

Dear Reader,

The draft below is a fairly straight forward literature review that focuses on collaboration theory and research in health care. Just because the writer believes it to be a fascinating topic does not necessarily mean that readers will find it as interesting. I am very open to reducing /condensing the theory/research focus of the article and possibly introducing a mini-case in the body of this article or as a companion piece for the purpose of breathing some life into the article by providing students with a tangible example of successful partnerships – Dave Sarcone

Growing a Healthy Community: A Review of the Community Health Partnership Literature

Introduction

The addition of a prescription program for uninsured and underinsured persons to the services of a community health center ; the creation of a non-profit program designed to eliminate fear and stigma related to behavioral health issues; and, the development of a pilot workplace wellness project among seven area employers are all examples of collaborative community health initiatives.¹

Beginning in the middle of the 1980's, an approach to address health care issues that went beyond attempts to fix existing financing and delivery models began to emerge and gain support. This community based approach champions the collaborative development of holistic models of social and health related activities for the purpose of improving community health status. Health care policy specialists (Iglehart, 1994; Dilulio and Nathan, 1994; Colmers, 1998; Boufford and Lee, 2002; Budetti, 2004) consistently support community level reform as a way to achieve true comprehensive health reform. Pragmatically speaking, health care reform activity at the community level may simply be driven by “a growing realization by average Americans that the risks of the current system to them personally and to the country as a whole outweigh the risks of comprehensive reform” (Fuchs and Emmanuel, p.1412, 2005).

Growing a healthy community starts with the development of local management capacity capable of affecting institutional and behavioral changes that in theory lead to improved community health status. Voluntary collaborative networks of diverse community organizations

¹ These are examples of Carlisle Area Health and Wellness Foundation (CAHWF) initiatives. The Health Community Rx Program is managed by The Sadler Health Center. “In My Own Words” is a collaborative effort between CRME, the RASE Project, NAMI, and CAHWF. The Wellness at Work pilot project is co-sponsored by CAHWF and the Greater Carlisle Chamber of Commerce.

generally referred to as community health partnerships pursue these efforts. This chapter begins with a review of conceptual and empirical contributions to the community health partnership literature. The chapter concludes with commentary on the promise and performance of community health partnerships. To accomplish these objectives, the chapter is divided into three sections – introduction, community health partnerships, and summary.

Community Health Partnerships

The literature review is composed of five subsections. These are concepts and definitions, models and types, developmental process, governance and management, and research.

Concept and Definitions

Concept

Community health partnerships come together to address a meta-problem namely society's diminishing capability to maintain community wide health and well being for its members. Participating members of these multi-sector partnerships recognize the need to rally around a common vision and related strategies in order to affect positive systemic change at a community level (Roussos and Fawcett, 2000).

The vision of these partnerships is comprised of four interrelated elements: (1) a focus on the health status of the community; (2) a “seamless” continuum of care integrated into community institutions especially health, education and social service organizations; and, (3) based on democratic principals of community stakeholder involvement and accountability (4) an active management of the continuum within budgeted resources (Hasnain-Wynia, 2003).

The achievement of this vision is guided by a four-part theory of action. Support for these actions is drawn from social planning, policy advocacy, community organizing, and network development research (Roussos and Fawcett, 2000). The first required action is the development of an effective collaborative consisting of the right partners organized in ways that allows for good decisions based on a shared vision and trust. The second action involves the initiation of specific intermediate initiatives. These intermediate activities may focus on a specific community health issue; the needs of a group within the community; the development of the partnership; or improvements to community and health delivery infrastructures. By increasing network legitimacy,

collective membership trust, and individual member commitment to the partnership's vision and strategy, these activities set the stage for the third action step. The third action involves taking steps to address significant systemic problems in a comprehensive manner. Long-term success is dependent on the partnership's ability to maintain and improve efficient and effective health and social systems; demonstrate in measurable ways improved community health status; and, secure the financial resources required to sustain the partnership (Sofaer et.al. 2003).

Definition

Roussos and Fawcett define community health partnerships as "alliances among people and organizations from multiple sectors, such as schools and businesses, working together to achieve a common purpose" (Roussos and Fawcett, 2000, p369). Frances Butterfoss suggest that community health partnerships are "inter-organizational, cooperative, and synergistic working alliances" (Butterfoss et.al. 1993, p316). These definitions share common characteristics including the voluntary nature of the relationships; the coupling of independent entities; the reliance on both formal mechanisms of control and informal mechanisms of control based on cooperation and trust; and, a belief that the new entity is better designed than individual organizations to respond to significant policy and operational issues.

