels. We, I don't know whether the Council has seen the draft of the application actually. They get the work plan; they get monthly updates. In both instances, Title I and Title II, they do know that the work plan is directly related to

this. That they know about, but as far as seeing the planning document, I don't think so.

What is your process for conducting needs assessment? Any other comments?

One of the members his thoughts about needs assessments and stated,

> In my opinion, they're not doing a very effective job in doing a projection of need. I don't think they project. They do needs assessments. Those needs assessments, in my opinion, are narrowly focused. They are not projected far enough into the future to be able to impact on resources that may be allocated for future use. We have the ability to project numbers, but it's not enough to project the numbers if there's no strategy associated with the projection. What are you going to do? How are you going to move from this point to being able to accommodate those numbers, the increased numbers, just to plan for doing that. How do you make the services accommodate the need if you recognize there is a need?

Another person commented,

> We did a phenomenal needs assessment this year. We worked long and hard. The ideas for that came from Seattle and Boston, I think. We liked the booklet style that they used and ideas from the other one, and we added a few 'localisms,' issues that we had.

Does your consortium have an evaluation process? Is there achievement towards completing the goals and objectives of the plan? Is there a quality improvement process?

One respondent indicated, "The council as a whole does an effective job providing services to the people who are willing and ready to access those services." Another

person stated, "We hired a QA Coordinator recently and got together a QA Committee. We'll be devoting more time to this process during the next year."

Describe the prioritization and allocation methods/processes your consortium follows?

One respondent described the process with examples.

> The P & A committee is also responsible for making changes during the year if there is any budget changes. They make allocation recommendations; priorities don't change. The allocation recommendations could change for a variety of reasons. For instance, if you .. now most of the time that will heed administrative reports we receive from Title I, Title II, HOPWA, Patient Care network, etc., because those staff people doing their jobs will come in and say, in, say in the substance abuse category, just for the sake of talking, we allocated $100 thousand here. This is month six and they've only spent 80. They are not going to spend all of that money, so they recommend that we take $50 thousand out of this service category and put it over there. Now, the P & A committee, they will do several things, either accept that recommendation on its face or look at some other service categories and their spending patterns to see if somebody is overspending, see if that need is there. But, never once, for instance, if a provider that's providing a service that is, say, priority seven, unless it is something very, very crucial that money would not go to eight, nine, or ten. It goes back up to priority one, and then you start to look.

How does the consortium assure funding is adequate to meet the needs of the clients; how are services coordinated? How is the budget monitored? What is the impact of the consortium's activities on the client and the community?

One member described the job of the consortium is to assure services are provided to the clients.

> I think when it comes to services, the council does an excellent job of insuring that quality services for the treatment of those who are infected with HIV are available; and they provide those services to a wide cross section of individuals. And, I think their record is probably as good as anybody in this state, if not better, in doing that part.

Another member responded,

> Because Title II is a tenth of what Title I is, it doesn't get the scrutiny. Patient care and network is a valid tenth. When they're all together, they're a third. The Council always compares one to the other, and never looks at the whole package.

A person stated how the planning efforts went from coordinating a plan to coordinating services in the community.

> We went from unifying the planning process to coordinating the, and this sort of got out of order because this one really should have been up there. The guy who put it together, it's just the requirements--Title I requires the Council have a plan. So, we went from coordinating the plan and just said, 'Now we can coordinate the services,' and as they say, find out who's contracting with who. So we use all of these, including HOPWA funds and the city of West Palm Beach is about to pass a

little ordinance saying that the CARE Council will be the presiding body of the HOPWA funding. So, that will make things nice.

Another person described how the Council handled recent funding shortages in one of the budget line items.

If we take this statement a little bit further as an example to aid that money right now, potential, shortfalls on that, from the state, from the federal government, then you have to reallocate other monies. Let me give an example and tell you, first of all, we called attention to the ADAP Program before anybody recognized it. We wrote letters to the state back in December from this CARE Council because we have experienced five people who were cut off by their insurance companies, and we are talking about to the tune of about a thousand dollars a month for medications and only two of them qualify for Ryan White.

So, we wrote, it came up at medical services committee, approved by the executive and the full care council, we wrote to the state and local health care district, and who else did we write. There were three letters that went out just apprising people of the problem and saying, hey, we need to do something about this problem all right. Most recently, at the last Executive Committee, or was it at the CARE Council meeting? We have discovered the fact that there's about a million-and-a-half dollars a year spent out ADEP money that rightfully in Palm Beach County should be paid for by the health care district. We have a care council member that either has gone to the health care district or will be going to their next meeting to say just that. We want you to take care of your own clients.

> Ryan White is the funder of last resort. We know that these people are eligible for the health care district.

Research Question: What characteristics of the partnership and its environment affect the outcomes?

What kind of training and team-building activities does the consortium provide to help the members?

One respondent indicated training occurs frequently.

> We have training on, we've had quite a few forums. Different kinds. We have like, we would have a facilitator. [Provider, Dr. X] did a big thing this past month, or last month in Belle Glade, to update on medications. We had trainings on, even in our meetings we have guest speakers. People can tell us what they need to know, what they don't know, what they don't understand. We've even had trainings on how to read an expenditure report."

Another member stated,

> We had a training, gosh, it's probably been a year ago, about parliamentarian. The chairperson's become such an expert with his little book that we used to have, we used to like, for five full council meetings we had a Robert's Rules of Order moment where he went over a couple of things. He didn't bombard you with it; just a couple of things, you know, each meeting. Then we would have, like for five meetings, we had like a moment of information. We had an informational moment; that's what it was.

A person spoke about the annual retreat, which the CARE Council calls, "conference;" "We didn't discuss CARE Council business at all. It was like 'a get to know you'." One respondent stated,

> We have a new council coordinator, who's only been here since last week. Her whole role is to train the council members. She has to come up with a training curriculum first. She has to finish training/orientation manual that we had started from the previous person that I won't talk about, but I had to terminate him. As far as them being trained yet, formalized training, no. But, sure some of them were around when we had the parliamentary Roberts Rules of Order training. Yes, some of them were around for that. But, we have not done any....I think we have kind of been blessed with timing.
>
> The Board of County Commission appointed those people actually January 9, I think it was, and we had our Council Conference on the sixteenth of February which was all about working together, getting to know each other, team building, the whole bit. So, the timing was excellent. And, some people, I could even see it this morning, if you didn't attend the training you wouldn't pick it up, but I could see it this morning. We had a whole session on being hosts, I saw members practicing: 'Good morning. How are you? Please find a seat. Come on up front.'

The person further described mentors and the retreat.

> Then we set up a mentoring program. That's just starting. The first time 'mentees' and mentors got together was at the conference. We had a session, hired a consultant and had a whole two pages of questions that if you were my partner I'd ask you and then you'd ask me the same question, and we just got to know each

other. It was great. Then there was another exercise where people paired off and you told a lie about yourself and you told something that nobody would necessarily believe but it was the truth. Then you had to pick the lie as opposed to the truth. It was a great exercise because it was so funny. Anyway, that kind of get together, it was great. We fed people. We always kept some refreshments there, and I even had a bed in case somebody wanted to go lie down, but nobody used the room.

Another person stated the personal touch and recognition was important,

We've had, when our thirteen new members came on, we asked everybody to be here a half hour earlier and we had a little reception, and I did the name tags, and we ate cookies and punch. It was (a member)'s birthday, we had a cake moment. We gave out certificates of appreciation, and we might have a cake moment. You know, we'll break and have cake for fifteen minutes and then come back to the meeting. Anybody that leaves the council gets a certificate. They had, when was it, they even did it for staff one time. It was this past year.

With regards to training new members, one respondent commented,

Training is in the process. I would say I didn't get very good training because there wasn't any training program. But now we have, and that's another thing that the Membership has worked on, is the training program and a manual. In fact, even during, when people are wait listed, even pending in employment, even when they are interviewed, we encourage them to go to committee meetings, you know sit on a committee. We look that at that from the training too. Go to committee meetings. Get on a committee, and look at training too, and come to the full council meetings too. It's nothing personal. It's like kind of preparing people to be

> involved in the meetings on a small scale and then as they normally go about that, to expand and become more a part of the full council. And, I think too as we have cases come up where it may be a person that infected, in the community may have lacked the skills of being on the council, and the encourage them. You know, we tell them what to expect and encourage them to go on to committees and not become a member of the council, or they could make application for council later.

Another person commented about training and helping new members. The person stated his sensitivity to helping others and encouraging them to learn about the Council and its processes,

> ...because of the environment that we have here, the family environment, I like that term. That we try to make people feel comfortable. Not that they make mistakes; they are learning how to talk out and speak out and advocate for themselves to other people here, and use the process, and not be intimated by the process. I think sometimes, particularly for people of color who have a tendency to talk one way when they are among themselves; then, when they are put in an environment where the speech is formalized in the Roberts Rules environment, for instance, they feel uncomfortable and at a disadvantage. My goal is to show them they don't have to be intimidated by that. That, even if they don't use the right terminology, as long as they get the point across, the chair, if he is at all sensitive and aware, will conceptualize in such a way that it hits necessary points with respect to Roberts Rules. But it's just a way of talking and a difference that people shouldn't be intimidated by, but just be aware of. That's all, more than anything else. So, I try to debunk it and demystify it a little bit for people.

What kind of support do the leaders, staff and members provide to each other?

One respondent stated he offered support to others by being a role model. "Essentially what I am trying to do is develop leaders for the future, using myself as a role model for what to do and not do because I am not a perfect individual, and sometimes don't have good ideas." Another member indicated,

> I was always amazed by their [staff] capacity to listen to and hear so many different voices and try to respond professionally to the needs of each of those. I was always struck by that. Now that we've increased the staff by at least doubled it, so that there at least six people on the council staff, I think, we're even more efficient. We're much more efficient obviously because we've many more hands doing the work. But, we've managed to attract some quality people to this work that makes the difference. And, so yes, they are part of the collaborative in the sense that the staff, the committees, and they do the real grunt work of most of the committees.

One person spoke of the lead agency staff,

> She has always been somebody that you could talk to and who was willing to listen, whether she agreed with you or not. She always gave you the courtesy of listening. And, her answers, if not an affirmative or a negative, were always sensitively phrased and put. So, I think a combination of things have come together to make this council into what it's become. And, that to me is a forum of diverse interests and ethnic backgrounds and objectives into a symphony of harmony and working together in a sense of we're headed in the right direction,

and we are all pushing together to go that way. I like it now. I like it much better than I did earlier.

One respondent talked about the recognition of members as being business partners.

It would just send a nice little signal if all Council members had business cards. You saw it this morning. They had never had business cards before. But, we can do all this stuff in house, so I had [staff] to give every CARE Council member ten business cards a piece. We will be telling them again, if they want us to change the phone number on there, because the phone number comes here. If you want us to change the phone number on there to where ever you want it to go, we will do just that for you.

Another participant discussed the responsiveness of people and stated,

I'll tell you something else that I've realized, you would be amazed that anyone I have had either direct or indirect contact with, they have been very responsive. They are cooperative and I think it's basically because we are perceived as being in this boat together, if you will. Swaying every five years of reauthorization and this is something that is not going to go away in five years, and I hope that somebody will look at it and take the emergency off the act and say, It's here to say.

Do the political and bureaucratic systems have an impact upon your consortium? If so, how? Please describe.

One of the respondents talked about resource shortages and the growing numbers of HIV infected people, and that the consortium needs to be more aware of this.

> The African American Community will be impacted by HIV for many, many, many years to come. And, impacted in a way that the gay community and others won't be because Ryan White will not be a sufficient resource to impact on the numbers of people that will have the virus. And, with the conservative Republican administrations that are in place and will be in place in the future, along with representatives and senators and so forth, they are cutting the growth of the Federal budget. So, the resources aren't going to be there to impact on people in the same way. So, my concern is that we're going to have pockets of South Africa right here in this country; pockets of areas where people will be dying from the virus simply because the resources aren't available to help them manage that illness.

In speaking about "disposable people," one member stated,

> Nobody really cares about that particular group even though you'd be hard pressed to find somebody to say that publicly, but the truth of the matter is that when they make laws and do tax refunds, they are thinking about the top one percent of the country. They are not thinking bout the people that they consider non-producers, the people that are the drain on the economy, and that sort of thing. And, it's that group that is being impacted by this virus in numbers that are scary, and they always have been.

One member commented about the religious groups have an impact,

> Believe it or not, you got to show people things because behavior is learned, and if you don't show them, then can visualize it or imagine it, and do it wrong. Even though they use a condom, still infect themselves or their partner. So, part of the

> problem again here is conservative, religious institution has such an impact on the politics of HIV that we can't teach, we're handicapped in teaching kids the things that need to know.

One respondent talked about the confusion regarding the laws, "Sometimes, for example, the government, I guess it's HRSA, sends down directives and it's like changing rules in the middle of the middle of the game. The rules are confusing enough."

Describe how the consortium collaborates with other organizations, if applicable; and impacts the community.

One member talked about collaborating with community citizens,

> When we decided to do outreach in Belle Glade, for instance. We brought people from Belle Glade and made them the center of the focus. They did the planning. I stepped out of it. I was on the side. I was on the periphery and the leadership just rose. It was unbelievable, and the planning just took hold and we had a lot of support from local community groups that were in Belle Glade.

Another respondent describes the impact of the CARE Council's activities on the community.

> To leave in place when you go from one place to the other, you've left something great, like when we left Belle Glade we got testimonials from people who were not part of the planning process, that nobody knew was HIV positive, but because the environment that we created was so warm and so loving and so supportive, these folks stood up and said, 'Yeah, I have the virus too, and that's the first time I've ever said to anybody.' So, they are more active, and you leave one or two. You

know the numbers aren't significant, but when you have one, then you can add two or three, so you do what you can.

The problem is so big and so huge that you can only go at it a little bit at a time. So, we can have an impact in our small way; hopefully through forums we establish dialogue and relationships where we didn't have them before. And, we can encourage them to carry on when we move on. And, at this moment, that's as good as it gets. If we can have a reciprocal line of communication between council and community; and let people know that this council is here to hear them and to, at least on the education side of the divide, do what it can to impact on the virus in those communities that are most adversely impacted.

Another member also commented about Belle Glade,

They'll come here to go to the doctor instead of going to the health department there because they see you go in there, you know. So, it's kind of hard to get those people involved, and now they are which is a necessity. Because Belle Glade needs a lot of help. Our forums out there. We have, was it last year or the year before, we had two forums out there just for the P & A process. Just to ask them 'What do you do? What do you think about...?' to get their input. We've had guest speakers out there. Having committee meetings or having full council meetings doesn't work out there. It really doesn't because most of our people are here. They don't want to go all the way that far and the people, I mean, we taxi them in from Belle Glade, so..." "There was a very good turn out. I can't remember those figures too well. I would say there was a good 30 people there. But the forum they just had on the docks, there was about 500 people there. Five to six hundred

> people on the docks. Then, the dinner for them, they had the week after, they think there was about 100 people just from Belle Glade. It was excellent. That was when [provider speaker] was speaking. That was very well planned.

Several people thought the CARE Council was very efficient and effective in the way they conducted business. One person had a vision and further described how the Council would collaborate with other consortia in the future.

> It's a process in which, as it's going along, is becoming more efficient, that's evolving and becoming more effective or efficient. I predict, and it's a good prediction in a matter of Nostradamus' prediction, I think we're going to become a model for not only other committees, but for other planning councils. Even on a, not only on a national level, but I think maybe in the future, some of the things we're doing may become a model for let's say, an international level in places that have high incidences of, you know, urban populations having HIV, and so forth.

Describe the top three (3) to five (5) characteristics you feel contribute to the collaboration, empowerment, and effectiveness of this consortium.

One member indicated several characteristics,

> I would say the leadership of the council. I would say that the individuals we have represent diverse interests, are dedicated, civil, truly kind people who are concerned one another. And, I would say the staff that we have is professional to the staff that they are not anal retentive; they do their jobs well which means they're professional. They get paid for doing a good job, but they are also people who are sensitive, empathetic, caring, kind people. Sometimes professional has

> been interpreted to be anal retentive and robotic, but these folks are genuine people and I like most if not all of them.
>
> So, those combination of factors have come together and make us the council that I think that we are. I also think, too, that we have a sufficient number of individuals from the community that lend us, that give us a 'funk- element' that prevents us from puffing up too big and keeps us mindful of the fact that the people that we serve are people who sometimes are inarticulate, sometimes uneducated, sometimes at the bottom of the socio-economic scale, but that they are just as valuable and just as capable of serving as members of this council as people with alphabets that are so long behind their name, it took them twenty minutes to say their name."

One participant gave a brief listing, "One, a strong chair. Two, dedicated people. Three, a half-way decent staff." Another person summed up by stating,

> The funders; the commitment; the organization; the staff; the council members; especially the committee members; that we're not fighting each other, we're working together for a common goal; we all get along. I've heard of some horrendous stories, my goodness, of police having to be at meetings, you know. I think, overall, our EMA [eligible metropolitan area] is doing as well as it is because we all work together.

Another respondent stated,

> One of the things that makes it the most effective I think is representation. We have male/female, Black/White/Hispanic, infected, community leaders, health care providers. That's a nice note. It's out of balance, but it certainly is representative.

> We have everybody at the table, a very diverse group. We are trying to still include some of the others, like the Latinos, more people, more representation there. We also have a good recruitment program, very involved. There is recognition of the work that's done. [The chair] is very good about that. Like people, they work, they have to leave, he does have a recognition of the work they have done, some type of scroll or plaque. I think the efficiency of the staff is excellent. Never unpreparedness. Nothing like 'pops up.' I think the idea of keeping membership up to par, make sure the open chairs are filled, that there is an efficient way to get members in, to get them trained, to get them active right away, making them feel like they are a part of everything and so they can contribute and participate. I think there's recognition and that is very important. That is recognizing people's experience. Not just the book learning, but also the streetwise.

Summary of Area 9 Interviews

In summary, the participants interviewed from the CARE Council perceived the consortium was effective in its work, extremely collaborative and empowered. Each of the participants perceived the meetings were very effective because of the structures and processes in place. The use of parliamentary procedures (i.e., Robert's Rules of Order) has made the meetings more organized, on task and effective. Several people stated that this occurred due to the size and diversity of the group. Most of the participants believe the chairperson is well organized and agendas are followed. Meetings are held at a stable location with support staff available.

The participants perceive the members of the CARE Council to be very well informed. They receive much information in the mail and at the meetings of the CARE

Council and its committees. One member perceived communication to be "semi-chaotic," reflecting the Sunshine Law in Florida precludes them from talking with one another. Several members believed that staff are good at informing the membership and leaders about different activities and important issues. In fact, the lead agency has assigned specific tasks and committees to specific staff members, which allows the Council members to be able to have someone assist them with questions and concerns. Additionally, all the participants interviewed feel that minutes, agendas, and other information is sent to them in a timely fashion. Most of the participants believe there is lots of communication.

Several participants believe the ability of Council members to go to specific staff for assistance helps them to be effective in their duties. Staff support is important to the Council achieving their goals and objectives. All of the people discussed the relationship between Council members and staff to be very good and very open. They all believed the Council members and staff understood their respective specific roles and responsibilities. Each of the participants perceived the Chair and the officers as leaders of the Council, with staff being there to assist and offer support. All of the participants believed the Council members were provided opportunities for training on a regular basis and this has allowed the Council to become better at their jobs.

The members also believed the CARE Council to be well known in the community. Several people interviewed perceived the past history of the Council and other partnerships has had an impact on how the Council is currently structured. One member presented a brief historical review and indicated how funding and services are better coordinated through the Council's efforts, and the agencies are more collaborative.

Several of the participants gave examples of the outreach provided in the Belle Glade community as an example of collaborative work in the community.