Models and Types

Models

Several models exist to describe and evaluate community health partnerships (Francisco, Paine, Fawcett, 1993; Butterfoss, Goodman, Wandersman, 1993, 1996; Mitchell and Shortell, 2000; Shortell et al 2002; Provan and Milward, 1995, 2001; Milward and Provan, 2003; Lasker and Weiss, 2003; Hasnain-Wynia et al, 2003). There are a number of common characteristics shared by these models. These characteristics include but are not limited to: the stated purpose for partnership formation; the recognition of an organizational development process; the identification of external and internal determinants of partnership effectiveness; the identification of indicators of effectiveness; and, the relationship between determinants and indicators of effectiveness at varying organizational stages of development. An effort to capture these

relationships is provided in Table 1. Brief descriptions of several partnership models are provided below.

Butterfoss et.al. (1993) describe community health partnerships as community based or agency dominated coalitions organized to complete planning, coordinating and advocacy functions for their respective communities. The researchers employ a developmental model to describe the structure and function of these partnerships. Essentially they state that partnerships proceed through four stages – formation, implementation, maintenance, and goal accomplishment. At each stage the researchers suggest that there are specific determinants that positively effect partnership development and outcomes,

Mitchell and Shortell (2000) provide a typology of governance and management characteristics of community health partnerships. The authors suggest that effective partnerships result from the ability of the partnership to attain appropriate external and internal alignment. External alignment is the primary concern of governance. External alignment refers to the match between community priorities and problems addressed with partnership composition. Internal alignment is primarily a management responsibility. Internal alignment relates to management efforts to organize membership activity to match the complexity of partnership tasks. The authors provide seven dimensions to classify partnerships. There are several measures provided for each dimension. The authors suggest that community health partnerships may be described and classified by defining governance and management practices for each of the dimensions. In a subsequent evaluation of twenty-five Community Care Network health partnerships², Shortell et. al. (2002) identified six governance and management determinants of highly performing community health partnerships. In this study, a composite indicator of community health partnership effectiveness was constructed from the interrelated elements of the community health partnership vision as defined by the Community Care Network demonstration project.

² In 1995, The Health Research and Education Trust (HRET) with the American Hospital Association and the Catholic Health Association developed the Community Care Network (CCN), a national demonstration project focused on restructuring local health delivery systems into community care networks. Grant support for the 25 demonstration projects was provided by the W.K. Kellogg Foundation and the Duke Endowment.

Provan and Milward (2001) outline an inter-organizational network model of community partnerships. According to the authors, participating constituency groups define the partnership. In the case of community health and human services networks these groups include those who monitor and fund the network (principals); network administrators and service providers (agents); and receivers of services (clients). The authors further state that partnership members interact at three levels of activity. These levels are the community level, the network itself, and the network's participant level. Utilizing agency theory as an organizing framework for the three constituent groups, the authors detail the importance of each level of analysis for each group, recognizing that an agent at one level is principal at another level.

Key stakeholders at the community-level of analysis represent principals and clients. Examples include regulators, advocacy groups, funding organizations, politicians and consumers. In general, effectiveness at the community level is best judged by actual and perceived community health system improvements. At the network level, the organization represents both principals and agents. The network is characterized by a collection of programs and services spanning a broad range of autonomous organizations. According to the authors, these partnerships are often led, coordinated and managed by a central, local administrative entity. This entity may be viewed as a network broker. In an agency theory context, this central entity is both an agent of the community and the principal of the network participants. Effectiveness is judged by the ability of the partnership to develop sufficient capacity to deliver needed services efficiently and effectively to the community. The network participant level is comprised of service providers (agents) and clients. Network effectiveness at this level is determined by the ability of each service provider to access those resources necessary to better serve their clients.

A critically important point made by the authors is that network effectiveness is based on the interactions across all three levels of the analysis because only by minimally satisfying the needs of each group (principals, agents, clients) can network effectiveness be realized. Network effectiveness at one level, however, does not ensure effectiveness at the other two levels. In fact there is typically an inherent tension in community service networks between the needs and expectations of the community, network, and individual agency and client stakeholders and the

effectiveness outcomes valued by each group. In addressing this dilemma, the authors conclude that networks of service delivery are to be built and maintained at the network participant and network levels but community level stakeholders will ultimately judge overall network effectiveness. In a related paper on network management, Milward and Provan (2003) continue to build their network model by identifying and describing a set of effectiveness determinants. Three of the determinants relate to the composition and management structure of the network and two determinants focus on organizational process.