Several of the participants indicated the importance of having bylaws, policies and procedures developed by the members. A few of the people thought having policies and procedures provided the structure, or "framework" to conduct business. They perceived that member inclusion in the development of the rules offered more "buy-in" and feelings of empowerment. One member believed that members are more empowered than ever before because they have a voice, and they feel are making a difference. It was indicated that the "voice" is accomplished through participation on the committees, by speaking up, and through the meeting process. They indicated that work is done in committees and actions are recommended to the CARE Council members during its monthly meetings. The participants perceived that the committee structure was important to the success of the Council.

Most of the people stated that decision making is done through voting. Several people perceived that decision making was done through consensus. Several participants perceived the membership was not swayed or influenced by the staff or leaders. Each of the participants indicated that there was a process in place for the CARE Council to handle conflict, pointing out training offered, mentoring, and parliamentary procedures. The members will attempt to dissuade or handle the conflict, but if necessary, the staff will step in as a last resort. Most of the members perceived that the Council has become very trusting in the evolution of working together, which have reduced conflict and anger.

Each of the participants indicated the importance of the Membership Committee and the work they accomplish in recruiting and training new members. The process

includes seeking applications from prospective members, interviewing the prospects, inviting them to participate on committees, and voting on the person's acceptance into the CARE Council. Several participants mentioned that new members are also sought after with specific expertise or knowledge in certain areas. The bylaws describe the membership requirements. Most of the participants described the mentoring program in place for new members and perceived this helped people to learn more quickly about Council business, and contributed to feelings of satisfaction, inclusion and empowerment.

Several of the people indicated they were not involved in the planning process or in developing the grant application and plan with goals and objectives. They indicated that was left up to the staff and trusted the staff to complete the requirements of submitting the application or plan. They all described the needs assessment process and felt all the Council members were included in this activity. It was believed this was more important in the planning process than actually submitting the plan. It was also perceived the Council received regular updates and progress reports during the meetings. The needs assessment process was believed to be "phenomenal" this year, more accurately projecting needs and priorities. The priorities and allocations committee then prioritizes services based on the needs, and funding is then allocated. All of the participants believed this to be a very good process and effective for their area. Most of the people believed the Council does an excellent job of reviewing funding regularly with adjustments made to assure services are provided to clients.

Values appear to be a major theme associated with the collaboration, empowerment, and effective operations of the CARE Council. All of the participants interviewed gave many examples of expressing their values, and also discussed specific

values shared by the Council members. Most of the people perceived the leaders and staff to be compassionate, caring, understanding, and giving of themselves. All of the people believed everyone was treated with respect, honesty, and compassion. The leaders and staff members interviewed perceived this to be true as well. The value of helping other people was very important, having the "day-to-day impact" on people's lives. Several of the people talked about values being equated with "passion," believing that everyone of the Council and the staff involved had a passion for helping others. Each of the participants interviewed believed that the Council members and staff had an intense level of commitment and motivation.

In conclusion, all of the participants believed that leadership and having a strong chairperson was a key factor in conducting the business of the Council effectively. Most of the people believed that staff support and having diverse and dedicated people on the Council also contributed to its effectiveness.

Comparison of Interviews between Jacksonville and Palm Beach

Members of both partnerships perceived their respective consortium to be collaborative, empowered and effective. Table 14 (p. 241) provides a more in-depth review of the responses from the interviews.

The lead agencies in both areas were perceived to provide exceptional work and support, as well as providing information and communication to the members of their respective consortium/council. Both groups were perceived by the participants to have difficulty recruiting minority and HIV-infected people to become new members, but the members from the CARE Council in Palm Beach perceived their membership process to be highly effective.

Both consortia offered training and education to the membership. Participants from each partnership believed values contributed to the effectiveness of the consortium/council, believing the other members to be friendly, caring, compassionate, and respectful, valuing each person's input. Most of the people from each group perceived the members and staff to be committed to the client population.

While the Council in Palm Beach followed parliamentary procedures during their meetings, the consortium in Jacksonville did not. The members of the CARE Council in Palm Beach believed the committee structure was important in accomplishing the work of the Council and that committees contributed to the effective operations. The members of the First Coast CARES Consortium in Jacksonville perceived committees were important in accomplishing the work of the consortium, but through a major restructuring this past year, eliminated most of the committees. Some of the members from the Jacksonville consortium perceived this to be a mistake.

The members from Jacksonville perceived the decisions at consortium meetings to be made by consensus, with majority vote on budget and funding decisions; while the members from Palm Beach believed all decisions to be made by majority vote on all motions brought forward. Participants from both partnerships believed there were effective processes in place to handle conflict.

The members from the CARE Council in Palm Beach believed everyone very clearly understood the roles and responsibilities of the Council, the lead agency and other funders. They knew and understood the Chair and the officers to be the 'leaders' of the Council. The members from the First Coast CARES Consortium in Jacksonville believed there was understanding about the role and responsibility of the consortium, but perceived

there was confusion about the leadership role. Several members thought the lead agency to be the 'leader,' while several others thought the co-chairs to be the leaders.

All of the participants from the Jacksonville group believed the whole planning process was very inclusive of the membership of the First Coast CARES Consortium, from needs assessment to the prioritization and allocation of funding to the actual writing and submission of the application/plan. Most of the members from the CARE Council, though, indicated the members were included in the needs assessment and prioritization and allocation, but not in the actual writing and submission of the application/plan. Members from both groups perceived the annual retreat to be the evaluation process for their respective consortium.

Table 14. In-depth Interview Comparisons

Theme	FCCC, Jacksonville	PBCHIVCC, Palm Beach
Decisions	Difficulty of making decisions due to lack of understanding and feelings of inadequacy	Decisions easy to do; Robert's Rules of Order help with the process
Values and Empowerment	Clients come first Feel empowered	Values perceived to be highly important; Member "voice" and inclusion offered more buy-in and feelings of empowerment
Communication	Good, much interaction	Chaotic due to the Sunshine Law; well informed; staff support
Formality/informality	Belief that informality was good for the group	Parliamentary procedures; great bylaws and policies
Membership recruitment	Look to get people on the consortium	Recruitment is made for specific expertise and knowledge needed by the consortium; offer mentoring to new members
Conflict	Perceived occasional "heated" conflict	Reduced due to training, mentoring, and parliamentary procedures
Planning process	Belief that everyone is involved	Trust the staff to accomplish; members are not involved; feel the needs assessment is more important
Application/Plan	Belief that the plan was realistic and quality	Perception of high quality
Monitoring of Plan	Did not think plan was reviewed during meetings	Trust that the staff will do
Training	Belief that education & training is effective	Training has allowed members to be better at their jobs; regularly
Meetings	Belief food attracts clients to attend meetings.	Belief that meetings were very effective due to structures and processes in place: • size & diversity of group • staff support • parliamentary procedures
Meeting attendance	More people attend meetings and get involved because of the training and education	Excellent; no problems
Relationships	Congenial, trusting, caring, open	Caring, respectful, empowering, open between members; Well known in the community
Leadership	Confusion exists	Superb
Structure	Informal; have bylaws	Belief that bylaws, policies & procedures important and provides the "structure"

The Survey Responses

Data were gathered from participants of the two study sites at different times and using two (2) different instruments: (1) the Group Environment Scale (Moos, 1994); and (2) a revision of the Plan Quality Instrument (Butterfoss et al., 1993), revised for the current study and renamed the "Application Quality Instrument" (Appendix J). The two (2) surveys were administered in person to the members of each consortium. The GES was administered verbally to the whole membership of each community partnership and the data was collected at the time of administration. The AQI was administered to a smaller number of participants from the planning committee within each partnership by electronic email attachment. The respondents returned the results back to the researcher by one of the following methods: fax, email, or by U.S. mail. The results of each of the surveys are presented separately by regional area.

The Group Environment Scale

GES Respondents in Area 4, Jacksonville

On March 21, 2001, the researcher attended the First Coast CARES Consortium meeting. The researcher had arranged previously for half an hour on the agenda to verbally administer the Group Environment Scale to the consortium members. There were 33 members in attendance that evening.

The researcher distributed 33 survey booklets and 33 computer-scanned response sheets to the consortium members. The researcher then read the instructions to the participants. The participants were asked to complete brief demographic information on the answer sheets. The demographic information contained information about race;

gender; age; length of time in the consortium; and whether they were a member, leader, or other.

As indicated in Table 15, there were 33 members in attendance, 18 were white and 15 were African American. There were 18 males and 15 females in the group. There were eight (8) African American males and seven (7) African American females, and there were ten (10) white males and eight (8) white females. The largest subgroup of the First Coast CARES Consortium membership is white male.

Table 15. Race and Gender of GES Respondents, Jacksonville

Gender	African American	White	Total
Male	8	10	18
Female	7	8	15
Total	15	18	33

Twenty two participants indicated the length of time within the consortium, as reported in Table 16, and two (2) did not respond to this question.

Table 16. Length of time as members, Jacksonville

Years	Members	%
>5	5	22
4	2	9
3	1	5
2	1	5
1	7	32
<1	6	27
Total	22	100

The majority of members on the First Coast CARES Consortium, 59%, have been members for one year or less. The second largest majority included 31% of members with longevity of four (4) years or more.

Twenty two of the respondents answered the question of status within the consortium as either leader, member, or other; as indicated in Table 17, and two (2) did not respond to this question.

Table 17. Member Status within group, Jacksonville

Status	#	%
Leader	2	9%
Member	12	52%
Other	9	39%
Total	23	100%

Two (2) participants, 9%, of the group indicated they were 'leaders'; 12 participants, 52%, indicated they were 'members'; and nine (9) participants, 39% indicated they were 'other,' which included visitors, guests, and staff members.

The age of the respondents is indicated in Table 18. Nineteen of 24 of the participants responded to the question of their age. Four (4) participants, 21% of the group, indicated they were 50 years of age or older. Seven (7) participants, 37%, indicated their age to be between 40-49; and eight (8) participants, 42%, indicated they were between 30-39 years old. There were no other ages reported by the respondents. The membership includes a variety of age groups.

Table 18. Age of Respondents, Jacksonville

Age	#	%
50 years or older	4	21%
40-49 years old	7	37%
30-39 years old	8	42%
Total	19	100%

GES Respondents in Area 9, Palm Beach

On March 26, 2001, the researcher attended the Palm Beach County CARE Council meeting. The researcher had previously arranged half an hour on the agenda to verbally administer the Group Environment Scale to the consortium members. There were 43 members in attendance that evening.

The researcher distributed 43 survey booklets and 43 computer-scanned response sheets to the council members. The researcher then read the instructions to the participants. The participants were asked to complete brief demographic information on the answer sheets. The demographic information contained information about race; gender; age; length of time in the consortium; and whether they were a member, leader, or other.

There were 43 members in attendance that evening. Six (6) of the 43 members did not respond to the survey. Of the 37 members that did participate in the survey, 33 participants completed the demographic section on the answer sheet, as indicated in Table 19. Four (4) respondents did not complete the demographic section, but did answer the survey questions. Of those 33 members, 17 were white and 15 were African American;

one (1) did not indicate their race. Of the 33, there were 13 males and 19 females in the group; one (1) did not indicate their gender. There were seven (7) African American males and eight (8) African American females, and there were six (6) white males and eleven (11) white females.

Table 19. Race and Gender of GES respondents, Palm Beach

Gender	African American	White	Total
Male	7	6	13
Female	8	11	20
Total	15	17	33

Table 20 indicates the length of time participants were members of the consortium, reflecting membership longevity between less than one (1) year to nine (9) years.

Table 20. Years as members, Palm Beach County CARE Council

Years	Members	%
6-9	2	7%
>5	3	10
4	4	14
3	5	17
2	4	14
1	6	21
<1	5	17
Total	29	100

The largest subgroup of members, 38%, have been on the CARE Council for one year or less. Nine (9) individuals, or 31%, have longevity of four years or more, up to nine

years as a member of the CARE Council. The other nine (9) members, 31%, fall in the mid-range of having been on the CARE Council between two to four years.

Thirty two of the participants responded to the question of member status within the consortium as either leader, member, or other; three (3) did not respond to this question, as reported in Table 21. Two (2) participants of the group indicated they were 'leaders'; twelve participants indicated they were 'members'; and nine (9) participants indicated they were 'other.' Two (2) individuals identified themselves as being a leader and a member.

Table 21. Member Status within group, Palm Beach

Status	#	%
Leader	2	6%
Member	15	47%
Other	15	47%
Total	32	100%

Fifteen members, 47%, considered themselves to be members only, while two (2), 6%, considered themselves to be leaders of the Palm Beach County HIV CARE Council. The 15 others, 47%, included staff, guests, and visitors to the meeting.

Twenty four of 33 participants responded to the question of their age, as shown in Table 22. Two (2) participants, 8%, indicated they were over 60 years old. Six (6) participants, 25%, of the group indicated they were between 50-59 years of age. Eight (8) participants, 33%, indicated their age to be between 40-49; and eight (8) participants, 33%, indicated they were between 30-39 years old. There were no other ages reported by the participants.

Table 22. Age of Respondents, Palm Beach

Age	#	%
60 years or older	2	8%
50-59 years old	6	25%
40-49 years old	8	33%
30-39 years old	8	33%
Total	24	100%

The largest subgroup of the Palm Beach County HIV CARE Council is between the ages of 30 to 49, or 66%. The other 33% include those 50 years of age and older.

GES Survey Results

The data from the GES were analyzed using the non-parametric, Pearson's Chi-square statistical test in the SPSS 10.0 computer software program. The chi-square test was used to test the statistical significance of the responses to the GES by comparing the responses between the groups for each question. The groups include the two community health partnerships in this study. The respondents from Jacksonville included N=21, and the respondents from Palm Beach included N=37, with a total of 58 respondents. The chi-square analysis used the observed and expected frequencies to test the eight (8) null hypotheses presented in Chapter 1. The expected frequencies of true or not true responses on the GES for the consortia in Area 4 and Area 9 are those that would make the proportions the same. The evidence for rejecting the null hypothesis would be "the extent that the observed (actual) frequencies differ from the expected frequencies," as Dickter and Roznowski report in Leong and Austin's (1996) text. The test statistic at the significance level of $a = 0.05$ was used.

Comparison of GES Results between Jacksonville and Palm Beach, Areas of Similarities

Of the 90 true-false questions on the Group Environment Scale, 73 responses, or 81%, were found to indicate similarities between the two groups, as represented in Table 23 on page 251-252. The table is structured with the responses from Area 4, Jacksonville, identified in Columns 1-3; and the responses from Area 9, Palm Beach, identified in Columns 4-6. Column 7 shows the significance level for each question. As represented in Table 23, one may see that the chi-square statistical test did not find any of these responses to be an area of significance. Areas of differences are discussed in the next section of this paper.

It was found that both the partnership in Jacksonville and the one in Palm Beach were similar on four (4) of the 10 sub-scales: expressiveness, self-discovery, order and organization, and innovation. There were no differences found in any of the 40 items on the four sub-scales. The expressiveness sub-scale on the GES measures the independence of action and verbalization of feelings being encouraged in the group. The self-discovery sub-scale measures how much the group encourages others' discussion of personal problems. The order and organization sub-scale measures the formality and make up of the group, as well as the clarity of the rules and controls on the group. The innovation sub-scale measures how much the group promotes diversity and transformation in its own operations and activities.

The groups were similar in all respects to the responses of questions related to cohesion, responding similarly to 8 of the 9 questions. It appears that the members from each partnership are very much involved and committed to their respective group and they show concern and friendship towards others in the group.

Of the nine (9) questions related to the sub-scale of leader support, the two (2) groups were similar in responses to only four (4) questions. Members from both partnerships feel the leader supports the members by the following activities and behaviors: spends time encouraging the members; explains things to the group; and takes a personal interest in the members. Members from both groups also perceive they can count on the leader to help them out of trouble.

Of the nine (9) questions related to the independence sub-scale, seven (7) of the nine (9) questions were responded similarly from members between the two partnerships. Members from the two partnerships perceive they are encouraged to take independent action and to be expressive.

The responses to the questions related to the task orientation sub-scale indicated similarities between the two partnerships in seven (7) of the nine (9) questions. The members from the two groups perceived there is emphasis on completing concrete and practical tasks, as well as on decision making and training.

Of the nine (9) questions related to the anger and aggression sub-scale, six (6) of the nine (9) questions were responded to similarly by members from the two partnerships. The members from each partnership responded similarly of the extent to which there is open expression of anger and disagreement in their respective group.

The responses to the questions related to the leader control sub-scale indicated similarities between the two partnerships in six (6) of the nine (9) questions. The members from the two groups perceived there are similarities in the extent to which the leader directs the group, makes decisions, and enforces rules.

Table 23. GES Results, Comparison of Similarities Between Area 4 and Area 9

	Area 4, Jacksonville			Area 9, Palm Beach			
	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Question #	% No Response	% True	% False	% No Response	% True	% False	Chi-Square
1	4.8	85.7	9.5	5.4	83.8	10.8	.981
2	4.8	9.5	85.7	5.4	2.7	91.9	.529
3	0	95.0	5.0	5.4	89.2	5.4	.567
4	0	81.0	19.0	5.4	91.9	2.7	.065
5	9.5	33.3	57.1	2.7	21.6	75.7	.275
6	4.8	42.9	52.4	5.4	32.4	62.2	.729
7	4.8	19.0	76.2	5.4	35.1	59.5	.414
8	4.8	71.4	19.0	8.1	86.5	5.4	.190
9	0	33.3	66.7	5.6	11.1	83.3	.081
10	0	85.0	15.0	8.1	78.4	13.5	.425
11	0	28.6	71.4	8.3	11.1	80.6	.123
13	0	28.6	71.4	5.4	29.7	64.9	.541
15	4.8	76.2	19.0	2.7	81.1	16.2	.875
16	4.8	52.4	42.9	2.7	75.7	21.6	.191
18	0	47.6	52.4	5.4	54.1	40.5	.436
19	0	47.6	52.4	2.7	59.5	37.8	.457
20	9.5	47.6	42.9	2.7	67.6	29.7	.252
21	0	62.9	38.1	2.7	73.0	24.3	.433
23	0	47.6	52.4	5.6	52.8	41.7	.456
24	4.8	9.5	85.7	8.1	2.7	89.2	.487
25	0	9.5	90.5	8.1	2.7	89.2	.233
26	0	57.1	42.9	13.5	51.4	35.1	.209
28	0	52.4	47.6	8.1	32.4	59.5	.184
30	4.8	57.1	38.1	5.4	75.7	18.9	.275
31	4.8	52.4	42.9	5.4	51.4	43.2	.993
32	0	85.7	14.3	2.7	94.6	2.7	.193
33	0	85.7	14.3	8.1	62.2	29.7	.130
34	0	61.9	38.1	2.7	51.4	45.9	.498
35	4.8	90.5	4.8	5.4	91.9	2.7	.915
36	0	38.1	61.9	5.4	43.2	51.4	.474
37	0	52.4	47.6	5.4	24.3	70.3	.071
38	14.3	19.0	66.7	8.1	48.6	43.2	.082
39	4.8	76.2	19.0	5.4	89.2	5.4	.261
40	9.5	71.4	19.0	10.8	75.7	13.5	.853
43	9.5	38.1	52.4	5.6	35.1	58.3	.821
44	19.0	57.1	23.8	5.4	83.8	10.8	.076
45	0	90.5	9.5	8.1	86.5	5.4	.358
46	4.8	81.0	14.3	8.1	75.7	16.2	.862
47	4.8	42.9	52.4	8.1	56.8	35.1	.432
48	9.5	61.9	28.6	5.4	64.9	29.7	.838

50	9.5	47.6	42.9	8.1	35.1	56.8	.589
51	4.8	57.1	38.1	2.7	29.7	67.6	.093
52	9.5	38.1	52.4	2.7	67.6	29.7	.080
53	0	57.1	42.9	5.4	35.1	59.5	.189
54	4.8	66.7	28.6	2.7	51.4	45.9	.420
55	0	19.0	81.0	2.7	13.5	83.8	.655
56	4.8	76.2	19.0	2.7	86.5	10.8	.608
58	4.8	85.7	9.5	2.7	86.5	10.8	.911
60	0	61.9	38.1	5.4	73.0	21.6	.260
61	14.3	76.2	9.5	2.7	89.2	8.1	.234
63	0	57.1	42.9	8.1	59.5	32.4	.347
64	4.8	90.5	4.8	10.8	81.1	8.1	.629
65	0	57.1	42.9	8.1	48.6	43.2	.389
66	9.5	14.3	76.2	5.4	16.2	78.4	.831
67	9.5	85.7	4.8	2.7	73.0	24.3	.108
68	0	90.5	9.5	5.4	94.6	0	.096
69	4.8	28.6	66.7	5.4	21.6	73.0	.838
70	4.8	52.4	42.9	5.6	69.4	25.0	.384
71	0	38.1	61.9	5.4	13.5	81.1	.067
73	4.8	57.1	38.1	5.4	43.2	51.4	.591
76	4.8	9.5	85.7	8.1	29.7	62.2	.157
78	4.8	95.2	0	8.1	89.2	2.7	.657
79	0	47.6	52.4	8.1	51.4	40.5	.340
80	0	90.5	9.5	8.1	75.7	16.2	.287
81	0	57.1	42.9	8.1	62.2	29.7	.297
82	19.0	42.9	38.1	8.1	56.8	35.1	.394
83	9.5	38.1	52.4	8.1	37.8	54.1	.981
84	0	33.3	66.7	5.4	32.4	62.2	.554
86	4.8	14.3	81.0	8.1	24.3	67.6	.548
87	9.5	42.9	47.6	5.4	54.1	40.5	.663
88	9.5	28.6	61.9	8.1	37.8	54.1	.775
89	9.5	33.3	57.1	5.4	64.9	29.7	.069
90	4.8	85.7	9.5	10.8	73.0	16.2	.526

Comparison of GES Results between Jacksonville and Palm Beach, Areas of Differences

Of the 90 true-false questions on the Group Environment Scale, 15, or 17%, were found to indicate differences between the two groups, significant at or below the $p = .05$ level. Two additional responses, questions #17 and #74, were approaching significance, with $p = .055$ and $p = .053$, respectively. The 17 responses found to represent the significance of the differences between Area 4 and Area 9 are presented in Table 24. The

table is structured with the responses from Area 4, Jacksonville identified in Columns 1-3; and the responses from Area 9, Palm Beach identified in Columns 4-6. Column 7 shows the significance level for each question.

Table 24. GES Results, Comparison of Differences Between Area 4 and Area 9

	Area 4, Jacksonville			Area 9, Palm Beach			
	Column 1	Column 2	Column 3	Column 4	Column 5	Column 6	Column 7
Question #	% No Response	% True	% False	% No Response	% True	% False	Chi-Square
12	9.5	52.4	33.3	2.7	86.5	10.8	.034
14	19.0	71.4	9.5	5.4	59.5	35.1	.047
17*	4.8	47.6	47.6	2.7	18.9	78.4	.055
22	-	47.6	52.4	8.3	16.7	75.0	.026
27	-	9.5	90.5	5.4	56.8	37.8	.001
29	4.8	14.3	81.1	8.1	67.6	24.3	.000
41	-	57.1	42.9	8.1	86.5	5.4	.001
42	4.8	38.1	57.1	8.1	78.4	13.5	.002
49	4.8	52.4	42.9	10.8	81.1	8.1	.007
57	-	14.3	85.7	5.4	56.8	37.8	.002
59	14.3	23.8	61.9	2.8	8.3	88.9	.050
62	4.8	33.3	61.9	8.1	5.4	86.5	.018
72	14.3	52.4	33.3	5.4	89.2	5.4	.006
74*	9.5	47.6	42.9	5.4	78.4	16.2	.053
75	-	38.1	61.9	8.1	8.1	83.8	.012
77	14.3	14.3	71.4	8.3	47.2	44.4	.042
85	9.5	52.4	38.1	5.4	86.5	8.1	.012

(*these two questions were not significant but close to being significant)

Summary of the GES Results Between Jacksonville and Palm Beach

The non-parametric, Pearson's chi-square statistical test was utilized to test the statistical significance of the responses to the GES. The results produced 15 areas of significant differences between the two partnerships, and two (2) items approaching significance. Table 25 represents the relationship between the hypotheses and the findings from the GES sub-scales and the 17 GES items that indicated significant differences

between the partnerships. Four (4) of the sub-scales did not reflect any GES items that indicated statistical differences. While these 17 items, 19%, indicated significant differences, 73 other items, 81%, did not reflect any significant differences, and thus, the determination that the hypotheses could not be rejected.

Table 25. Relationship between Hypotheses and Findings from the GES

Hypotheses	GES Sub-scale	Findings- GES Items with significant differences	Decision
#2 – There is no difference in group cohesion between the two partnerships. #6 – There are no differences in increased member participation and member satisfaction between the two partnerships.	Cohesion	Only 1 item of 9 indicated statistical difference: # 41	Hypotheses could not be rejected with finding.
#3 - There is no difference in the perceived support between each partnership.	Leader Support	5 of 9 items indicated statistical difference: #12, 22, 42, 62, 72	Hypothesis could not be rejected.
#1 – Three is no difference in the social climate between each of the two partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.	Expressive-ness	No items indicated statistical differences	Hypotheses could not be rejected.
# 3 - There is no difference in the perceived support between each partnership.	Independence	2 of 9 items indicated statistical difference: #14, 74	Hypothesis could not be rejected.
#8 – There is no difference in the formality and structure between the partnerships.	Task Orientation	2 of 9 items indicated statistical difference: #75, 85	Hypothesis could not be rejected.
#1 – Three is no difference in the social climate between each of the two partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.	Self Discovery	No items indicated statistical differences	Hypotheses could not be rejected.
#1 – There is no difference in the social climate between each of the two partnerships. #5 – There is no difference in positive social climate characteristics evident between the partnerships. #7 – There is no difference between the two partnerships' interpersonal relationships.	Anger and Aggression	4 of 9 items indicated statistical difference: #17, 27, 57, 77	Hypotheses could not be rejected.
#8 – There is no difference in the formality and structure between the partnerships.	Order and Organization	No items indicated statistical differences	Hypothesis could not be rejected.
#4 – There is no difference of leader control between the two partnerships.	Leader Control	3 of 9 items indicated statistical difference: #29, 49, 59	Hypothesis could not be rejected.
#8 – There is no difference in the formality and structure between the partnerships.	Innovation	No items indicated statistical differences	Hypothesis could not be rejected.

Leader characteristics

Leadership style, commitment, and support are reflective of effective community partnerships. These areas were found in the literature about collaboration, empowerment, groups and teams, and social ecology. Nine (9) of the areas of significant responses between the two partnerships are related to the leader's support, reward, and relationship to the group; knowledge of the members; communication; and control and expectations of the group, as found in Table 26. Questions 12, 22, 29, 42, 49, 59, 62, 72, and 77 relate to the leader on the following GES sub-scales: leader support, leader control, and anger and aggression. These are discussed below.

The members of the Palm Beach County HIV CARE Council perceived their leader to be friendlier, more expressive and helpful, more in control, and had greater expectations of the membership than the leader(s) of the First Coast CARES Consortium in Jacksonville. The leader of the CARE Council in Palm Beach also rewards the members more frequently and is perceived to get angry more than the leader(s) of the First Coast CARES Consortium in Jacksonville.

Table 26. GES Results, Leader Characteristics

GES Question #	Leader Characteristic	Jacksonville	Palm Beach
12	Leader goes out of way to help members.	52%	87%
22	Leader knows members well.	52%	75%
77	Leader does not get angry at members.	71%	44%
29	Leader has final say in disagreement.	81%	68%
42	Leader helps new members get acquainted with group.	57%	78%
49	Leader corrects members who break rules	52%	81%

59	Leader does not give in to pressure from members.	62%	89%
72	Leader tells member they are doing well.	52%	89%
62	Leader expects much of the members.	62%	87%

- The members in both partnerships thought the leader went out of his way to help members, with a greater proportion thinking so in Palm Beach, 87%; and approximately half, or 52% in Jacksonville.
- The members (48%) from Jacksonville thought the leader does not know the members very well; while in Palm Beach, a 75% of the members perceived the leader to know the members very well.
- In Palm Beach, 68% of the members perceived the leader had the final say in a disagreement; while in Jacksonville, 81% of the members thought the leader does not have a final say in a disagreement. This might mean that members in Jacksonville perceive someone else to have power and be in control.
- The Palm Beach members, or 78%, perceived the leader to help new members get acquainted with the group. In Jacksonville, 57% did not think the leader helps new members get acquainted with others in the group.
- Most of the respondents, 79%, from both partnerships thought the leader did not give in to pressure from the members. With 62% of the Jacksonville members and 89% of the Palm Beach members agreeing, this might mean that the leader in Palm Beach may be perceived as being stronger to be able to not succumb to member pressure.
- The leader in Palm Beach expects much of the members, with 87% of the respondent members thinking so. In Jacksonville, a slightly lower rate indicates 62% of the

members think the leader expects much of the group. Therefore, the leader in Palm Beach might have higher expectations than the leader in Jacksonville, or it might mean that the expectations of the leader in Palm Beach are more widely known.

- The leader from Palm Beach tells members when they are doing well, with 89% of the members perceiving this to be true. In Jacksonville, only 52% of the members believe their leader tells them when they are doing well. This might mean that the leader in Palm Beach may be more expressive.
- In Jacksonville, 71% of the members believed the leader did not get angry at members of the group. In Palm Beach, approximately half, 47% perceived the leader did get angry, while the others, 44% perceived the leader did not get angry. It appears the leader expresses anger at the CARE Council members.

Member characteristics.

Member identity, autonomy, interactions, self-empowerment, and satisfaction are found in the literature on community partnerships, empowerment, and collaboration. Responses to five (5) questions were found to be statistically significant about the differences between the two groups' members' support of one another, autonomy, enthusiasm and vitality, self-reliance, and skills, as found in Table 27. Questions 14, 41, 74, 75, and 85 relate to members as found on the following GES sub-scales: independence, cohesion, and task orientation.

Member relationships, autonomy, interactions, self-empowerment, enthusiasm, and skills are important within a community health partnership. Individuals contribute much of their time and energy to the activities of a partnership. The members in Jacksonville thought they were becoming more autonomous, while less believed this in Palm Beach.

More of the members in Palm Beach believe they put a lot of energy into the activities of the partnership; believe the CARE Council helps its members to become more self-reliant and helps its members to make practical decisions and learn new skills. Five (5) items related to these issues were found to be areas of significant differences between the partnerships.

Table 27. GES Results, Member Characteristics

GES Question #	Member Characteristic	Jacksonville	Palm Beach
14	Members feel they are becoming more autonomous and empowered.	71%	60%
41	Members believe they put a lot of energy into the activities of the partnership.	57%	87%
74	Members feel that the group helps its members to become more self-reliant.	48%	78%
75	Members perceive the group helps its members to make practical decisions.	62%	84%
85	Members think the consortium helps members to learn new skills.	52%	87%

- A total of 64% of both partnerships felt they were becoming more autonomous and empowered, with 71% of the members in Jacksonville and 60% of the members in Palm Beach perceiving so.
- The members in Palm Beach, 87%, and those in Jacksonville, 57% believed they put a lot of energy into the activities of the partnerships. More members in Palm Beach perceive a significant amount of time is spent in CARE Council activities. Possibly, more empowerment in Palm Beach is evident than in Jacksonville.

- In the Jacksonville partnership, 48% of its members felt that the group helps its members to become more self-reliant, while 78% of the Palm Beach members perceive this to be so. This might mean that Palm Beach members are more helpful to one another than in Jacksonville.
- The members in Jacksonville, 62%, and those in Palm Beach, 84%, perceived the group does help its members to make practical decisions.
- In Jacksonville, 52% of the members think the consortium helps members to learn new skills. In Palm Beach, 87% of the members perceive the council helps members to learn new skills.

Characteristics of conflict.

Conflict is a characteristic found in the literature about community partnerships related to social ecology, collaboration, empowerment, and organizational effectiveness. The ability to manage conflict is evident of a strong and functional partnership that has processes and policies, strong leadership and effective communication to handle disagreement. The responses to questions 17, 27, and 57 relating to conflict were found to be significant in this study, reflecting the differences between the two partnerships, and relate to the following GES sub-scale: anger and aggression.

Table 28 reflects the characteristics of conflict evident from the GES. The members of the CARE Council in Palm Beach perceive that they argue, yell at each other, and that some members are hostile to others; while in Jacksonville, the members perceived themselves to be cordial and better able to manage conflict. Three (3) items were found to be areas of significance between the two partnerships on issues related to conflict management.

Table 28. GES Results, Characteristics of Conflict

GES Question #	Characteristic of Conflict	Jacksonville	Palm Beach
17	Members believe they rarely argue.	44%	78%
27	Members sometimes yell at each other.	91%	57%
57	Some members are quite hostile to other members.	14%	57%

- The members of Palm Beach, 78%, believe the members of the CARE Council argue. In Jacksonville, approximately half, 44% thought they did argue and 48% thought they do not argue.
- Within the Jacksonville consortium, 91% of the members perceived that people did not yell at each other, while the opposite is evident in Palm Beach, whereby 57% of the members thought that people did yell at each other.
- In Jacksonville, 86% of the members perceived they are cordial to each other and are not hostile to other members. In Palm Beach, 57% of the CARE Council members perceive some members are quite hostile to other members.

The Application Quality Index

Survey Results in Area 4, Jacksonville

The AQI was sent by electronic mail on April 17, 2001, to six (6) members of the planning committee of the First Coast CARES Consortium (Appendix J). Five (5) members, 83%, returned their responses to the AQI, three (3) by email and two (2) by U.S. postal mail.

The results of the survey presented in Table 29 reflect the frequency of the response for each rating in each of the 25 application components. The table indicates the 25 application components found in the survey instrument reflecting member perceptions of the adequacy of the annual application. Column 1 shows the rating response "does not exist," meaning the factor did not exist in the First Coast CARES Consortium's annual application. Column 2 shows the rating response of "very low," meaning that the application component exists between 1-20% of the time. Column 3 shows the rating response of "low," meaning the component exists between 21-40% of the time. Column 4 shows the rating response of "average," meaning the application component exists between 41-60% of the time. Column 5 shows the rating response of "high," reflecting the application component exists between 61-80% of the time. Column 6 shows the rating response of "very high," meaning the component exists between 81-100% of the time. Column 7 reflects the response of "NA" if the response was not applicable.

The rating of "average" showed the greatest number of responses, 42, or 34%. Three of the 25 questions showed responses of "average" from four (4) of the Jacksonville respondents. The four (4) respondents felt the goals of the application reflected desired outcomes to the identified needs; at least one objective was stated for each goal; and an identified agency, group, or individual was named to coordinate each activity at least 41-60% of the time.

The second highest response was "low," with 33 responses, or 26% of the total. The application component, 'application is innovative,' shows the highest frequency of "low," with 4 responding. Four (4) application components showed three (3) "low" responses and include the following: 'specific, feasible activities are provided for each

goal'; 'a timeline is indicated'; 'preventive activities are coordinated'; and 'media coverage is planned.'

The next highest response was "high," with 23 responses, or 18%. The components showing a frequency of three (3) responses include: 'sources of coordination among agencies are identified'; 'facilities are specified and will be available for activities'; and 'application is logically developed.' Thirteen of the responses indicated "very high," or 10% of the total, and each was responded to once.

Six (6) responses, or 5%, were "very low." The application components that showed two (2) "very low" responses each includes 'media coverage is planned' and 'strategy is planned for seeking funding.' The other two (2) were 'application represents state of art technology,' and 'activities appear to be sufficient in intensity.'

A review of the results of the AQI indicates a total of 28% of the responses were "high" and "very high," with 60% of the responses being "average" and "low"; while only 5% was "very low." Three (3) responses were "NA," not applicable.

Table 29. Annual Application Quality Index (AQI) Results, Jacksonville

APPLICATION COMPONENTS	Column 1 Does Not Exist	Column 2 Very Low	Column 3 Low	Column 4 Average	Column 5 High	Column 6 Very High	Column 7 NA
Goal(s) reflect(s) desired outcomes to problems/needs	0	0	0	4	0	1	0
At least one relevant objective is stated for each goal	0	0	0	4	0	1	0
Specific, feasible activities are provided for each goal	0	0	3	1	0	1	0
A timeline projects the start and completion of each activity	0	0	3	2	0	0	0
The agency/group/individual who will coordinate each activity is identified	0	0	1	4	0	0	0
Sources of coordination/collaboration among agencies/groups are identified	0	0	1	1	3	0	0
Specific target populations are identified for each activity	0	0	1	3	1	0	0
Preventive activities are coordinated with existing community programs/activities	0	0	3	1	0	0	0
Strategy to develop community support/participation in planned activities is provided	0	0	2	2	1	0	0
A budget is provided which outlines sources of funding and expenses for the activities	0	0	0	2	2	1	0
Staff is specified and available to coordinate and train volunteers	0	0	1	1	2	1	0
Facilities are specified and will be available for convening activities	0	0	0	0	3	1	1
Equipment and supplies for activities are specified and will be provided	0	0	0	1	2	1	1
Media coverage is planned to promote activities	0	2	3	0	0	0	0
Strategy is planned for seeking funding beyond grant period	0	2	2	1	0	0	0
Strategy is provided to monitor or revise the application	0	0	2	1	2	0	0
Application is written clearly and concisely	0	0	1	1	2	1	0
Application represents state of art technology in education, prevention and intervention of HIV	0	1	1	2	0	1	0
Application is logically developed	0	0	0	1	3	1	0
Application considers constraints in the community (e.g., political)	0	0	1	3	0	1	0
Application is feasible	0	0	1	2	0	1	1
Activities appear to be sufficient in duration	0	0	1	3	0	1	0
Activities appear to be sufficient in intensity	0	1	0	3	1	0	0
Application is innovative	0	0	4	0	1	0	0
Activities are designed to become part of regular community practice	0	0	2	3	0	0	0
TOTAL RESPONSES	0	6	33	42	23	13	3
PERCENT OF RESPONSES	0	5%	26%	34%	18%	10%	.02%

Figure 11. Perception of Plan Adequacy, Jacksonville

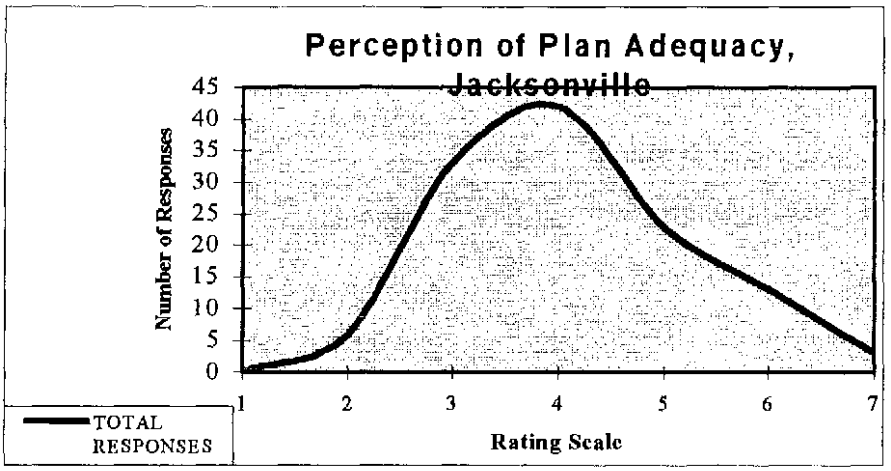


Figure 11 reflects a graphic display of the results from the AQI administered to the small group in Jacksonville. The 'rating scale' numerals on Figure 11 reflect columns 1 through 7 in Table 29; and the 'number of responses' reflects the total responses found within each column of the table. The graph is skewed to the left, reflective of the average-to-lower range of perceptions of adequacy of the annual application.