Lasker and Weiss (2003) describe a community health collaborative process as community health governance. The authors identify three challenges to community problem solving. These are the prevalence of political interest groups; the eroding sense of community; and, the reduced involvement of community residents in matters directly affecting them. To attain long term community health goals the authors suggest that several intermediate (proximal) goals must be reached. These include creating a sense of individual empowerment; building social capital; and generating new ways of thinking and acting on these innovations. To reach these intermediate goals partnerships must identify and recruit a wide array of participants especially those most directly affected by the problems being addressed. Second, equitable and efficient processes must be in place to encourage participation in decision making; to reach consensus on problem solutions; and to address conflict resolution. Third, the problems and related solutions must be addressed at a systems level. In summing up the authors indicate that the most important determinant of collaborative success is leadership. In their model effective leaders promote broad and active participation; assure broad based control; create a positive organizational climate; and grow the capacity of the partnership in order to take on more complex issues.

Types

There are many variations of community health partnerships. Examples include grassroots and advocacy initiatives; network predominated by service agencies; and collaboratives made up mostly of health care providers (Roussos and Fawcett, 2000). The type of partnership selected is often determined by contextual factors (local political issues, prior organizational interactions, available resources, or identified issues) (Hasnain-Wynia et.al. 2001).

Romania Hasnain-Wynia et.al. (2001) offer a typology of community health partnerships consisting of centralized action, decentralized action, facilitating and foundation types. Centralized action partnerships are self contained, formally organized entities. These partnerships have dedicated staffs. Upon completion of a community health status assessment, this type of partnership allows for a significant amount of membership control in creating the partnership agenda. In addition these partnerships directly act on implementing their strategic plans. Typically a hospital or health system serves as the anchoring organization for the activities of the partners. Similar to centralized types, decentralized action partnerships identify community health needs and jointly agree on programming to address these needs. Decentralized types, however, do not collectively act on the formulated plan. The decentralized action partnership recommendations are independently implemented by one or more of the partnership members and at times by organizations that are not formally recognized as members of the partnership. Facilitating community partnerships come together to allow participating members to exchange ideas on problem solving and collaboration. Similar to decentralized action partnerships, these partnerships do not collectively implement actions rather they attempt to mobilize support among members for the organizations implementing actions. The foundation partnership also facilitates the development of community based planning. In contrast to the other forms of partnerships, foundation representatives in the partnership have more power than other members to prioritize community objectives and influence actions taken through their review and financing of selected community initiatives. Although the authors present four distinct types of community health partnerships, they warn that operating partnerships often reflect characteristics of more than one of the types and that partnership characteristics may change as these a partnerships develop over time.

Developmental Process

Community health partnership researchers and writers (Butterfoss, Goodman, Wandersman, 1993; Kreuter, Lezin, Young, 2000) offer numerous reasons for the formation of partnerships and delineate partnership development stages. Commonly cited reasons for the formation of community health partnerships include recognition of a mutual purpose; resource scarcity; and

the realization that a single organization cannot solve the agreed upon problem (Butterfoss, Goodman, Wandersman, 1993).

Each of the development models offered by community health partnership specialists differs slightly in the range of activities and timing of activities listed in each stage. Yet, across all of the models several key activities are commonly recognized beginning with the decision to form the partnership and culminating in the achievement of partnership goals. An integration of these models is provided in Table 2.

Governance and Management

Governance

Mitchell and Shortell (2000) state that community health partnership governance consists of the following tasks: setting priorities for strategic goals; choosing partnership members; ensuring accountability for partnership actions; and, securing financial resources. Effective community health partnership governance must therefore successfully negotiate three interrelated sets of governance issues (Weiner and Alexander, 1998).