Survey Results in Area 9, Palm Beach

Several attempts were made to administer the AQI to the planning committee of the Palm Beach County CARE Council. One attempt was made on March 6, 2001, to the 11 members of the planning committee after being invited to the planning committee meeting, but was not successful. The chairperson of the planning committee indicated that the whole planning committee was not familiar with the application and would not be able to answer the survey questions. After receiving further guidance from the lead agency

staff, another attempt was made on June 4, 2001, to administer the AQI to a group of members that were identified as having worked on the development of the application and plan. The selected individuals did not respond to the survey at that time. Follow up email reminders were then sent to the members identified to complete the instrument. A response from a staff person at the lead agency indicated that the CARE Council members did not directly participate in the application process, as it was the responsibility of the Grantee to file the application. The staff person further commented that CARE Council staff did have input in various portions of the application, but a consulting firm in Jacksonville did most of the work on the application. It was indicated that the only CARE Council member participating in the application process was the chairperson, because of the requirement of the chair to sign certain assurances and certifications.

Subsequently, after another discussion between the researcher and the lead agency staff person, it was decided that the AQI survey should be given to a smaller group of individuals that actually had input into various portions of the application. Another attempt was made on June 4, 2001, and the AQI was sent to four (4) individuals by electronic mail. Again, there was no response.

The researcher consulted with the lead agency staff person once again, who then suggested that a different group of members worked on the annual application and that the questionnaire should be sent to the identified group of six (6) partnership members. On August 29, 2001, a final attempt was made and another email was sent to the six (6) members. Follow up phone calls were made to encourage submission of the survey response. Three members responded and sent their responses via facsimile to the researcher.

The results of the survey presented in Table 30 reflect the frequency of the response for each rating in each of the 25 application components. The table indicates the 25 application components found in the survey instrument reflecting member perceptions of the adequacy of the annual application. The columns found in Table 30 reflect the same rating responses and meanings, as described in a previous section. Since only three (3) individuals responded to the survey, those application components discussed here include those with a frequency of 2 or higher.

The rating of "high" showed the greatest number of responses, 39, or 52%. Five (5) of the components showing a frequency of 3 responses within each item include the following: 'a timeline'; 'application is feasible'; 'activities appear to be sufficient in duration'; 'application is innovative'; and 'activities are designed to become part of regular community practice.' Ten application components rated "high" with response frequencies of 2 within each of the eight (8) items, including the following: (1) 'at least one relevant objective is stated for each goal'; (2) 'specific activities are provided for each goal'; (3) 'strategy to develop community support in activities'; (4) 'budget is provided'; (5) 'staff is specified'; (6) 'facilities are specified'; (7) 'equipment and supplies are specified'; (8) 'strategy is provided to monitor the application'; (9) 'application represents state of art technology'; and (10) 'activities appear to be sufficient in intensity.' The responses indicate specifics about the structure and support of the partnership in accomplishing its goals. The members of the Palm Beach County HIV CARE Council may perceive their annual plan to be rated high because of the structure and support received.

Sixteen of the total responses, 21%, were "average." All of the respondents perceived the 'source of coordination among agencies and groups are identified' to be

"average," as well as 'strategy is planned for seeking funding.' The application components rated "average" with response frequencies of 2 within each item include 'specific target populations are identified for each activity'; 'media coverage is planned to promote activities'; and 'application considers constraints in the community.' These are reflective of community linkages with the CARE Council.

The response rating of "very high" included 16% of the responses and reflects perceptions of clarity about the application. Two (2) of the application components, 'application is written clearly and concisely' and 'application is logically developed,' were responded to by 2 of the members as "very high." The other responses of "very high" were mentioned in the previous paragraph discussing the responses of "high."

A review of the results of the AQI indicates a total of 68% of the responses were "high" and "very high," with 21% of the responses being "average" and only 1% to be "very low." Seven of the responses were "NA," not applicable. A graphic display of the tabular results is shown in Figure 12.

Table 30. Annual Application Quality Index (AQI) Results, Palm Beach

APPLICATION COMPONENTS	Column 1 Does Not Exist	Column 2 Very Low	Column 3 Low	Column 4 Average	Column 5 High	Column 6 Very High	Column 7 NA
Goal(s) reflect(s) desired outcomes to problems/needs	0	0	0	1	1	1	0
At least one relevant objective is stated for each goal	0	0	0	0	2	1	0
Specific, feasible activities are provided for each goal	0	0	0	0	2	1	0
A timeline projects the start and completion of each activity	0	0	0	0	3	0	0
The agency/group/individual who will coordinate each activity is identified	0	0	0	1	1	0	1
Sources of coordination/collaboration among agencies and groups are identified	0	0	0	3	0	0	0
Specific target populations are identified for each activity	0	0	0	2	0	0	1
Preventive activities are *coordinated* with existing community programs/activities	0	0	0	0	0	0	3
Strategy to develop community support/participation in planned activities is provided	0	0	0	1	2	0	0
A budget is provided which outlines sources of funding and expenses for the activities	0	0	0	0	2	1	0
Staff is specified and available to coordinate and train volunteers	0	0	0	0	2	1	0
Facilities are specified and will be available for convening activities	0	0	0	0	2	1	0
Equipment and supplies for activities are specified and will be provided	0	0	0	0	2	1	0
Media coverage is planned to promote activities	0	1	0	2	0	0	0
Strategy is planned for seeking funding beyond grant period	0	0	0	3	0	0	0
Strategy is provided to monitor or revise the application	0	0	0	1	2	0	0
Application is written clearly and concisely	0	0	0	0	1	2	0
Application represents state of art technology in education, prevention and intervention of HIV	0	0	0	0	2	0	1
Application is logically developed	0	0	0	0	1	2	0
Application considers constraints in the community (e.g., political)	0	0	0	2	0	0	1
Application is feasible	0	0	0	0	3	0	0
Activities appear to be sufficient in duration	0	0	0	0	3	0	0
Activities appear to be sufficient in intensity	0	0	0	0	2	1	0
Application is innovative	0	0	0	0	3	0	0
Activities are designed to become part of regular community practice	0	0	0	0	3	0	0
TOTAL RESPONSES	0	1	0	16	39	12	7
PERCENT OF RESPONSES	0	1%	0	21%	52%	16%	9%

Figure 12. Perception of Plan Adequacy, Palm Beach

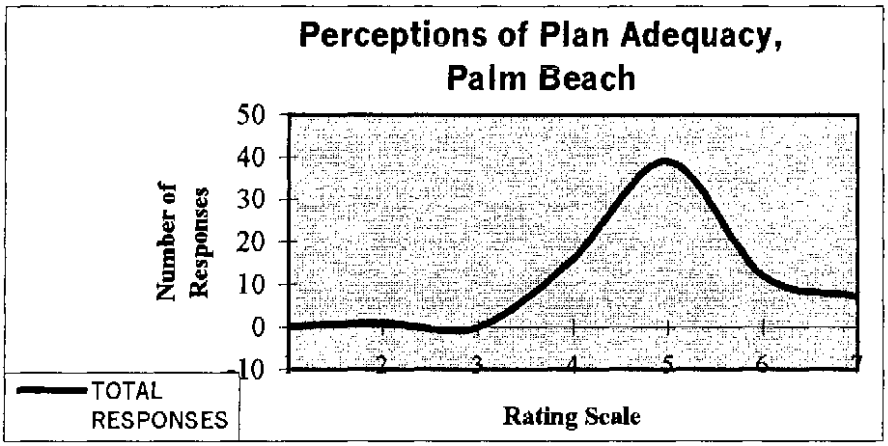


Figure 12 reflects a graphic display of the results from the AQI administered to the small group in Palm Beach. The numerals on the 'rating scale' in Figure 12 reflect columns 1 through 7 in Table 30; and the 'number of responses' reflects the total responses found within each column of the table. The graph is skewed to the right, reflective of the higher perceptions of adequacy of the annual application.

Summary of the AQI Results Between Jacksonville and Palm Beach

The AQI was sent to six members in Jacksonville and five were returned. The AQI was sent to six members in Palm Beach and three were returned. The members in Jacksonville perceived the adequacy of the annual application to be low-to-average; while the members in Palm Beach perceived the adequacy of their annual application to be high-to-very high.

In Jacksonville, the rating of "average" was the most frequent response, with 42, or 34%. A total of 28% of the responses were "high" and "very high," with 60% of the responses as "average" and "low," and 5% as "very low." The graph in Figure 11 presents

the skew to the lower range of the rating scale, reflective of the lower perceptions of adequacy of the annual application.

In Palm Beach, the rating of "high" was the most frequent response, with 39, or 52%. The "high" responses indicate specific perceptions about the structure and support of the partnership in accomplishing its goals. A review of the total results indicates a total of 68% to be in the "high" and "very high" range, with 21% in the "average" range, and 1% "very low." The graph in Figure 12 presents the skew to the higher range of the rating scale, reflective of the higher perceptions of adequacy of the annual application.

Summary

In summary, the major findings from this study indicate that two (2) different partnerships are perceived to be effective, collaborative, and empowered. The findings developed from a review of the documents, observations of meetings, two different questionnaires, and interviews with key participants.

The documents reviewed from both partnerships reflect structure through its bylaws, policies and procedures. Both of the partnerships have the support of staff from the lead administrative agencies. Both of the partnerships have a membership policy within their respective bylaws. The CARE Council in Palm Beach has an identified number of members within the bylaws, while the First Coast CARES Consortium in Jacksonville does not identify a particular number of members. Both consortia provide education and training opportunities for their members. Committees play a significant role within the CARE Council of Palm Beach, while committees do not play a significant role within the Jacksonville partnership. Both consortia communicate with their respective members through monthly mailings. The monthly packet sent from the CARE Council in Palm

Beach to its members includes more information than the monthly packet from the First Coast CARES Consortium in Jacksonville to its members.

Minutes from both of the consortia reflected membership had risen slightly during the year 2001. The agendas from the CARE Council in Palm Beach reflected more specificity than the agendas from the First Coast CARES Consortium in Jacksonville. The top 5 meeting topics from the First Coast CARES Consortium in Jacksonville include regular consortium/committee business, presentations and/or trainings, budget and finance, community activities, and services. The top 5 meeting topics from the CARE Council in Palm Beach include committee business/reports, budget and finance, consortium business, services, and staff activities. The topics least discussed during the meetings at both sites include bylaws and the annual application/plan.

The three (3) goals identified in the application from the Jacksonville consortium include: increase recruitment of infected clients, make them feel more comfortable in participating and making decisions; increase recruitment of minorities; and consolidate consortium committees with the Title I planning council. The five (5) goals identified within the plan from the Palm Beach consortium include the implementation of the following: a county-wide management information system; a continuous quality improvement plan; standards of care and outcome indicators; a strategic planning process; and a member recruitment, retention, and training plan. Those of the Palm Beach partnership reflect improvements or building the infrastructure to support the CARE Council.

Findings from the observations revealed the meetings of the First Coast CARES Consortium in Jacksonville to be more informal and slower paced than the meetings of the

CARE Council of Palm Beach, which tended to be more formal and fast paced. Both consortia conduct their meetings in a stable central location. The members of each consortium appeared to be congenial, talkative, friendly, and respectful of one another. Each consortium had many distractions occurring during the meetings—people leaving their seats, walking about, and speaking. Recognition and praise was offered to members of the CARE Council, while none was observed in the Jacksonville consortium.

Findings from the interviews revealed values to be important within each of the consortia. Members from both site locations perceived staff support to contribute to the partnerships' effectiveness and success. It was perceived from participants at both locations that training and education were important for members to be knowledgeable and effective at completing their respective tasks. Feelings of commitment, compassion, care, and understanding were evident in both groups. The participants from Palm Beach believed the Council worked better due to Robert's Rules of Order and its committee structure. The participants from Jacksonville perceived their consortium worked better on a more informal basis.

It was perceived by participants from both site locations that the members understood their respective role and responsibilities, separating lead agency, CARE Council member, and funder roles and responsibilities. The people from Jacksonville, though, perceived confusion about the lead agency's role as 'leader.' The perceived leader of the consortium in Jacksonville was the staff of the lead agency, while the perceived leader of the CARE Council of Palm Beach includes the Chair and officers.

Findings from the two (2) surveys revealed interesting information. The GES respondents from Jacksonville were white male, members for one year or less and between

the ages of 30-39. The GES respondents from Palm Beach included white female, between the ages of 30-49, with 38% as members for less than one year. The GES revealed 15 statistically significant responses, indicating group differences, including those in the following areas: leadership style, behavior, support, relationship to the membership and communication, membership relationships, autonomy, interactions, self-empowerment, enthusiasm, skills; ability to manage conflict; and contribution of time and energy. Two other responses approached significance. The AQI revealed that consortium members from Jacksonville perceived the adequacy of their annual application reflected and "average" to "low" rating, skewing a graph to the lower range of the rating scale upon looking at the graphic display. In Palm Beach, the council members perceived the adequacy of their annual application/plan to be "high" to "very high," reflecting a skew to the higher range of the rating scale upon looking at the graphic display.

CHAPTER V

SUMMARY AND CONCLUSIONS

Chapters 1 and 2 presented an overview of the study and a review of the literature relevant to the study of effective community health planning partnerships and their characteristics. Background on the planning and funding structure for HIV/AIDS was presented from the federal, state, and regional perspective; as well as a background of community planning in the HIV/AIDS epidemic. Research literature in the areas of social and human ecology; community partnerships and coalitions; collaboration theory; and from the psychological and sociological theories and models of empowerment theory, group and team theory, and organizational effectiveness were reviewed to provide a foundation for the current research.

The research setting and methodology of the study were presented in Chapter 3. A rationale for the case study approach was provided, inclusive of the qualitative aspects used in this study. Rationale for using quantitative elements was also stated. The design and the analysis and interpretation of data were presented.

Chapter 4 presented the findings of the study. Information collected from the documents and other written materials, observations of meetings, interviews, and the two survey instruments were collated and analyzed to discover the characteristics of collaboration, empowerment, and effectiveness of community health planning partnerships in the context of the HIV/AIDS planning councils or consortia.

Chapter 5 offers discussion and conclusions based on the findings of the study reported in Chapter 4. Conclusions are presented by three overall themes of structure, process and outcomes; then by the research questions applicable to a specific theme area;

and then by a discussion. The hypotheses are discussed. References from research literature are used where applicable to illustrate similar or divergent findings from the study. In conclusion, implications for the future of community health planning partnerships with recommendations are offered and suggestions for future inquiry are presented.

It was important to note the similarities and differences between the two partnerships under study to better understand the complexities and intricacies of the structure, process, and outcomes of community health planning partnerships and their relationships within the frameworks of empowerment, collaboration, ecology, and effectiveness. Perkins and Zimmerman (1995) suggest that empowerment consists of the structures and processes that "enhance participation and improve goal achievement for the organization" (p. 571). The design of the study allowed the researcher to spend time observing meetings in operation and to talk to the members of the consortia to capture their perceptions and feelings. The design also allowed the researcher to capture member perceptions about each other, their leaders, and their outcomes from two survey instruments and to review many of the documents for additional hints of how the partnerships conducted their business.

The conclusions presented are based on data gathered from two different community health planning partnerships over a period of one and a half years and reflect that period of time only. The conclusions from the qualitative information gathered are not meant to be generalized to other consortia, but are reflective of what was happening at the time in the two settings. Conclusions drawn from the Group Environment Scale may not be generalized to other community planning partnerships as the findings reported from this study reflect what the perceptions were from members of the two partnerships at the time

of the study. The hypotheses could not be rejected with the limited findings from the GES. The GES reflected only 15 of 90 items with significant differences between the groups, and 2 questions approaching significant differences. The limited findings from the GES were not able to provide for support to reject the null hypotheses. Conclusions from Application Quality Index may not be generalized, but are reflective of key informants' perceptions about the adequacy of their respective applications. The purpose of this study was to find characteristics that may contribute to the collaboration, empowerment, and effectiveness of community planning partnerships, i.e., federally mandated Ryan White CARE Act, Title I or II, HIV/AIDS planning councils or consortia.

The planning councils and consortia have the task and responsibility of planning for and allocating resources within infected or affected populations of the community and must identify and assess client and community needs (U. S. Department of Health and Human Services, 1996, 1999). Community partnerships must bring people together in a manner that contributes to each individual's worth and self-image. Being respectful in coalition efforts often may be difficult if there are sensitive or potentially conflicting issues being discussed. Member relationships to one another and to the leader are factors affecting collaboration and empowerment. Participation with others is vital within a partnership and basic to empowerment of individuals and groups. Group cohesion, as well as reducing conflict, is important to the effectiveness of a partnership. The quantitative data and the qualitative data gathered in this study suggest that some significant differences exist in member perceptions. This chapter discusses the results in relation to three overall themes that emerged from the findings: structure, process and outcome. Findings are discussed by the research questions presented in Chapter 1.

Structure

Structural characteristics of community planning partnerships are found in the literature related to community partnerships, ecology, empowerment and organizational effectiveness. The structural themes that emerged from this study include the following: physical environment, meetings, customs and rituals, identity of administrative agency, committees, decision making, management of conflict, membership, training, communication, leadership characteristics, values, staff support, roles and responsibilities, bureaucratic and socio-political factors.

Four research questions that were presented in Chapter 1 are found to relate to structure. Three of the questions are grouped together for ease of response as they are similarly related to outcomes and effectiveness. The other question relates to conflict and decision making. These four research questions are presented below, with relevant conclusion.

Research Questions Related to Outcomes and Effectiveness

Three (3) research questions (numbers 1, 2, and 8 from Chapter 1) explored the relationship between the partnerships' structural characteristics to outcomes and effectiveness include the following:

1. What characteristics of the partnership and its environment affect the outcomes?
2. How does a partnership's structure influence the partnership's effectiveness?
3. How do the rules, roles and procedures influence and impact on the partnership's effectiveness?

Butterfoss et al. (1993) had indicated that partnerships are differentiated according to differences in function, organizational structure, membership, and reason for forming. As the two (2) geographical regions in this study receive federal funds for HIV/AIDS services, the partnerships must meet the requirements of the Ryan White CARE Act (U. S. Department of Health & Human Services, 1996). Each of the partnerships in this study meet different requirements for membership, structure and function, as indicated in the descriptions provided in Chapters 1 and 2. Several authors suggest the most important elements for partnerships include a clear purpose, or mission, shared vision, and shared values (Bond & Pyle, 1998; Butterfoss et al., 1993, 1996; Ettlinger, 1994; Gray, 1985; Jones, 1997). Kraft & Dickinson (1997) indicate that decision making is made easier by having a clear vision. Both partnerships have a clear mission, but they are lacking in a shared vision. While both partnerships expressed the importance of values to their respective group, and individuals provided support from the interviews, each of the partnerships has not identified its shared values as a collective ingredient of the partnership.

It was recommended by several authors for partnerships to become formal in their roles, rules and procedures to assure success in the implementation and sustenance of their activities (Butterfoss et al., 1993; Goodman et al., 1996). Formalization may impact a partnership's success and effectiveness in a positive manner. It was evident that both of the partnerships in this study had developed formalization in their respective structures and processes. Regarding the structure of an organization, Chinman et al. (1996) believe that joint decision-making, jointly defined goals, and democratic management contribute to

empowerment. They further suggest that "as a result, individuals are empowered as part of the organizational process" (p. 264).

A review of the documents, interviews and observations reflect a difference in the structure, formality, and expressiveness of members within each partnership. The CARE Council in Palm Beach follows parliamentary procedures, while the partnership in Jacksonville is very informal in its proceedings. The meetings are fast paced in Palm Beach, while the meetings in Jacksonville move at a slower, more relaxed pace. The difference is assumed to be reflective of the parliamentary procedures in place at the CARE Council. Following such procedures tends to limit informal discussions and allows the group to adhere to the order of business on the agenda. The CARE Council appears to be effective in the use of parliamentary procedures, realizing there is a constant need for training of its members about such procedures.