Given the voluntary nature of partnerships, it is not surprising that the first of these challenges is aligning partners' interests and goals with those of the partnership. This requires resolving conflict resulting from divergent views (turf issues) and may be addressed by creating guidelines on membership selection, member socialization, project selection, and requiring membership resource commitment prior to joining the partnership

The second challenge relates to community accountability. According to the researchers, partnership accountability is often too narrowly defined as representing only those clients of participating organizations or the preservation of partnership assets. Accountability requires a broader view of the community and its constituencies. The creation of measurable indicators of partnership progress, which meet multiple community stakeholders' needs beyond those of partnership organizations and serve as a basis for resource allocation among partnership members, is suggested as one way to address this challenge.

The third challenge involves sustaining partnership development and growth. Effective governance requires the establishment of an organizational structure and the cultivation of an

organizational culture that creates the capacity and the commitment to grow partnership resources and capabilities. The typical community partnership challenge involves securing sufficient internal and external funds to sustain the partnership for the period required to achieve its goals. Achievement of short term and intermediate objectives focused on specific health issues or at risk populations is a suggested way to demonstrate partnership value and secure funding (Sofaer et.al. 2003).

Management

Complementing their definition of community health partnership governance, Mitchell and Shortell (2000) describe partnership management as the execution or implementation of governance responsibilities. Partnership managers are therefore responsible for: developing and maintaining partnership management decision making structures; coordinating and supporting partnership actions; implementing information systems to collect and report partnership activities; and, sustaining members' interest in the partnership's vision and mission.

In a related article on community health partnership management, Bryan Weiner et.al. (2000) present guidelines on effective health services management participation in community health partnerships. Although the article focuses on partnership participants and not directly on the role and responsibilities of partnership administrators, the guidelines presented are nevertheless relevant to the community partnership executive position. In the article the authors (Weiner et. al. 2000) mirror Mitchell and Shortell's (2000) description of partnership management responsibilities. Utilizing a health partnership development model presented by Howard Zuckerman (1987), the authors assign these responsibilities by importance to partnership development phases. For example, the authors state that during the emergence phase of the partnership, management responsibilities include communicating the purpose of the partnership; recruiting members; and, clarifying member roles and expectations. In the transition phase managers are responsible for developing mechanism for decision-making and coordination necessary for effective membership participation. It is during this phase, managers must also begin to develop mechanisms to measure partnership progress. In the maturity and "critical

crossroads” phases, managers are primarily responsible for sustaining the partnership for the time period necessary to accomplish the partnership’s mission and related long term goals. During these phases managers must find ways to maintain partner’s commitment by demonstrating the benefit of partnership achievements compared to each partner’s costs in time and resources.

Community health partnership managers must possess excellent traditional management abilities and skills – planning, organizing, allocating resource, directing, coordinating, and evaluating. Given the nature of the organization, the success of the partnership manager requires more than command of traditional skills. It requires a sense of the timing and use of appropriate management styles. These styles range along a continuum from collaborative/ empowering to directive/ task focused (Zakocs and Edwards, 2006).

Research

Extensive empirical research has been completed on community health partnerships. This research is organized along two trajectories – evaluations of partnership effect on community health outcomes and assessments of internal partnership functioning. There are several published literature reviews on community health partnership research (Roussos and Fawcett, 2000; Zakocs and Edwards, 2006) that detail these trajectories. Roussos and Fawcett (2000) provide an excellent overview on community health outcomes research. The authors summarize findings on the impacts of community health partnerships on population outcomes, community behavioral change; and, community and systems changes.

Based on their review, the authors conclude that even though one third of the reviewed studies indicate a positive correlation between partnership interventions and community health status improvements, there is insufficient evidence to determine the relationships between partnership interventions and community health outcomes. Other researchers suggest caution as well when reviewing these findings (Mitchell and Shortell, 2000; Shortell et.al. 2002). The inability to definitively assess the relationship between community actions and community outcomes is a result of numerous research challenges. First, there are several issues related to research design. For example when the unit of analysis is a community the absence of appropriate

comparison groups creates an inherent design weakness. In the event other communities are incorporated into the study there is still the issue of low statistical power. Second, although the effects of secular trends are routinely factored into studies of this nature, the size and strength of these influences may be underestimated. Third, the lack of the community partnership intervention impact may be attributed to the limited duration and intensity of the program. Finally, although community interventions are designed based on various theories of behavioral change and community organization, these theories may not be robust enough to take into considerations the complexities of effectively managing change at multiple levels through multiple channels. Given this, the intervention model may be flawed and related research on the model ineffective or misleading (Merzel and D'Afflitti, 2003; Roussos and Fawcett, 2000).

A review of studies focused on community-wide behavioral changes revealed better results. Improved behavioral outcomes resulting from community programming were reported for tobacco use, alcohol use, illicit drug use, physical activity and safer sexual practices. The authors caution readers that the weaknesses of these studies involve the population level behavioral outcome data employed in the research. Poor survey methods often limit the accuracy and reliability of the collected data (Roussos and Fawcett, 2000).

Roussos and Fawcett (2000) define community and systems change as an intermediate outcome resulting from community health partnership action to create or modify individual institution or community programs, policies or practices. Examples of these targeted interventions include the introduction of health prevention programs in business settings; creation of walking trails within the community; and, changes or modifications of smoking policies in public settings. There is an abundance of studies in the literature demonstrating a connection between the actions of community health partnerships and the development or improvement of programs, services and policies. Although these findings appear to unequivocally demonstrate the value of the collaborative efforts, there are several methodological limitations in these studies that call into question the degree of partnership effectiveness. First, there is no standard way of defining environmental change, collecting information on change indicators or measuring change. Second, these studies have not thoroughly measured the effects of these intermediate steps on the

achievement of long-term community partnership goals. Of course the question then becomes whether there is any long-term benefit associated with these intermediate interventions. Third, related to the second limitation and similar to limitations associated with population outcome studies, there still exists a theoretical gap in the literature linking partnership formation, achievement of intermediate outcomes, and the value of these intermediate outcomes to the long term process of community health improvement (Roussos and Fawcett, 2000).

In addition to studies on partnership influences on community level change, a significant number of studies solely target community health partnership development. These studies routinely attempt to answer questions on how to build effective coalitions. Two literature review articles (Roussos and Fawcett, 2000; Zakocs and Edwards, 2006) provide information on determinants and indicators of community health partnership effectiveness commonly used in studies. In their review of the literature Zakocs and Edwards (2006) identified 55 determinants of community health partnership effectiveness. Only six of these determinants were used in five or more studies. Roussos and Fawcett (2000) identify and summarize seven interconnected determinants of partnership effectiveness commonly found in the literature. Interestingly, only two determinants cited by Roussos and Fawcett (2000) are similar to the six determinants, used in five or more studies, identified by Zakocs and Edwards (2006).

The literature also does not provide a consistent definition of intermediate partnership effectiveness. In their review, Zakocs and Edwards (2006) provide evidence to support this position. First, the conceptualization of determinants and indicators varied across studies. Several factors appear as determinants and indicators (membership participation, agency collaboration). Second, partnership effectiveness determinants are defined differently across studies. Third, studies measuring the same effectiveness determinants did not measure the same effectiveness indicators. Fourth, studies measuring the same effectiveness indicators did not measure the same effectiveness determinants. Finally, conflicting results were reported when the same determinants and indicators were used in several comparable studies (Zakocs and Edwards, 2006).

The failure to date of empirical research to determine those factors that explain the relationship of partnership actions to community outcomes or define effective internal operations of community health partnerships is not surprising given the overall state of effectiveness research. This statement is not meant as a criticism of efforts to date but simply a reflection on the current state of the field. There are numerous challenges associated with the study of community health partnerships including but not limited to the complexity of the societal problem being addressed; the complexity of inter-organizational network structures and functions; the limited availability of network effectiveness theory; and, the practical limitations associated with the application of effectiveness theory in research.

Concluding Remarks

Individual communities have responded to the growing national concern over health and the financing and provision of health care services. At the local level, efforts to implement health care reform have been aggressively pursued by community health partnerships. These partnerships reflect public acceptance of a network organizational approach to resolve complex and difficult health related issues. They form in the belief that sustainable improvement requires the assessment of multiple determinants of health and the development and execution of coordinated strategies aimed at ameliorating health risk factors and health system deficiencies. Although faced with the same health care challenges as those faced at the national and state level, community health care reform advocates believe there are several reasons why implementing coordinated community strategies have the best chance of generating system reform. First, reform advocates believe at a local level there is greater acceptance of shared ownership of problems and a more immediate sense of urgency to correct problems. These problems affect individuals and families community members know and care about. And, community representatives are frustrated because resources to correct these problems are chronically scarce. Second, there is a sense that local solutions more accurately reflect the community's beliefs. Third, with sufficient community social capital, systemic problems are more manageable and better resolved at the local level. Fourth, given the importance of the issues and the existence of practical solutions, there is a greater willingness to tap into the community's reserve

of social capital to support collaborative initiatives (Bracht, 1990; Schlaff, 1991; Alter and Hage, 1993; Zuckerman, Kaluzny, and Ricketts, 1995).