The First Coast CARES Consortium has a value of seeking input and valuing each person's opinions, allowing for more informal discussion and participation of its members. The CARE Council also seeks and values input, but they put it into a more formal structure. The researcher found from the interviews that consortium members in Palm Beach felt more empowered than the consortium members in Jacksonville. With feelings of inclusion, competence, and positive self-esteem, members tend to feel more empowered and satisfied, and will participate more in the activities (Zimmerman, 1995). Question 14 of the GES indicated a difference between the groups, reflecting that members are learning to depend more on themselves. More members (35%) in Palm Beach did not think they were empowered, compared to 10% feeling this way in Jacksonville.

Morgan (1982) reports that the link between the structure of organizations and their respective activities and decision making processes have been examined and documented for many years. The structure of the First Coast CARES Consortium in Jacksonville and of the Palm Beach County HIV CARE Council in Palm Beach includes a standard set of bylaws that guide the processes of each consortium. The CARE Council has developed 22 other policies and procedures, as well as standards for care and treatment of the clients.

The CARE Council in Palm Beach believes that committees are important to their work. Committees are one of the many processes used to achieve the mission of the partnership. With over 10 committees, the members have ample opportunity to interact on a regular basis and get to know each other, as well as to have input into the service coordination to clients. McMillan et al. (1995) report that active member participation is a key to achieving empowerment. Members in Palm Beach are actively involved in the committees. The lack of a committee structure in the Jacksonville partnership reduced the active participation of various members.

Another factor contributing to empowerment is that of organizational climate. Moran (1992) describes organizational climate as characteristics of an organization that distinguishes itself from other organizations. The dimensions of differences may include the following: members' perceptions of their organization inclusive of such factors as trust, autonomy, cohesiveness, support, fairness, and recognition; norms, values and attitudes of the organization's members; and influences the shaping of behaviors. It is suggested by Moran (1992) that organizational climate has a direct influence on organizational performance.

Butterfoss et al. (1993) stated that a partnership's "membership is its primary asset" (p. 321). Attention to the membership is vital for partnerships to succeed at their mission. This may include recruitment efforts, training and skill development, and communication. Recruitment efforts are underway at both consortia, but appears to be more successful in Palm Beach. Community empowerment is a reason why members join and sustain their membership in a partnership (Mayer et al., 1998), particularly believing the partnership could impact the community's health policy. The recruitment process in the CARE Council enables community empowerment.

While both partnerships had guidelines for the number and type of members, it was unclear what the number and type of members the First Coast CARES Consortium desired to have. Without this determination, the consortium would constantly have different members from month to month and not be able to have stability in its membership, as in the Jacksonville consortium. Having a stable membership allows the group to form relationships and cohesion.

The majority of members in the Jacksonville consortium have been on the consortium for less than one year. This may be reflective of the lack of clarity in the membership guidelines by not stipulating membership terms and identifying specific members. Longevity affects such cohesive development of the members in a partnership. The longevity of members in Palm Beach reflects only one third as being on the council for less than year. There appears to be stability of membership, as members are appointed for a term of two years.

If members are acquainted with the group, they will feel as though they belong to the group. A leader may be expected to help the members become acquainted with the

group. An area of significance on the Group Environment Scale reflected differences in leader support, question 42, which indicated the members from the CARE Council in Palm Beach perceived the leader to help members get acquainted with the group, while in Jacksonville, the members did not perceive this to be true.

The CARE Council recognizes each member as a valuable asset to its purpose. There is respect and recognition of the members. Name placards are placed at each member's seat during the meetings. There are personal moments to recognize individual contributions and successes. The researcher believes, based on observations and interviews, the First Coast CARES Consortium also recognizes its members as valuable assets, but they are not as demonstrative, lacking overt recognition to its members.

Fleishman et al. (1992) indicated that the "degree of internal cohesion was related to the identity of the lead agency" (p. 547). Both lead agencies from each partnership provide administrative support to the consortium. Several factors contribute to the functioning and cohesion of the consortium, including the frequency of meetings and communication; and the degree of trust, conflict and cohesion among member agencies (Fleishman et al., 1992; Luft, 1984). The lead agencies in both partnerships foster communication between the members through the newsletters and other monthly mailings. This keeps the members informed of activities within the partnerships.

The lead agency in Palm Beach offers support and encouragement to the CARE Council members, taking its lead from the consortium. The lead agency in Jacksonville offers support and encouragement to the CARES Consortium members as well, but takes more of a leadership role in its activities. This may be a result, as perceived by the

members, of the more active role of the state HIV/AIDS Program Coordinator in Jacksonville.

Support received refers broadly to resources that may contribute to an individual's "quality of life and to their ability to cope with stressful situations" (Maton & Salem, 1995). Staff may help to reduce stress placed on the membership (Butterfoss et al., 1993). Support in the context of this study includes such resources as the leader(s), the other members, and staff. An area of difference between the groups from the GES was question 12, reflecting the perception that the leader goes out of his way to help members. The participant members from Jacksonville did not think the leader went out of his/their way, while the members in Palm Beach believed the leader went out of his way to help and support the Council members.

Additionally, the leader(s) characteristics and style affect the partnership. Maton and Salem (1995) identify two (2) mechanisms in which a leader contributes to empowerment, collaboration, and effectiveness of a partnership. The first is the direct influence the leaders may have on members, and the second is the "indirect effect through the leaders' capacity to motivate and influence those who interact regularly" (p. 650). The leader may not know the members very well which may impede the work and empowerment to the members. A strong leader promotes community and inclusion within the group, promotes shared decision making and leadership, and is committed to members' growth. Strong leaders also encourage full participation in activities and is related to participation (Carr, 1997). Statements obtained from Jacksonville respondents during the interviews reflected confusion as to who the leader was of the consortium. There appears to be a strong leader in the Palm Beach consortium, one that promotes

inclusion, empowerment, and a feeling of community. The leader in the Palm Beach consortium promotes and motivates active participation and individual members' growth.

Partnerships can encourage membership participation, satisfaction, and tenure by recognizing and rewarding the members (Chavis, 1995; Butterfoss et al., 1993, 1996; Chinman et al., 1996). In fact, Chinman et al. (1996) suggests that the recognition and reward of partnerships' members is a key variable affecting organizational behavior, and thus in achieving its mission. One question (#72) from the GES reflected a significant difference between the groups, with members in Palm Beach perceiving they were recognized and rewarded, while those members in Jacksonville did not feel so.

Research Question Related to Conflict and Decision Making

Decision making within a partnership is often wrought with emotions, conflict, and difficulty. Partnerships and organizations need to have a structure and process in place to be able to make clear decisions. Black (1997) indicates that the following all contribute to increased member satisfaction and member participation: structure and process of the decision making, form, degree of member involvement, work design, and strategy issues. Butterfoss et al. (1993) suggest that decision making is more important than problem-solving and conflict resolution strategies. The research question (number 7 from Chapter 1) that relates to conflict and decision making includes the following: How are decisions made, conflicts and problems solved?

The research question was supported by findings from the data obtained through the interviews, observations, and the GES indicates that the two partnerships help their memberships make practical decisions by providing education and training, and considerable written and verbal information that offers explanation and clarity. The group

in Jacksonville used consensus in their decision making, while the group in Palm Beach used a more formal approach of parliamentary procedures. Question 75 from the GES reflected an area of difference between the two groups. Each of the partnerships perceived the members make practical decisions, but 38% of the members in Jacksonville and only 8% of the members in Palm Beach perceived they help one another make practical decisions.

Conflict management is a key factor contributing to the success of a partnership. Weider-Hatfield (1995) describes factors contributing to conflict: differences in knowledge, values, beliefs, competition, need to release tension, personal dislike, and different perceptions or attitudes of the members.

Information obtained from the interviews and the observations of the meetings reflected that people were civil and congenial, and very respectful of each other. Data reflected from the GES, though, reflected a conflict with the qualitative findings. Several questions on the GES related to conflict in the sub-scales of anger and aggression were found to reflect areas of significant differences between the groups. This may be reflective of past feelings or past occurrences at the CARES Consortium or CARE Council. The members of the First Coast CARES Consortium in Jacksonville may feel there is a perception of arguing more frequently because of the informal discussion held on issues that my cause emotions to become evident. The members in Palm Beach follow parliamentary procedures, which tends to inhibit arguments.

Leadership is a significant factor in the success of a community health partnership. Selecting competent leaders and assuring the development of leadership skills and abilities is critical to the effectiveness of a partnership (Butterfoss et al., 1996). Kraft and

Dickinson (1997) suggest that leaders who focused on outcomes, made quick decisions and stuck to them were important to the success of a partnership.

Several themes related to leadership emerged from the findings of this study. Leadership style and behaviors may impact the manner in which conflict and decision-making are perceived by members and handled within partnerships. In Table 25, two sub-scales on the GES, leader support and leader control, indicate eight GES items that reflect significant differences between the members' perception of leadership in the two partnerships.

Question 29 indicates the leader has the final say in a disagreement, suggesting the leader is in control of the issue at hand and can bring closure to conflict. The responses reflected an area of difference between the partnerships, with 81% of the members in Jacksonville perceiving the leader not having the final say in disagreements and 68% of the members in Palm Beach perceiving the leader did have the final say so in disagreements. It is assumed that the leader in Palm Beach, with greater knowledge and skill in using parliamentary procedure, has the ability to maintain effective control.

Setting clear expectations of a group is characteristic of a leader's ability to promote and affirm a vision for the organization. The researcher assumes there was a difference of leader control between the two partnerships, as found from the interviews and observations. Evidence from the observations and interviews reflects that the leaders in both Jacksonville and Palm Beach expected much from the membership. The findings from question 62 of the GES also reflected an area of difference between the two partnerships with 62% of the members from Jacksonville and 87% from Palm Beach who perceived the leader expected a lot from its members. On question 59 related to

leadership, it is suggested that occasionally the leader will "give in" to pressure from the group. This was as an area of significance representing differences between the two partnerships. While the leaders at both the Jacksonville and Palm Beach sites were perceived not to give in to pressure from the membership, there was a difference between the two, suggesting the leader from Palm Beach may have been more in control and could not be swayed.

Butterfoss et al. (1993, 1996) suggest that organizational climate may include such factors as relationships of members, relationships between staff and members, communication patterns, decision-making, problem solving, and conflict management. A difference exists in the positive social climate characteristics evident between the community health planning partnerships from the interviews, observations, and the GES findings. The GES findings from question 17 asserted that members from Jacksonville think they argue and members in Palm Beach believed they do not argue.

Another question (number 27) relating to conflict suggests that people sometimes yell at each other. There was a difference between the two groups, with a greater proportion of the First Coast CARES Consortium members of Jacksonville believing they did not yell, while a greater proportion of the CARE Council members in Palm Beach believing they do yell at each other in meetings. Differences between the groups were also found between the partnerships related to hostility. In Jacksonville, evidence from the interviews, observations and the GES reflected congeniality and respect. While members of the CARE Council in Palm Beach reflected behaviors of congeniality and respect in the data from the interviews and the observations, a conflict was evident from the GES data. Members of the CARE Council perceived on the GES they were hostile to one another.

Process

Process factors within community planning partnerships are found in the body of literature related to community partnerships in general and those established for HIV/AIDS, ecology, collaboration, empowerment, groups and teams, and organizational effectiveness. The process themes that emerged from the data include the following: needs assessment, prioritization of services and allocation of funds, development of plans, promoting coordination and integration of services and resources, individual and group empowerment, communication, advocacy and power, responsibility, decision making, training, member interactions, leadership style and characteristics, adaptation, cooperation, management, membership recruitment, and problem solving.

The supportive research questions presented in Chapter 1 that relate to process are presented below with appropriate findings. The research questions are presented in the following manner: processes related to relationships are presented first, and those related to task processes are presented next. There are three (3) questions related to relationship processes and two (2) questions related to task processes. Relevant conclusions are drawn from the data.

Research Questions Related to Relationship

Three (3) research questions (numbers 2, 4, and 5 from Chapter 1) that are relevant to relationships within partnerships include the following:

1. What contributes to collaboration and empowerment within a partnership?
2. What is the relationship between the partnership's members' and leaders' perceptions of their group?

3. What are the relationships and behaviors of participants in a partnership and how do they relate to its effectiveness?

Many contributing factors are related to the collaboration, empowerment and effectiveness of a partnership. Many of those factors stem from relationships and perceptions of one another within the group or within the community. The focus of relationships within partnerships is reported by several authors (Butterfoss et al., 1993; Speer & Hughey, 1995) as important to the partnerships success. They indicate that partnerships based on relationships sharing values and emotional ties are more meaningful and sustainable than those based on partnership or community issues. The desired outcomes of partnerships may include change in the community, increased services to a specific population group, increased funding, or development of a new program related to the mission of the partnership (Butterfoss et al., 1993; Campion et al., 1993; Fawcett et al., 1995). Many of the responses from the interviews provided triangulation and offered support to the quantitative findings.

The interviews produce evidence that members perceive they receive support through training and skill development, which has an impact on the collaboration and empowerment of members (Fawcett et al., 1995). Observations of both partnerships indicate education and training occurs, as well as development of certain skills. In the partnership at Palm Beach, there are "educational moments" on a regular basis that highlight certain points for further understanding. The partnership in Jacksonville has at least four (4) regularly scheduled educational meetings in place of a business meeting. Both partnerships have an annual retreat, or conference, that provide further training opportunity.

Membership characteristics within each partnership is guided somewhat by the requirements of the CARE ACT legislation, requiring a certain number of clients, providers, and other community representatives. Both partnerships have a goal of increasing minority representation on each consortium. It appears that the CARE Council in Palm Beach has been creative in their membership recruitment process, establishing a process for mentoring new members, which may contribute to the apparent success of increased minority representation. Additionally, part of the CARE Council's membership recruitment process includes seeking and attaining members that have certain skills and knowledge needed by the partnership. The CARES Consortium in Jacksonville, though, has struggled with recruitment of new members, especially those from within the minority community.

Communication is an important part of the work of the partnerships and is related to the success of a partnership. Hall et al. (1977) indicate that the caliber of communication is positively related to coordination and detrimentally related to conflict. Direct and open communication helps individuals within a group focus on the common mission of the group, increases trust and the sharing of resources and information, and develops coordination (Butterfoss et al., 1993; Campion et al., 1993). Discussion of issues within the group fosters trust and eliminates the perception of secrecy and conspiracy (Luft, 1984). The CARE Council in Palm Beach continually communicates with its members through newsletters, monthly mailings, and through the many committee meetings held each month. An extensive agenda is prepared by the CARE Council in Palm Beach for the monthly committee meetings and the full Council meeting. Comprehensive minutes are prepared and sent to every member monthly. Communication in the First

Coast CARES Consortium in Jacksonville is done through monthly mailings and through the consortium meetings. The First Coast CARES Consortium agenda is much shorter than that of the CARE Council and the minutes are complete, but not as comprehensive as that of the CARE Council. Every member and guest attending the meetings at either partnership has an opportunity to speak and communicate openly throughout the meeting; each partnerships' leaders encourage participation from the membership.

Satisfaction of members participating on community partnerships is derived from the benefits received by its members, often indicating whether a member will stay with the group or leave. Butterfoss et al. (1996) studied the relationship between key characteristics of a partnership and member satisfaction and participation. One of the findings they reported is relevant to this study. Butterfoss et al. (1996) reported several factors that predicted satisfaction and participation. A slight increase of membership is evident from the documents obtained. Increased participation and member satisfaction is more evident in the CARE Council of Palm Beach, as supported by the findings from the interviews, observations, and the GES.

Member satisfaction is also derived from the perceived support obtained from other members of the group. One of the ways people derive such support is in the development of new skills. Question 85 of the GES speaks to this method. All the respondents from both partnerships believed they received support through training and skill development, but a greater proportion of the members from Palm Beach perceived this to be true than from Jacksonville.

Black (1997) found that a key area of member participation included decision-making. One of the conclusions from this study reveals the decision-making process at

both partnerships allows for the input of the members. A value of assuring member participation and having their comments honored is stressed at each of the partnerships studied. Black (1997) reports that individuals directly involved in decision-making leads to increased participation and involvement in the group. While each partnership follows different processes, (i.e., consensus versus parliamentary procedures) they appear to both be effective. It does appear from the data, though, that the CARE Council members in Palm Beach are more directly involved in decision-making and participation in the partnership's work.

Research Questions Related to Tasks

Two research questions from Chapter 1 (number 3 and 6) relate to the tasks of a partnership and include the following:

1. How does a partnership's processes influence the partnership's effectiveness?
2. What is the link between the partnership's planning activities and its outcome of the plan?

Gladstein (1984) indicates that groups organized to achieve a task provide a link between the individual and the effectiveness of the larger organization. Kegler et al. (1998) relates that a task focus has an impact on the organizational climate, and that group cohesion has an impact on the accomplishment of tasks. A major task requirement of both partnerships is the development of an annual application/plan. The partnerships' annual applications/plans were developed by a small group within each partnership knowledgeable about the area's needs in developing its goals and objectives. The small group within each partnership also indicated from the interviews that they constantly monitor the progress of the plans, thus contributing to the partnership's effectiveness.

One of the key goals of a community health planning partnership is developing a plan and achieving the goals and objectives within the plan. Bazzoli et al. (1997) addresses the need to explore the processes partnerships undertake to "plan, implement, and monitor collaborative action..." (p. 556). Butterfoss et al. (1996) suggest a "cohesive, task-oriented, and innovative environment..." that may contribute to member satisfaction and participation. The attainment of goals helps individuals remain interested in their work. In this study, the Application Quality Index was used as a tool to ascertain whether the members of each respective partnership perceived their plans to be quality and adequate. Although the instrument did not produce statistically valid results and there was a limitation of the small sample, the information obtained from the key participants suggested supportive information to the other qualitative and quantitative data.

The findings from the First Coast CARES Consortium in Jacksonville suggest that members perceive an average-to-low perception of adequacy of the annual application. In Palm Beach, the CARE Council members reflected a high-to-very high perception. Both of the partnerships' responses reflected a low score to the questions of 'media coverage if planned' and 'strategy is planned for seeking funding,' indicative of such partnerships. It is assumed by this researcher that the membership within both partnerships is not knowledgeable in the application process, as determined by the interviews, as well as by the small sample of participants within each partnership knowledgeable about the application/planning process.

Outcome

Outcome characteristics of community planning partnerships are supported in the literature about community partnerships in general and those established for HIV/AIDS,

ecology, collaboration, empowerment, groups and teams, and organizational effectiveness. Moos (1996) suggests that understanding processes and environmental factors links to the outcomes of a group. The principal outcome indicator of partnership effectiveness is whether the partnership attained its mission, goals, and objectives (Butterfoss et al., 1993, 1996). The outcome themes that emerged from this study include the following: administrative assessment of effectiveness, increased services and coordination, efficient costs, evaluation, comprehensive services in place, increased member participation, accountability, member satisfaction, team effectiveness, increased community linkages, less conflict, more communication and interaction, empowered members, increased productivity, and less stress.

The outcomes evident from this study indicate that each partnership is collaborative, empowering, and effective in their respective roles and responsibilities. Evidence comes from the interviews, documents, surveys, and observations. The members of both partnerships perceive they are collaborative, empowering, and effective because they indicated they both have funding left at the end of each year, both monitor and review funding and priorities and make adjustments as needed. A response from one of the interviewees said that the consortium is successful and has positive outcomes because "there was funding remaining." Responses from interviews suggest that the needs assessment process and the planning process lead to increased funding and increased service coordination for the clients. The coordination and integration of community services and resources are effective in both partnership areas. Many service organizations are represented in the membership of each consortium. The review of the documents

indicates the accomplishments of the prior year goals, as well as identifying the goals for the upcoming year.

Both of the partnerships have strong administrative, lead agencies to support the consortium. Support for the partnership is important to the outcomes of the partnership (Fawcett et al., 1995). The authors identify some enabling activities within four main strategies of community empowerment important in the facilitative support of partnerships. The four main strategies include: "enhancing experience and competence; enhancing group structure and capacity; removing social and environmental barriers; and enhancing environmental support and resources" (p.684). The administrative agencies have contributed to the success of the two partnerships. Adhering to the four (4) strategies and enabling activities (Fawcett et al., 1995), the following include those enabling activities identified from the findings of this study, contributing to the determination that the two partnerships in this study are effective in their work because they:

1. Conduct needs assessments, surveys, and focus groups;
2. Develop an inventory of the community resources;
3. Use the federal and state information relevant to the incidence and prevalence of problems related to HIV/AIDS;
4. Identify potential target populations in their plans;
5. Develop and disseminate guidelines about membership and leadership, through the establishment of by-laws, and policies and procedures;
6. Provide training activities for the membership and leadership related to planning and analysis;
7. Encourage the inclusion of individuals affected by HIV/AIDS;

8. Actively assist in recruiting, developing, and supporting individuals who participate on the partnership;
9. Actively participate with the administrative agency in developing plans for financial viability and sustainability;
10. Promote the coordination of services and funding through cooperative agreements;
11. Provide training in conflict resolution, parliamentary procedures;
12. Encourage individual involvement and having a voice in the group;
13. Provide continual and on-going information related to their mission, goals, outcomes, satisfaction, needs, and planning efforts;
14. Adapt to the changing needs and resources;
15. Encourage networking between the members as well as between the members and the community;
16. Provide educational opportunities and outside experts;
17. Promote celebration and recognition of individual and group accomplishments;
18. Monitor policy and resource allocations.

Having capable administrative agencies for the two partnerships of this study allowed the CARE Council and the CARES Consortium to achieve their respective goals and follow their missions. The goals of the CARE Council tend to be more related to building the infrastructural support, while those of the CARES Consortium tend to be related to increasing recruitment of clients and minorities and attempting to consolidate two planning bodies. Recruitment of minorities may be related to values and structure. For example, the consortium in Palm Beach appeared to be more successful in recruiting

minority members. They expressed strong values about membership, recruitment, and diversity. Both consortia achieved their respective goals and objectives. Results from the data offer support through the triangulation of the findings of the observations, the documents, the GES, the AQI, and the interviews. The CARE Council in Palm Beach may run more effective meetings due to the parliamentary procedures it follows, thus reducing conflict and unnecessary discussions of issues.

Comparison between Area 4, Jacksonville and Area 9, Palm Beach

Upon reviewing and analyzing the information obtained from the interviews, observations, surveys, and documents, the two (2) HIV planning consortia/councils are fulfilling their legislative mandate as outlined in the legislation. Each of the partnerships meets on a regular basis, reviews and adapts funding based on the changing needs of the client population, prioritizes and allocates funding based upon an annual needs assessment, develops an annual application/plan, promotes coordination and integration of community services and resources, and evaluates its services. Both partnerships attempted to include the infected client population as members in the duties and tasks of the consortium. Both groups offer training to the membership. Both partnerships developed bylaws for the operation of the consortium. The CARE Council in Palm Beach has developed 22 other policies to assist the manner in which they do business.

The interviews conducted in each area revealed many similarities and few differences. One of the differences included the perception of lack of clarity about who the leader was in the Jacksonville partnership; the group from Palm Beach knew who their leader was. Another difference is the manner of decision making; in Jacksonville they use consensus, in Palm Beach, they use parliamentary procedures.

The Jacksonville members reflected their perceptions of the adequacy of the annual application/plan to be in the average-to-low range, while the Palm Beach members perceived the adequacy of the application/plan to be in the high-very high range. The GES reflected only 17 of 90 items with significant differences between the groups, and 2 questions approaching significant differences, most in the areas of leadership, conflict, and member perceptions. The limited findings from the GES were not able to provide for support to reject the null hypotheses.

Practical Implications for Community Health Planning Partnerships

Several lessons can be learned from this study. The design and methodology of this study enabled the researcher to collect a vast array of data that enabled the researcher to gain insights that may not have been revealed from one single method. In many instances, the data obtained from the observations or interviews were validated by the data revealed from the surveys or documents. Data collected often did not conflict between methods, but were rather consistent between them.

An important theme that emerged from the members of each group was that of values. During the interviews the participants expressed their values in response to many of the questions. The surveys asked questions about values in several ways, and the observations of people within the meetings revealed values of the people through their behaviors and actions. Values and belief systems of members help to shape structures and processes of the partnership and provide opportunities for individual growth and change efforts (Maton and Salem, 1995). Another significant discovery revealed that the use of parliamentary procedures did not necessarily override the values of the participants, i.e.,

their concern for others, compassion, respect, and caring. Values of individuals or those shared by the group often were expressed.

Several other important results are related and presented here. One of the key implications for practice is the importance that partnerships have a formalized structure in place to allow the members, through their relationships and tasks, to produce an outcome. The selection of competent leaders is important to assure this occurs. Leaders must know how to develop bylaws, guide meetings, understand and be able to use parliamentary procedures, handle conflict, and guide the group to decisions. Leaders must know how to be accountable and to seek accountability, keeping on task and providing updates. The continued development of skills is important for the leader as well as the members of a partnership.

While planning is an important task of a partnership, it can be seen from this study that partnerships can be deemed to be successful without continual attention to the planning. It was evident that the partnerships placed little priority on the planning process throughout the year, but rather made planning a top priority for only a brief time during the year prior to when plans were due at the state and/or federal levels. Staff and a small group of members from each partnership supported the ongoing monitoring of the plan.

Table 31 identifies the most prevalent themes evident from the study and the specific implications. As leaders of a community planning partnership, these implications could be used to offer a better understanding of why partnerships are collaborative, empowering, and effective. If heeded, a leader may be able to avoid issues, barriers, and conflict that may arise in the event of lack of understanding or knowledge.

Table 31. Implications for Community Planning Partnerships

Theme Area	Implication
Leadership	The leadership of the partnership must be shared and done collectively (co-chairs, officers, staff), but it is necessary that an identified leader have a clarity in their role, as perceived by the members.
Structural and Process Design	Ground rules and governance are important for everyone involved to know their responsibility and their role. It may include the following: Parliamentary procedures Location of meetings Membership guidelines Meeting process Decision making Staff support How work gets done: individuals vs. committees vs. consortium
Membership	Specific criteria, with guidelines for recruitment, should be developed.
Values	The importance of values proved to be an important finding from the interviews, surveys, and observations.
Planning	Having a vision, mission, needs assessment, plan, and evaluation
Awareness of different cultures	Understand that each partnership tends to believe they have the *right* system. Understand the "etiquette and taboos." Each partnership has certain ways of behaving, communicating, interacting, handling business (i.e., free to walk about, speaking out freely) Rituals, rites of passage are important to the members and offers cohesion (i.e., moment of reflection, educational moments); reward and recognition.
Training	Training is necessary for members of partnerships, community leaders, agency directors. Training is important for partnership members related to certain areas: recruitment, meeting management, parliamentary procedures, conflict management, leadership skills, teamwork & team building

Several recommendations that relate to Table 31 are offered:

- Training is a necessary component of assisting the members of the community partnerships to become knowledgeable and skilled in their tasks and responsibilities. Topics for training could include those related to any specific legislation related to the partnership's purpose (i.e., Ryan White CARE Act),

basic meeting management, parliamentary procedures, Sunshine Law, conflict management, as well as those related to leadership development, team dynamics and teamwork. As the government requires more individuals and agencies to form planning partnerships, it is clear from the study that additional training is needed to better prepare the community health leaders, agency directors, and non-professional citizen members to perform their tasks.

- Further assistance could be sought by both partnerships of this study to enable them to do more recruiting from the minority and the HIV-infected populations. Perhaps requesting technical assistance from HRSA would provide additional knowledge and ideas of best practices in recruitment efforts.
- Four (4) specific suggestions are offered to the First Coast CARES Consortium in Jacksonville as methods to increase effectiveness:
    1. They should explore the feasibility of a joint partnership with the Title I planning council in the area and seek opportunities to conduct more consortium business with the Title I planning council. Greater efficiencies and effectiveness could be an outcome.
    2. They should explore the possibility of developing specific membership guidelines related to the minimum and maximum number of members, as well as length of terms. The flexibility of people coming and going does not allow for consistency within the group.
    3. They should increase the importance of the co-chairpersons role as the leaders of the consortium, rather than the lead agency remaining in this

perceived capacity. It may allow for increased motivation and participation of members, knowing the leader(s) was (were) "one of them."

4. They should reconsider the value of committees and re-establish a committee structure to attain increased member participation, empowerment, and satisfaction.

- Structures that enable full participation are likely to be important when individuals (staff, professionals, leaders) are initially in a stronger position to contribute that others (persons with disability, client).
- The level of trust among partners needs to be high for organizations and individuals to accept partnership action. Inclusion of community partners in the leadership and management of the partnership is vital to developing trust.
- To increase satisfaction, members should be encouraged to become actively involved in the partnership's activities. Including members in activities leading to decision-making, and the recognition of individuals is important for continued member participation and member satisfaction.
- There is a need to balance the partnership's activities essential to maintaining the partnership against those activities needed to implement goals and objectives and monitor them. Skill development in this area would assist leaders and staff support of partnerships. It is important for the partnership to develop and formalize shared values and a shared vision.
- Understanding the need for staff support to a partnership is important for funders; as well as contributing to the continued success of a partnership.

- The better preparation of the partnership members allows for more effective implementation of its mission.
- It is important for members of a partnership to understand that a partnership's unique history and traditions impact the current structure and process.
- Informal processes can be subtle but powerful forces in the organizational culture of partnerships. For example, the use of reward and recognition of its members that may offer beneficial outcomes.
- The incorporation of a value for diverse people is evidenced by structure and process. For example, the development of specific membership criteria to assist in the recruitment of diverse populations would assist in the assurance of diversity.
- The selection of competent leaders and developing their skill should be important, and thus developing and implementing a leadership development training program would enhance the leadership of the partnerships.

Recommendations for Future Research

The findings of this study have added to the body of knowledge related to community health planning partnerships. However, as this case study was limited to two (2) HIV planning consortia/councils in Florida, all the findings and conclusions from this study are not expected to generalize to all HIV planning consortia/councils. All the findings are not expected to generalize to other types of health planning partnerships; nor are all the findings and conclusions expected to answer all of the questions about general health planning partnerships.

Additional areas of study, however, might lead to a better understanding of community health planning partnerships. Partnerships hold the potential for improving community health and enhancing the service delivery in communities. The continued study of these efforts will provide opportunities for guidance and direction to communities seeking to develop partnerships

- It may be beneficial to expand the study to include more partnerships. This may offer a larger sample for the emergence and development of common themes, as well as offer greater validation of the findings. A comparison of more HIV planning consortia/councils may provide valuable information in further studies. The group size(s) was/were limited in this study. Expanding the study to include more partnerships would provide a greater richness to the understanding of partnerships. Generalizations from this study are limited.
- Exploring the developmental stages of a partnership is another need for research. Little evidence was found in the research. It appeared that the partnership in Palm Beach was further ahead of the Jacksonville partnership developmentally. Undertaking a longitudinal study of the existing partnerships in this study may provide further insight in the developmental stages of partnerships in this context.
- The instrument in this study, the AQI, was developed based on the Butterfoss et al. instrument, the PQI, used in several other studies. The instrument has been used on a limited basis. It is recommended that researchers interested in seeing the relationship between the plan (outcome) of a partnership and other individual factors or variables (related to structure and process), use the PQI or

the AQI to add to the body of literature. Key components within the instrument(s) and significant findings could be further examined.

- It is recommended that individual components found within the Application Quality Index in this study be further examined and investigated as separate variables. Increasing the number of respondents may offer greater insight.
- There appears to be a growing trend in the area of partnerships, offering a further need to explore and understand better how partnerships operate and sustain themselves. Partnerships hold the potential for improving community health and enhancing the service delivery in communities. The continued study of these efforts will provide opportunities for guidance and direction to communities seeking to develop partnerships.
- Studies that address 'capacity building' could provide greater knowledge for leaders of partnerships.
- Research related to specific skill development, support, training, infrastructure needs or requirements, would offer further richness in the field of community planning partnerships.
- Exploring the impact of funding and staff support to partnerships is another area of opportunity for research.
- Exploring the values and structure of a partnership's lead agency would be interesting to find the relationship to a partnership's structure and process.
- A limitation of the GES is offered for other researchers considering the future use of the instrument. The GES was very limited in the application of this study. It did not pick up many of the differences between the two

partnerships. The data from all the research methods used (i.e., interviews, observations, documents, and instruments), showed the cumulative differences between the partnerships. Data from the qualitative methods offered further richness and insight. For future research of partnerships, it is suggested that the GES be used in conjunction with other research methods and/or instruments.

In this changing society, the focus on parallel opportunities should be encouraged in the area of community planning partnerships. For example, lessons learned from this research have implications for those newly developing areas of partnerships, such as for bioterrorism. It is important that communities work together to develop specific plans on how to prevent bioterrorism in their community, and how to deliver services if there was such a need. The ecological approach to community partnerships highlights the inter-relationships of the individual level; the organizational, or partnership, level; and the community level. The challenges of providing assistance or guidance to a community partnership and promoting collaboration and empowerment are significant. Many dynamics are occurring within a partnership, as well as within a community, which may present either opportunities or barriers to the success of a partnership. Assessing a community partnership by its structure, processes and outcomes may be an effective method to address the dynamics and provide assistance to partnerships and communities.

Building empowered partnerships and communities continues to be a long-term process, requiring linkages across individuals, agencies, and professional sectors, while being attuned to the collective community concerns. Community citizens can now find themselves as a partner with business and government. They find themselves in a role with

responsibilities of establishing programs, setting policies, making funding decisions—all that affect people in their respective communities. A partnership's primary asset continues to its membership. Care must be taken to develop the required competencies of lay citizens and of professionals. This will, in turn, provide the opportunity for empowerment of individuals in the community. The key challenge may be to assist other community members to go through an emotional and behavioral shift necessary for the partnership governance to become a collaborative and shared responsibility of the community as a whole.

INTERVIEW QUESTIONS – (Semi-Structured)

What are the characteristics that contribute to the functioning and effectiveness in the collaborative activities of your local consortia?

Is there a relationship between the consortium's characteristics and effectiveness?

Is there a relationship between the group effectiveness and the local environment—social, political?

What are member perceptions or attitudes of other members' issues, power, and interactions?

Do you think your consortium can function effectively in the competitive marketplace when mandated to collaborate?

Do the individual or group characteristics of your consortium act as barriers or enhancers to the partnership's effectiveness?

Does community involvement contribute to improvement in conditions, resources; attitudes, behaviors, and expectations of patients and professionals; and depth and quality of partnership experiences?

Is there group motivation for positive functioning experiences? How do the characteristics of your group contribute toward its effectiveness in empowerment, advocacy, and improvement?

Do individual members work within cliches? Do they network with certain other members?

How does the consortium share in the decision-making? Is there consensus?

How does the leadership of the planning consortium affect the functioning and effectiveness of the group?

Has the leader been trained? Have the members been trained? Is there continual training?

How does the lead agent affect the functioning and effectiveness of the group? Describe their relationship to the consortium?

Do the consortia produce quality plans, needs assessments and other materials as mandated?

Has the lead agency staff been trained? Is the lead agency committed?

Does your lead agent affect the functioning and effectiveness of the consortium?

What kind of communication patterns exist between the key players?

INTERVIEW QUESTIONS – (Semi-Structured)

Is the needs assessment and plan developed a quality one and does it describe the needs of the local community?

Are outcomes written in the plan and evaluated?

How do you feel about the CARE Act's intent as desiring to empower community-based organizations, persons living with HIV or AIDS (PLWHs/PLWAs), public entities, and others at the local level through decision making in the planning council and consortium activities?

Describe the planning and coordinating functions of your consortium/planning council.

Can you describe the six (6) main tasks of the Title I planning councils within each EMA. Can you describe the seven (7) main tasks of the Title II consortia?

What is your opinion of how effective your consortium/planning council is in accomplishing those tasks?

A task characteristic of community partnerships would be the monitoring and adjusting the allocation of resources within a community. How effective do you feel the consortium is in monitoring and adjusting resources?

Adaptability is another characteristic that may be related to effectiveness. How do you feel your consortium responds to necessary changes.

Areas of communication and interchange between partnership members and organizations indicate a dependency on one another, while attempting to remain autonomous. The principle of interdependence focuses how persons and organizations are connected. What is your opinion? How do you feel about _____? How well do you think individuals of the consortium are well connected to organizations?

Succession in the context of community partnerships refers to the notion that environments change over time, benefiting some populations while being detrimental to others. This would have meaning to a community planning partnership in the distribution, allocation and priority setting of resources. Describe your feelings when I read this. What do you think of this notion? Does your consortium effectively accomplish the distribution, allocation and priority setting for the resources in your community?

How well do members of your local partnership share basic beliefs and assumptions? Do you think this affects its decision making and achievement?

The understanding of a community's culture is very important to its effectiveness. What do you think of this statement? What is your opinion?

INTERVIEW QUESTIONS – (Semi-Structured)

What are the benefits to you in participating in the consortium's activities? What are the costs to you? Is there a balance? Any suggestions to improve?

Do you feel consortium members take ownership of the problems as well as responsibility for the solutions?

Describe the following issues that occur within your consortium:
--turf, competition, governance issues, power and control, accountability, growth and development, membership recruitment and maintenance
How do members overcome these issues and work effectively together?

- How do the following determine the consortium's effectiveness—
--structure, process and outcome?

How would you describe the consortium's process of joint decision making?

What is the consortium's relationship to the political groups in your area: county commissioner's, city council, other planning bodies, County Health Department?

How do members overcome mistrust and skepticism?

What is the access to government and other community resources?

How do members handle conflict of interest issues?

Definition of Terms

In order to understand terminology and acronyms related to HIV/AIDS that are used in this paper, a brief listing follows. Specific health related terms, which are from the Ryan White CARE Act Title II Manual are identified (Bureau of HIV Services, 1999).

AIDS – Acquired Immuno-deficiency Syndrome is the disease caused by the human immuno-deficiency virus (p. 2).

ASO – AIDS Services Organization is an organization which provides medical or support services primarily or exclusively to populations infected with and affected by HIV disease (p. 2).

CARE Act – The Ryan White Comprehensive AIDS Resources Emergency ACT is the Federal legislation created to address the health care and service needs of people living with HIV disease and their families in the United States and its Territories. The legislation was enacted in 1990 and reauthorized in 1996 (p. 2). The Act directs assistance through Titles I, II, III, IV and Part F (see definitions below).

CBO – Community-Based Organization is an organization which provides services to locally defined populations, which may or may not include populations infected with or affected by HIV disease (p. 2).

CDC – The Centers for Disease Control and Prevention is the Federal agency within the U. S. Department of Health and Human Services that administers HIV/AIDS prevention programs, including the HIV Prevention Community Planning process, among other programs. CDC also is responsible for monitoring and reporting infectious diseases; administering AIDS surveillance grants and publishes epidemiological reports (p. 3).

Comprehensive Planning – The process of determining the organization and delivery of HIV services; strategy used by a planning body to improve decision making about services and maintain a continuum of care for people living with HIV and AIDS (p. 3). Comprehensive planning is required in both the CDC prevention grants to the states and in the HRSA patient grants to the states.

Consortium – A regional planning entity established by State grantees under Title II of the CARE Act to plan and sometimes administer Title II services within the communities (p. 3). The Florida Department of Health, Bureau of HIV/AIDS, has determined that Florida shall have consortia in its regions of the state to plan for patient care services under Title II of the CARE Act (HIV/AIDS, 1999). See the term, Planning Council, below for further definition.

EMA – An Eligible Metropolitan Area is the geographic area eligible to receive Title I CARE Act funds. Eligibility is determined by the number of reported AIDS cases to CDC. Boundaries of the metropolitan area are defined by the Census Bureau (p. 4). There are six (6) identified EMA's in Florida, which include the major cities and identified surrounding counties of Jacksonville, Orlando, Tampa, Miami, Ft. Lauderdale, and Palm Beach.