In the United States this approach to problem solving is especially appealing because it resonates with the values of democratic participation and local community control. Since the 1980's, this value-strategy linkage has largely served as the justification for the devolution of health problem responsibility from the federal to state level, and from the state level to the community level. Funding for these community initiatives serves as evidence of support for this transition. Community health partnership models have garnered substantial support from the public sector as well as private foundations (Butterfoss, Goodman, and Wanderman, 1996; Lasker, Weiss and Miller, 2001). Examples of these initiatives include Healthy Communities sponsored by HHS and the National Civic League; the Robert Wood Johnson Foundation's Community Care Network; and, the W.K.Kellogg Foundation funded Community Voices: Health Care for the Underserved and Turning Point: Collaborating for a New Century in Public Health. This downward pressure on responsibility combined with access to funding has correspondingly led to the rapid growth in the number of community health partnerships in the last three decades (Lasker, Weiss and Miller, 2001).

Based on a review of the literature, community health partnerships appear to hold some promise of improving the quality of community life. There are several reasons for this hope. First, the community health partnership model acknowledges that the multiple costs of poor health are associated with systemic social and environmental problems. Second, there is recognition of the difficulty of social problems; the growing complexity of the environment; the interdependence of groups; and, the limited availability of resources to address these complex, interrelated issues (Chisolm, 1996; Meyer et al., 1993). Third, these collaboratives are routinely perceived as effective by community stakeholders (Hasnain-Wynia et al, 2003). Finally there is strong evidence that these initiatives in the short run can affect positive institutional and behavioral changes (Roussos and Fawcett, 2000).

Despite the promise and early successes of these initiatives, empirical research has not conclusively demonstrated the superior effectiveness of partnerships over other types of

organizations to solve complex problems nor has it convincingly demonstrated that health partnerships are effecting positive community –wide changes (Zakocs and Edwards, 2006; Roussos and Fawcett, 2000; Lasker ,Weiss and Miller, 2001). To a significant extent, this gap between promise and performance results from several factors: an incomplete understanding of the complexities of the problem; incomplete knowledge of the organizational structures evolving to address the problem; and, the related theoretical and operational challenges associated with defining and measuring partnership effectiveness.

As reflected in the literature, concerted efforts to close this gap through the development of new theoretical approaches and the completion of empirical research have been undertaken in this decade. Examples include the collective work of Shosanna Sofaer and her colleagues in their review of the CCN demonstration project and Roz D. Lasker and her colleague’s interdisciplinary evaluation of the Turning Point demonstration project. Borrowing from their combined work as well as the work of Roussos and Fawcett (2000), suggested research questions include;

1. *What are the structural and functional characteristics of community collaborations that strengthen community problem solving and support action to improve community health?*
2. *What are sensitive and reliable community–level indicators of community health partnership effectiveness?*
3. *What generic community health partnership interventions result in the optimal improvements to community health status?*
4. *How best are improvements to community health status sustained within the community?*

Active participation by all stakeholders concerned about the America health care system is required in order to find solutions to persistent health and health care financing and delivery problems. Community health partnerships serve as one vehicle for locally addressing these problems in a collaborative way. Understanding how to create community health partnerships; mobilize community stakeholders within these networks; and sustain meaningful community

action capable of resolving complex problems is critical to our society's quality of life. Discovering ways to achieve these objectives through on-going theory building, disciplined research and action is essential to close the gap between community health partnership promise and performance.

Table 2 Community Health Partnership Developmental Stages

Pre-formation	The feasibility of the partnership is assessed prior to a decision to move forward with the formal funding and formation of the partnership.
Formation	The partnership is officially formed. Key tasks include establishing the mission, recruiting members, and formalizing rules, roles, and procedures.
Implementation	Key activities include the planning and implementation of strategies developed to achieve partnership goals.
Maintenance	Planning and strategy activities are continued and possibly expanded,
Outcomes	The partnership accomplishes its long term goals as measured by Community health status indicators.

(Butterfoss, Goodman, Wandersman, 1993; Kreuter, Lezin, Young, 2000)