Epidemic – The spread of an infectious disease through a population or geographic area (p. 4).

HIV disease – The entire spectrum of the natural history of the human immunodeficiency virus, from post infection through the clinical definition of AIDS (p. 4).

Home- and Community-based Care – A category of eligible services under Title II of the CARE Act (p. 5).

HOPWA – Housing Opportunities for People with AIDS is a program administered by the U. S. Department of Housing and Urban Development which provides funding to support housing for people living with HIV and their families (p. 5).

HRSA – The Health Resources and Services Administration is the governmental agency responsible for administering the CARE Act. HRSA is within the U. S. Department of Health and Human Services.

IGA – Intergovernmental Agreement is a written agreement between a governmental agency an outside agency (p. 5).

Lead Agency – The agency within a Title II consortium responsible for contract administration; also called a fiscal agent (p. 6).

Part F – The part of the CARE Act that authorizes funds for the AIDS Education and Training Center (AETC), the Special Projects of National Significance (SPNS), and the HIVAIDS Dental Reimbursement Program (p. 7).

Planning Council – Under the CARE Act, a planning council is a planning body in an EMA identified to establish a plan for the delivery of HIV care services and to establish priorities for the use of Title I CARE Act funds (p. 7). Sometimes Consortium and Planning Council are used intermittently, and in some cases within Florida, the HIV Planning Council consists of a combined body to oversee Title I and Title II CARE Act funds.

PLWA – Person or people living with AIDS.

PLWH – Person or people living with HIV disease (p. 7)

Resource Allocation – The legislatively mandated responsibility of planning councils and consortias to assign CARE Act amounts or percentages to established priorities across specific service categories, geographic areas, populations, or sub-populations (p. 7).

Target Population – A population to reached through some action or intervention; may refer to groups with specific demographic or geographic characteristics (p. 9).

Title I – The part of the CARE Act that provides emergency assistance to localities (EMAs) disproportionately affected by the HIV epidemic (p. 9).

Title II – The part of the CARE Act that enables States and Territories to improve the quality, availability, and organization of health care and support services to individuals with HIV and their families (p. 9).

Title III – The part of the CARE Act that supports outpatient primary medical care and early intervention services to people living with HIV disease through grants to public and private nonprofit organizations (p. 9).

Title IV – The part of the CARE Act that supports coordinated services and access to research for children, youth, and women with HIV disease and their families (p. 9).

UNIVERSITY OF NORTH FLORIDA.
ACADEMIC AFFAIRS
4567 St. Johns Bluff Road, South
Jacksonville, Florida 32224-2665
(904) 620-2455 FAX (904) 620-2457

Division of Sponsored Research and Training

MEMORANDUM

TO: Judith A. Bassett
College of Education

Signature deleted

FROM: James L. Collom, Institutional Review Board

DATE: January 6, 2000

RE: Review--Institutional Review Board
"Characteristics of Effective Community Partnerships: A Multi-site Case Study of HIV/AIDS Planning Consortia in Florida"

This is to advise you that your project "Characteristics of Effective Community Partnerships: A Multi-site Case Study of HIV/AIDS Planning Consortia in Florida" has been reviewed on behalf of the IRB and has been approved as submitted. This approval applies to your project in the form and content as submitted to the IRB for review. Any variations or modifications to the approved protocol and/or informed consent forms must be cleared with the IRB prior to implementing such changes.

If your project extends beyond 12 months in length, you must provide an annual status report to the IRB. The above annotated approval date establishes the baseline date for this required annual status report.

If you have any questions or problems regarding your project or any other IRB issues, please contact this office at 620-2455.

dch

Attachments

c: Dr. Marianne Barnes

April 17, 2000

Dear CARE Council member:

The Palm Beach County, Area 9, CARE Council has been identified as one of the most effective and functional Ryan White consortia in the State of Florida. As one of the leading consortia, the CARE Council has been selected to be included in a study to learn what characteristics contribute to its effectiveness. Because you are a member of Area 9's CARE Council, you have been selected to participate in the research study that will help determine what characteristics enhance the effectiveness and functioning of your consortium.

Your input will give valuable and much needed insight as to the effects of involving Ryan White Consortium members in decision-making processes at the local level and how this may contribute to the effective functioning of any Consortium. The study will occur between March 2000 and July 2000, and will include observation of meetings, interviews of consortium members, and completing several brief questionnaires. I will attend and observe at least three (3) of your Consortium meetings between March and July 2000. You may be asked to complete a questionnaire about the quality of the plan that your Consortium has develop, a leadership effectiveness survey, and/or a group environment scale to determine the Consortium's effectiveness. You may volunteer to participate in the interview process, which will last approximately 30-45 minutes and follows a semi-structured questionnaire. You will be given a copy of the questions prior to the interview. Your responses will be tape recorded to help authenticate the transcription of data. All information will be kept confidential and participation is strictly voluntary. Your consent may be withdrawn and participation discontinued at any time without prejudice.

This study poses no risk of social, physical, or psychological injury to you. The immediate benefit of participating in this study is the knowledge that you are contributing to a worthwhile study regarding the structure, process and outcomes that may contribute to the CARE Council's effectiveness. No monetary compensation will be awarded for your participation in this study; however, your help is greatly appreciated. There have been only a few studies in the United States on Ryan White Consortia, but none that have addressed effectiveness and functioning in a holistic manner. Perhaps knowing why your local Council is effective may be of benefit to others throughout Florida and the United States.

This letter will serve as a description of the study and includes a "Consent to Participate" form that is attached. Please sign the "Consent to Participate" form and return to me either in person at a Consortium meeting or by mail to the address listed below. If you have any questions or would like further explanation regarding the purpose or procedures of this study, please contact me.

Thank you for willingness to participate and assistance in returning this form. Your participation would be very beneficial in this study.

Sincerely,

Judith A. Bassett

For Further Information regarding this study, you may contact the following:
Judith A. Bassett, home (904) 291-1411, work (904) 323-2563; P. O. Box 1507, Middleburg, FL 32050; or

Dr. Marianne Barnes (904) 620-2520, University of North Florida, 4567 St. Johns Bluff Road, South; Jacksonville, FL 32224

Consent to Participate

I have read and I understand the procedures described in the attached letter. I agree to participate in the study as described in the letter, which includes completing survey questionnaires and perhaps participating in an interview, as well as being observed during the CARE Council meetings.

I understand that all information will be kept confidential and participation is strictly voluntary. I understand that a coded number will be assigned to my name to maintain confidentiality and the list will be kept in strict confidence. I also understand that my consent may be withdrawn and participation discontinued at any time. No monetary compensation will be awarded for my participation in this study. Further, this study poses no risk of social, physical, or psychological injury to me. The immediate benefit of participating in this study is the knowledge that I am contributing to a worthwhile study regarding the structure, process and outcomes that may contribute to the Consortium's effectiveness.

Please identify those areas of interest to you and willingness to participate in either one or more of the procedures:

☐ *I don't mind your attendance and observation of the CARE Council meetings.*

☐ *I am willing to participate in a brief interview regarding the Consortium.*

☐ *I am willing to complete the brief questionnaire(s) about the Consortium's efforts at planning, leadership effectiveness, and its environment.*

_____ _____ _____ _____
Participant *Date* *Witness* *Date*

H_____ _____W_____
Phone Number (home and/or work)

_____ _____ _____
Mailing address (street) *Relationship if other than you* *Date*

_____
City, State, Zip Code

Judith A. Bassett _____
Principal Investigator *Date*

For Further Information regarding this study, you may contact the following:

Judith A. Bassett, home (904) 291-1411, work (904) 323-2563, P. O. Box 1507, Middleburg, FL 32050; or

Dr. Marianne Barnes, (904) 620-2520, University of North Florida, 4567 St. Johns Bluff Road, South; Jacksonville, FL 32224

TIMELINE2000-2001

	February-March 2000	February	March (thru June)	March (thru July)	April -May	June 2000	January-March 2001	August - October	December 2001
WHAT	*Gather Data from each Site:* ▪ Bylaws ▪ Minutes ▪ P&P ▪ Annual application ▪ Budget ▪ Demographics ▪ Regional and political factors ▪ Membership information ▪ Correspondence ▪ Services and activities	→	*Administer Quantitative Surveys: the Group Environment Scales, the Campbell Leadership Effectiveness Survey, and the Plan Quality Index (quantitative instruments):* ▪ RWC Chair ▪ Lead Agent representative ▪ HAPC ▪ CH Director ▪ State BHIV area repr. ▪ RWC members ▪ Providers	*Begin Series of 3 Site Visits for Observations:* ▪ Attend RWC meetings	→ *Begin Interviews with Key Participants at each Site:* ▪ see prior list	*Follow-up:* ▪ interviews ▪ surveys	*Follow-up:* ▪ interviews ▪ surveys	Submit first draft to committee Rewrites; Final defense	Attend RWC meetings to share findings
WHY	To learn about the *structure* and background of each RWC: characteristics of group and its environment; as, well as the *outcomes* to date of each group	→	To learn about the *process* of the RWC: member interactions; assess changes in coalition efforts, its leadership and communication patterns; its impact and outcomes	→ To gather 1st –hand information about what key participants report; and to actually SEE how meetings and members function To measure effectiveness of planning efforts	→ To meet and gain the perspectives of key participants from each RWC	To clarify and validate what was found to date with key participants	To clarify and validate what was found to date with key participants		

TIMELINE2000-2001

	February-March	February	March (thru June)	March (thru July)	April	June 2000	January-March 2001	August - October	December 2001
HOW	Send letter to each RWC chair, HAPC, Lead agent, and State BHIV area representative requesting the identified information pertaining to the particular area RWC	Call and/or send letter requesting info. About attending a RWC meeting in March to explain my research in person, sign consent forms, etc.	The Group Environment Scale survey and the Campbell Leadership Effectiveness Survey may be given to the consortia members & key participants identified at each site	The Plan Quality Index will be given to the consortia members during meetings and collected at that time.	Letters will be sent to the key individuals identified and appoint-ments will be made to meet and interview them				Call, set appointmt. To attend meeting to present findings
Process for Analysis	Event logs and coding sheets for each type of document reviewed will produce themes found at each RWC		Results of Surveys will produce a computer analysis of various themes found at each RWC	Observations will be conducted with the use of coding sheets will produce themes and activities found during observations *GES Surveys & the PQI, observations and interviews will produce information about critical events that have had influence on the RWC effectiveness--- PQI will be analyzed with statistics*	Results of Guided interview questions will produce transcipts	Follow-up interviews by telephone or on-site will produce clarification and validation of interview transcripts, surveys, and observations	Follow-up interviews by telephone or on-site will produce clarification and validation of interview transcripts, surveys, and observations		Present findings in a PowerPoint Distribute handouts
	Analysis of Data and Reporting of the Findings	→	→	→	→	→	→	→	

NAME OF DOCUMENT	BHIV Or HAPC	Lead Agency	City or County
1. Ryan White Title I Application/Plan/Grant (HRSA)			X
2. Ryan White Title II Application/Plan/Grant (Florida BOHA)		X	
3. Membership Rosters		X	
4. By-Laws		X	
5. Consortium Meeting Agendas (7/1/99- current)		X	
6. Consortium Meeting Minutes (7/1/99- current)		X	
7. Committee Meeting Agendas (7/1/99- current)		X	
8. Committee Meeting Minutes (7/1/99- current)		X	
9. Florida DOH or BOHA site visit/monitoring review reports	X		
10. Florida BOHA peer review reports (1999 or current)	X		
11. State contracts (T.I and T. II) (SAMPLE)	X		
12. State monitoring reports (SAMPLE)	X		
13. Lead agency(ies) quarterly reports/narrative reports (7/1/99-current)		X	
14. Needs Assessments		X	X
15. Training information (community symposium/conferences, etc.)	X	X	
16. Grievance Procedures		X	
17. Grievance complaints/reports		X	
18. Evaluation plans/mechanisms/reports		X	
19. Monthly budgets/spend rate analyses/financial reports (7/1/99- current)		X	
20. Quality assurance/improvement, or evaluation plans/reports		X	
21. Lead agency contracts with providers in network		X	
22. Lead agency monitoring reports of providers in network		X	
23. Annual administrative report to State/HRSA		X	
24. Client satisfaction surveys/reports		X	
25. Standards of care for services		X	
26. Conflict of Interest Procedures AND Membership Information		X	
27. List of committees, frequency of meetings, members		X	
28. Other:			
29. Other:			
30. Other:			
31. Other:			
32. Other:			

Meeting:_____

	Time	Who is observed? (the key person) ...topic, emotion,	Race/Sex	Attending or Speaking to someone ... Who?	Standing or walking	Exiting Room (time)	Returning to Room (time)	Paying Attention to Speaker (or whomever is talking)...obse rving the speaker...	Not Paying Attention	Writing	Shuffling papers	Interrupting someone... Who?	Clarifying (after interrup-tion)	Daydreaming	Making a Motion, or a second	Comments, perceptions, assumptions

Appendix G

320

OBSERVATION GUIDELINES*

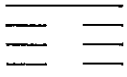
Area_____
Date of Observation_____ Time Period of Observation:_____to_____

A. Physical Environment

Type of building: Public Private
If public: CHD County/City Library Hospital/clinic
Other_____
If private: CBO/ASO Hospital/Clinic Other_____

Size of Room: Small Medium Large
(spacious, cramped, not enough seating?)
Capacity:_____Actual number of people in room:_____

Type of Furniture:
Arrangement of Furniture:

Octagon	*Semi-U*	*U-shape*	*Classroom*	*Square/rectangle*	*Other:*
					

B. Human/Social Environment

Characteristics of the people (#s,etc):
How many people present?_____
Who is present:_____

Race: White_____ African-American_____ Hispanic_____
Asian-American_____ Other:_____
Gender: M_____ F_____
Sexual orientation (if known): Heterosexual_____ Homosexual_____
Approximate ages: 20-29___ 30-39___ 40-49___ 50+___

Groups/subgroups:

Patterns of interactions: (see social network analysis for further info) (who to who?)
Direction of interactions
Changes in Patterns

Decision making patterns:
Who recommends/makes decisions?
Who doesn't recommend/make decisions?
How are decisions communicated?

OBSERVATION GUIDELINES*

Area_____
Date of Observation_____ Time Period of Observation:_____to_____

C. Program Activities/Participant Behaviors

Units of Activities: Consortia meeting Committee meeting Informal
Beginning Points:
- How introduced?
- Who is present?
- What was said and the response?

Middle Points:
- What happens?

Closure Points:
- Signals?
- Who is present?
- What is said?
- Participants reaction?

D. Informal Interactions

Who/what before the meeting:
Who/what after the meeting:
What are people doing?
What is being said?
Who is with whom?

E. Language of Participants

Nonverbal communication: fidgeting, up/down, physical space, dress, hands/legs
Unobtrusive measures:
- participants reactions to observations
- physical clues—furniture arrangements

F. Documents being used

Agendas	Minutes	Bylaws
Reports	Charts	Budget/financial reports
Grievance forms/complaints	Memos/correspondence	Plan/application
Contracts		

G. What is not happening?

Conflict, or potential of
Lack of representation by group: race, gender, age, agency
Lack of participation

Date:_____

Time:_____to_____

INTERVIEW GUIDE

APPENDIX I

Area:_____

Interviewee:_____Position:_____Agency:_____

TYPE OF QUESTION	Behavior and Experience Questions I	Opinion and Value Questions II	Feeling Questions III	Knowledge and Skill Questions IV	Sensory Questions V	Demographic and Background Questions VI
Ask about Activities and Behaviors → Who-What-When-Where-How-Why??	If I followed you through a typical meeting/day, what would I see you doing? What changes would you recommend?	What is your opinion of_____? What would you like to see happen? What do you think of___? How did that happen?	How do you feel about_____?	Tell me about _____. What do you know about_____? What are strengths/weaknesses?	What do/did you see when_____? What do/did you hear when_____?	Age? Education? How long have you been_____?
LEADERSHIP	(1)	(2)	(3)	(4)	(5)	(6)
L Past						
Present						
Future						
DECISION-MAKING	(7)	(8)	(9)	(10)	(11)	(12)
DM Past						
Present						
Future						
COMMUNI-CATION	(13)	(14)	(15)	(16)	(17)	(18)
COM Past						
Present						
Future						
CONFLICT	(19)	(20)	(21)	(22)	(23)	(24)
CON Past						
Present						
Future						
BENEFITS-COSTS	(25)	(26)	(27)	(28)	(29)	(30)
BC Past						
Present						
Future						

Date:_____

Time:_____to_____

INTERVIEW GUIDE

APPENDIX I

Area:_____

ORGANIZA-TIONAL CLIMATE	(31)	(32)	(33)	(34)	(35)	(36)
OC Past						
Present						
Future						
STAFF ROLES	(37)	(38)	(39)	(40)	(41)	(42)
SR Past						
Present						
Future						
CAPACITY BUILDING	(43)	(44)	(45)	(46)	(47)	(48)
CB Past						
Present						
Future						
MEMBER PROFILE	(49)	(50)	(51)	(52)	(53)	(54)
MP Past						
Present						
Future						
RECRUIT-MENT PATTERN	(55)	(56)	(57)	(58)	(59)	(60)
RP Past						
Present						
Future						
ORGANIZA-TIONAL STRUCTURE	(61)	(62)	(63)	(64)	(65)	(66)
OS Past						
Present						
Future						
COMMUNITY CAPACITY	(67)	(68)	(69)	(70)	(71)	(72)
CC Past						
Present						
Future						

APPENDIX I

Instructions
For the
Application Quality Index (AQI)

The purpose of the Application Quality Index (AQI) is to assess the quality of the Title I and/or Title II application developed as part of the annual activities of this area's Ryan White Council. This instrument will measure your perception of the quality of the application and the planning process that your Council undergoes each year. The AQI is also an indicator of the effectiveness of your Council. Annual Applications are important outcomes of your work with the Council. You may need to get a copy of the most recent annual application.

INSTRUCTIONS

Please read each question or statement listed on the questionnaire, under the section entitled "Components of the Application." There are only 25 questions or statements. Next to each question or statement are boxes that determine your perceptions of the adequacy of the annual application.

RATING SCALE

	0	1-20%	21-40%	41-60%	61-80%	81-100%	NA
(Specific questions are listed here)	**Does Not Exist**	**Very Low**	**Low**	**Average**	**High**	**Very High**	**Not Applicable**

Please mark a box in the appropriate column, as follows, if you perceive that a specific statement reflects that a particular component of the application:

Does not exist at all, mark the box under: *Does Not Exist.*
Exists between 1-20% of the time, mark the box under: *Very Low.*
Exists between 21-40% of the time, mark the box under: *Low*
Exists between 41-60% of the time, mark the box under: *Average.*
Exists between 61-80% of the time, mark the box under: *High.*
Exists between 81-100% of the time, mark the box under: *Very High.*
Is Not Applicable, mark the box under: *NA.*

Please place a checkmark ✓ or an **X** in the appropriate space next to each question or statement that identifies *your perception of adequacy* of the annual application.

Keep this explanation of the Adequacy Rating Scale before you while reading and rating each of the statements.

Annual Application Quality Index (AQI)

Please place a checkmark ✓ or an **X** in the appropriate space next to each question or statement that identifies *your perception of adequacy* of the various components of the annual application developed by this Ryan White planning body. If a specific statement is not applicable, please mark the box that indicates "**NA**".

COMPONENTS OF THE RW APPLICATION	0	1-20%	21-40%	41-60%	61-80%	81-100%	NA
GOAL(S), OBJECTIVES & ACTIVITIES:	**Does Not Exist**	**Very Low**	**Low**	**Average**	**High**	**Very High**	**NA**
1. The Goal(s) reflect(s) desired outcomes to problems/needs identified in needs assessment or by community members.							
2. At least one relevant objective is stated for each goal.							
3. Specific, feasible activities are provided for each goal.							
SCOPE OF APPLICATION:	**Does Not Exist**	**Very Low**	**Low**	**Average**	**High**	**Very High**	**NA**
4. A timeline projects the start and completion of each activity on the application.							
5. The agency/group/individual who will coordinate each activity is identified.							
6. Sources of coordination/collaboration among community agencies and groups are identified.							
7. Specific target populations are identified for each activity.							
8. New preventive activities are *coordinated* with existing community programs/activities.							
9. A strategy to develop community support and participation in planned activities is provided.							
COMMUNITY RESOURCES:	**Does Not Exist**	**Very Low**	**Low**	**Average**	**High**	**Very High**	**NA**
10. A budget is provided which outlines sources of funding and expenses for the activities.							
11. Staff is specified and available to coordinate and train volunteers.							
12. Facilities are specified and will be available for convening activities.							
13. Equipment and supplies for activities are specified and will be provided.							
14. Media coverage is planned to promote activities.							
15. Strategy is planned for seeking funding beyond grant period.							
16. Strategy is provided to monitor or revise the application.							
OVERALL IMPRESSION OF THE APPLICATION:	**Does Not Exist**	**Very Low**	**Low**	**Average**	**High**	**Very High**	**NA**
17. The application is written clearly and concisely.							
18. The application represents state of art technology in education, prevention and intervention of HIV.							
19. The application is logically developed (i.e., priorities identified in needs assessment lead to goals, which lead to objectives, which lead to activities which lead to resource requirements).							
20. The application considers constraints in the community (e.g., political) which could limit implementation of HIV/AIDS activities and offers means to overcome them.							
21. The application is feasible (i.e., activities can be set up by a small group working with a limited budget).							
22. Activities appear to be sufficient in duration to produce effects in the target population.							
23. Activities appear to be sufficient in intensity to produce effects in the target population.							
24. The application is innovative (i.e., a creative approach to local circumstances).							
25. The activities are designed to become part of regular community practice (i.e., organizations in the community will take responsibility for maintaining at least 50% of the activities.							

If you wish to add any comments about the Application developed for this Ryan White planning body, please do so on the back of this form.

Thank You for Your Time!

Judy

From: <Fbutterf@aol.com>
To: <2jbas@bellsouth.net>
Sent: Monday, October 11, 1999 9:04 AM
Subject: Re: Fw: Plan Quality Instrument

Hi Judy,
Thanks for your interest and of course, I'm always excited when someone takes on coalition work for their dissertation. The PQI has been widely available and I've had many requests for it, but I've yet to read any further published research. I will send you a copy of the chapter from Empowerment Evaluation that describes it in full as well as a copy of the instrument itself. Other than the developmental work that I did, no further reliability /validation work has been done to my knowledge - but it would be a great thing to do - with my n=3 for my dissertation research, I hardly had enough coalitions to use. I'll send the documents, then feel free to follow up with me by phone or email.

Phone 757-668-6426
FAX 757-668-6475
email fbutterf@chkd.com or fbutterf@aol.com at home

Best of luck, look forward to hearing from you, Fran Butterfoss

Bassett, Judy A

328

To:

Subject: Care Council Planning/Application process-

Dear members of the Palm Beach County Care Council:
I would like to thank you for your past assistance in helping me complete my research about what makes your Care Council an effective community planning partnership. I would also like to ask for your help one last time by participating in a brief survey about your Title II application/plan that was submitted this year. Gerald suggested that perhaps the few of you who were active in the planning application would be able to assist me...if there was anyone else who helped work on your plan, please forward this.

The attached one-page questionnaire is asking you about your perceptions of the quality of the latest RW application that you participated in creating for Area 9, Palm Beach County. I have attached the instructions for the survey and the survey questionnaire. While the quickest way to complete this is by e-mail, you may complete the survey in one of several other methods, too: by fax, or by U.S. mail.

By fax: Please print out both the instruction sheet and the survey form; complete the survey; then fax back to my attention at (904) 947-3473.

By e-mail: Save the attachment on your hard drive or a diskette. Go into the file and open it. Read the instructions (you may wish to print them out). With the survey up on your computer screen, mark an appropriate box next to each question that you feel best matches your perception. Save the file when complete. Then e-mail the completed survey form as an attachment back to me at either of the following e-mail addresses:
Judy_Bassett@doh.state.fl.us OR 2jbas@bellsouth.net

By U.S. mail: Print out the survey, complete the form and mail to my attention at: P. O. Box 1507, Middleburg, FL 32050.

I appreciate the time you take for this brief survey form. Looking forward to visiting you with your Care Council later this summer! Until then, take care and
Thank you,
Judy Bassett

RW Application Quality Index04...

#____

FIELD NOTES (cover sheet)

(see attached notes/transcripts)

Area:_____

Date:_____ Time Period:_____to _____AM/PM

Activity/Place:
[Int/Obs/Mtg/Surveys]_____

Who was Present?_____
_____
_____
_____

Describe details and specifics of activity *(on attached pages)*:

Describe physical setting.
What activities took place?
What social interactions occurred?
What did people say?
What are my feelings, reflections and reactions to the experience? Nature and intensity?
What are my insights, interpretations, beginning analyses, and working hypotheses about what is happening?

Cross-reference (#, date, activity):

Tape_____

Diskette_____

Other_____

Analysis Worksheet: categories & terms within theoretical frameworks

Theory / Category	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness
Needs assessment	X						
Prioritize for Services &	X						
Allocate funds	X						
Develop plans [comprehensive]; quality	X	X		X			
Assess effectiveness of administrative functions–services	X						
Participation in SCSN	X						
Seek input on needs and priorities	X						
Promote coordination & integration of community resources	X	X					
Assure comprehensive outpatient services	X						
Evaluation: cost effectiveness; examine and improve	X		X	X			
*Structure; characteristics		X	X			X	X
*Function, tasks		X					X
Group empowerment (benefits)		X				X	
Individual empowerment		X				X	
*Participation, member: increased		X				X	X
Services: coordination; increased		X				X	
Access to information and/or resources		X				X	
Commitment, member		X					
*Relationships: improved; staff:committee; patterns of;		X	X	X		X	
Costs are efficient		X					
*Communication; open;		X	X	X	X		X
Turf/competition (barrier)		X					
Power & influence-change; control (barrier); leader; shared		X	X	X		X	

*indicator/factor of effectiveness found in the literature

Category \ Theory	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness
Accountability (barrier/problem) *related to outcomes		X					X
Growth/development (problem)		X					
Bureaucracy (confusing); laws, healthcare (barrier/problem)		X					
Responsibility: shared; collective (critical precondition)		X		X			
Democratic participation		X					
Joint membership rights		X					
Member contribution (money, skill, time)		X					
Inclusion of population: disabled, minority	X	X					
*Decision making: shared; influence; joint ownership (critical precondition); consensus		X	X	X	X	X	X
*Satisfaction: member & group; of needs;		X		X			X
*Team effectiveness		X			X		X
*Training: team building; enhancing experience & competence, support, group structure & capacity		X			X	X	
*Organizational climate; culture		X	X				
*Community linkages		X					
*Interactions: individual level; member; team; between groups		X		X	X	X	
*Costs & Benefits		X					
*Performance: group; *related to outcomes			X		X		X
*Leadership characteristics; style; shared		X			X	X	
*Leader: commitment, involvement & visibility				X			
Vision: shared				X	X	X	
*Social/political/cultural factors			X			X	

*indicator/factor of effectiveness found in the literature

Theory / Category	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness
*Laws/policies; bylaws; contracts/moa's			X				X
Behaviors			X	X		X	
*Processes: goals; group			X	X		X	X
Cycling of resources; monitoring and adjusting resources (ecol. Process); resource dependency; use; sharing; access to			X	X		X	
Adaptation; change (ecol. Process)			X			X	
*Interdependency (critical precondition); communication & interaction			X	X	X	X	X
Succession (environments change over time)			X				
*Outcomes						X	X
Intergroup coopetation (pg)				X			
Group co-empowerment (pg)				X			
Member empowerment (pg)				X			
Linking environmental characteristics to outcomes			X				
Impact of environment to individual or group, and the indiv. Or group relationship to the environment			X	X		X	
Linking between individual, organization, and values				X		X	
Recognizing and valuing others' perspectives				X			
*Conflict: managing;			X	X		X	X
*Openness of process				X			
*Strong leadership of process				X			
*Involvement: broad based				X			
*Strong stakeholder groups				X			

*indicator/factor of effectiveness found in the literature

Theory / Category	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness
*Good timing and clear need				X			
*Overcoming mistrust and skepticism				X		X	X
*Support of established authority				X			
*Interim successes				X			
*Shift to broader concerns; individual develop internally & expand self interest; commitment to well being of others				X		X	
Problem solving (a process of collabrtn)				X	X	X	
Direction setting (a process of collabrtn); shared goals/purpose;				X	X	X	
Implementation (a process of collabrtn)				X			
Values: shared; group		X	X	X		X	
*Openness & creatively dealing with differences result in solutions (critical precondition); exploring differences; cohesion			X	X			X
Autonomy (level of independence)				X			
Individual: self worth, self image (contributions to)				X			
*Respectful; trust; caring				X	X	X	X
Support: social; guidance; staff				X	X		
*Self management; and self leadership					X		X
*Outcomes - of empowerment: development of a network; organizational growth; &/or increase in funding						X	
Individual strengths and competencies						X	
Recruitment/maintenance of members (barrier)		X					

*indicator/factor of effectiveness found in the literature

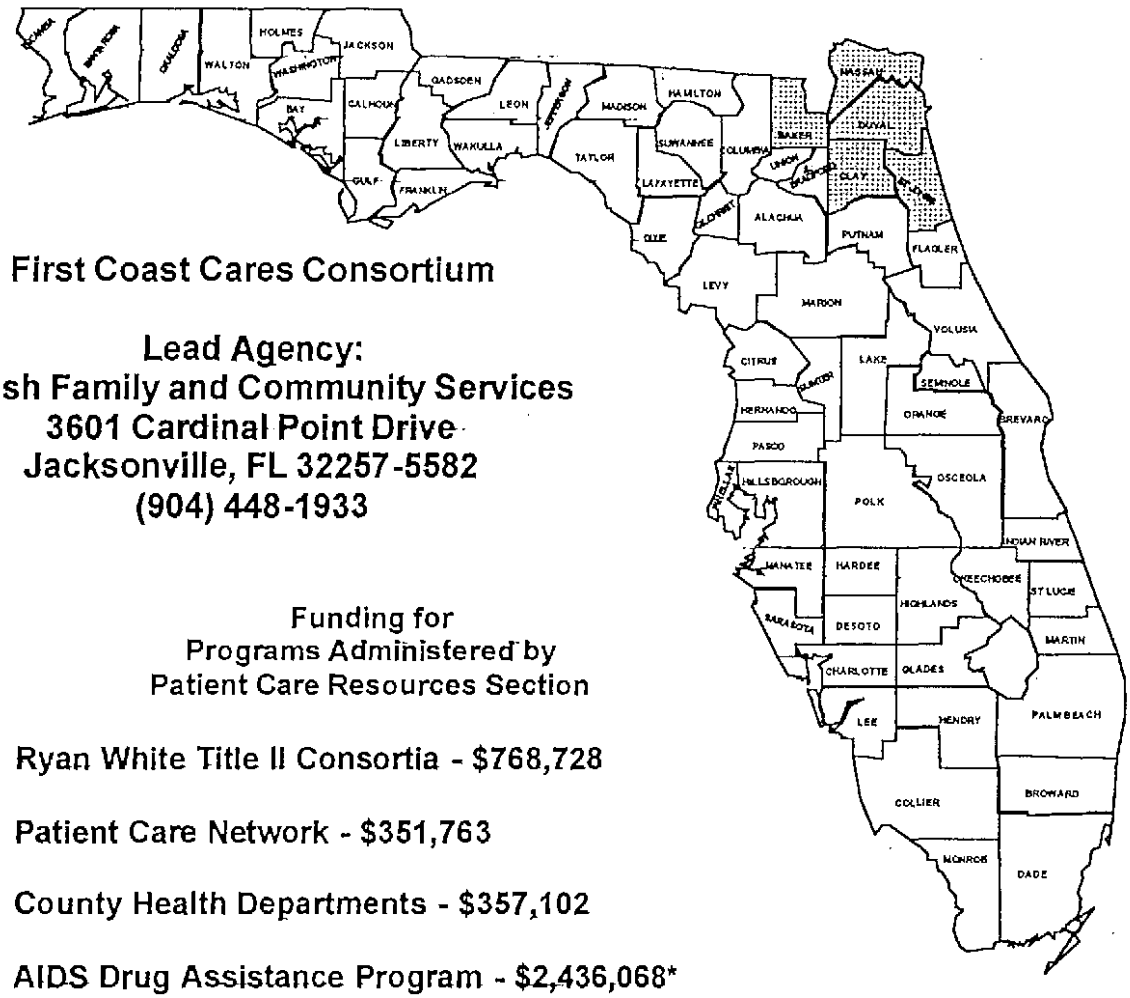
Theory / Category	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness
Physical environment			X				
*Roles (pe)			X				X
Social rules (pe)			X				
Customs (pe)			X				
*Lead agency identity							X
*Productivity							X
*Membership: group characteristics: composition;		X		X	X	X	X
Formality							
Innovation							
Staff roles							
Stress							
Work and/or Job design							

*indicator/factor of effectiveness found in the literature

Other Categories	Ryan White-HIV	Community Partnerships	Ecology	Collaboration	Group & Team	Empowerment	Organizational Effectiveness

*indicator/factor of effectiveness found in the literature

Jacksonville Service Area
(Area 4)



First Coast Cares Consortium

Lead Agency:
Jewish Family and Community Services
3601 Cardinal Point Drive
Jacksonville, FL 32257-5582
(904) 448-1933

Funding for
Programs Administered by
Patient Care Resources Section

Ryan White Title II Consortia - $768,728

Patient Care Network - $351,763

County Health Departments - $357,102

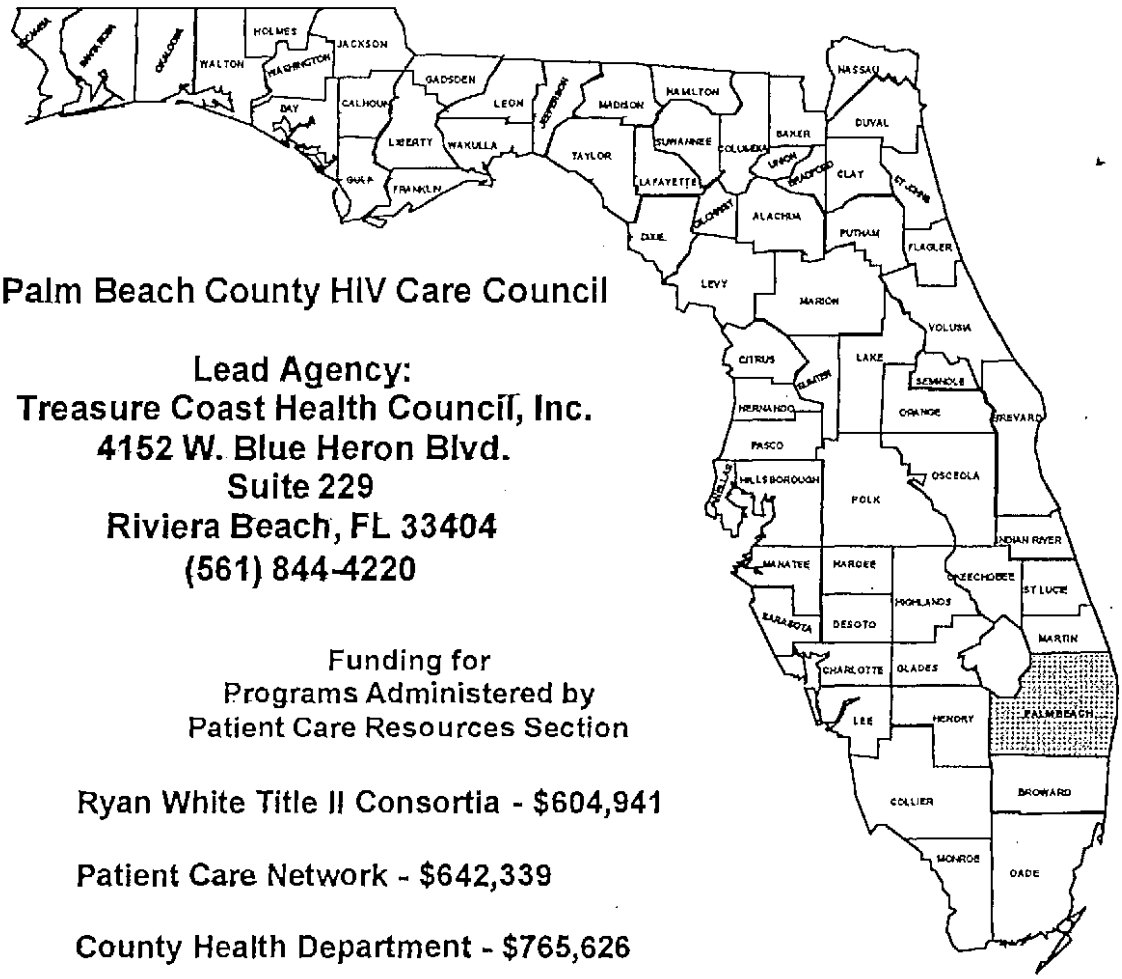
AIDS Drug Assistance Program - $2,436,068*

Housing Opportunities
for Persons With AIDS - $137,177

Total - $4,050,838

* Includes CHD allocations plus Category III expenditures

West Palm Beach Service Area
(Area 9)



Palm Beach County HIV Care Council

Lead Agency:
Treasure Coast Health Council, Inc.
4152 W. Blue Heron Blvd.
Suite 229
Riviera Beach, FL 33404
(561) 844-4220

Funding for
Programs Administered by
Patient Care Resources Section

Ryan White Title II Consortia - $604,941

Patient Care Network - $642,339

County Health Department - $765,626

AIDS Drug Assistance Program - $6,817,322

Total - $8,830,228

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Doctor of Educational Leadership – December 2001
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SUMMARY: I have been a proactive and creative leader with experience in health, mental health, and human services. My major areas of strength and experience include collaboration and community development; contract management; public relations and communications; quality and performance improvement; strategic planning and organizational development; administrative and programmatic monitoring; policy and program development; program evaluation and outcome/performance based measurement; training and education; and leadership development.

SIGNIFICANT PROFESSIONAL EXPERIENCE:
Management Consultant: Provide consultation and technical assistance to State-level Departments of Health and/or Behavioral Health regarding clinical, fiscal and administrative program evaluation and monitoring,

Manager, Planning and Performance Development: Provide oversight of the Quality and Performance Development Program within a local county health department and 8 other agencies in a consortium. Coordinate community health assessment and planning; develop community partnership; initiate internal strategic planning; develop training activities; integrate essential public health services with performance improvement.

Executive Director: Provide administrative and managerial oversight for a comprehensive, seven county rural health network. Develop and coordinate community planning partnership.

Operations and Management Consultant: Provide countywide operational and financial administration for Health, Mental Health, Substance Abuse, and Human Services programs in a semi-rural county.

Program Director: Serve as Program Director for children's and adult mental health and substance abuse services in five counties. Provide district-wide responsibility for the development, administration, and coordination of new programs and services, implementation of quality improvement programs.

Director, Community and Patient Relations: Responsibilities centered on the provision of community, public, employee and patient relations. Provided leadership for the development, function and operation of the Department of Community and Patient Relations in a 750-bed psychiatric facility. Received Distinguished Special Achievement Award by the Department of Health, State of Florida.

Teacher – Special Education: Provided instruction in reading and language arts and English as a second language to hospitalized mentally ill young adults and adolescents. Coordinated treatment and educational plans with treatment teams. Taught special education to children between the ages of 5-9.