

BUILDING HEALTHY
COMMUNITIES: LEARNING
FROM THE PARTNERSHIP
FOR A HEALTHY DURHAM



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Expanded Study Methods

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This document provides supplemental information for the study *Building Healthy Communities: Learning from the Partnership for a Healthy Durham*. This supplemental report provides additional details about the study methods. For a list of all study-related reports see Appendix A.

Expanded Study Methods

Study Design

Prior to beginning the study, the FHI 360 members of the study team met with members of the Partnership for a Healthy Durham leadership (i.e., steering committee, Partnership co- chairs, committee co-chairs, and coordinator) and the director of the Durham County Department of Public Health. These meetings were to describe the goals and objectives of the research, receive guidance on how to make the research mutually beneficial to the Partnership and FHI 360 and to obtain permission to attend public Partnership meetings as researchers to learn about Partnership functioning and conduct study participant recruitment with Partnership members. It is important to note that some FHI 360 members of the study team were also members of the Partnership by virtue of having attended Partnership meetings over the past several years; they have also shared research findings from other health-related research projects led by FHI 360 in Durham at Partnership meetings. Thus, the overall approach for this study is best described as community-based participatory research.

For qualitative and quantitative data collection, we structured our inquiry along classic lines to describe the structure, processes, and outcomes of the Partnership for a Healthy Durham (Ahgren, Axelsson, & Axelsson, 2009; Donabedian, 1966; Roussos & Fawcett, 2000; Valentijn et al., 2015). As shown in Figure 1 below, our framework also considered how these were molded by history, affected by challenges and constraints, and related to outcomes and impacts.

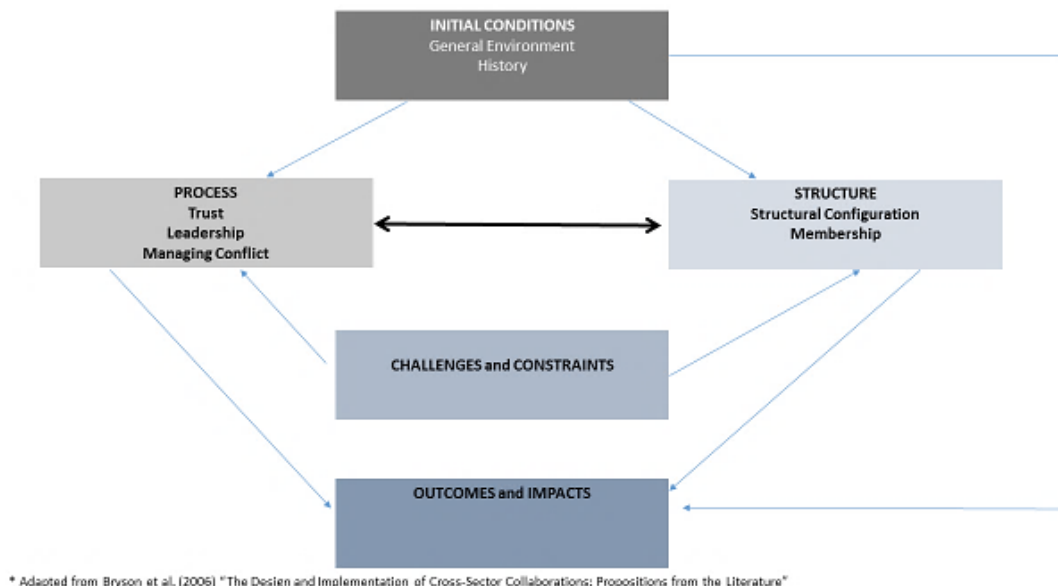


FIGURE 1. Framework of factors considered in our evaluation of the Partnership

Within this model of inquiry, we also focused on how and why social determinants of health are integrated into the structure, processes and outcomes of the Partnership’s work. The CDC Health Impact Pyramid (Frieden, 2010), Figure 2, was used as a tool for structuring conversation during qualitative data collection, as it is a familiar framework in public health settings for describing the relationship between socioeconomic determinants of health as a component of public health intervention.

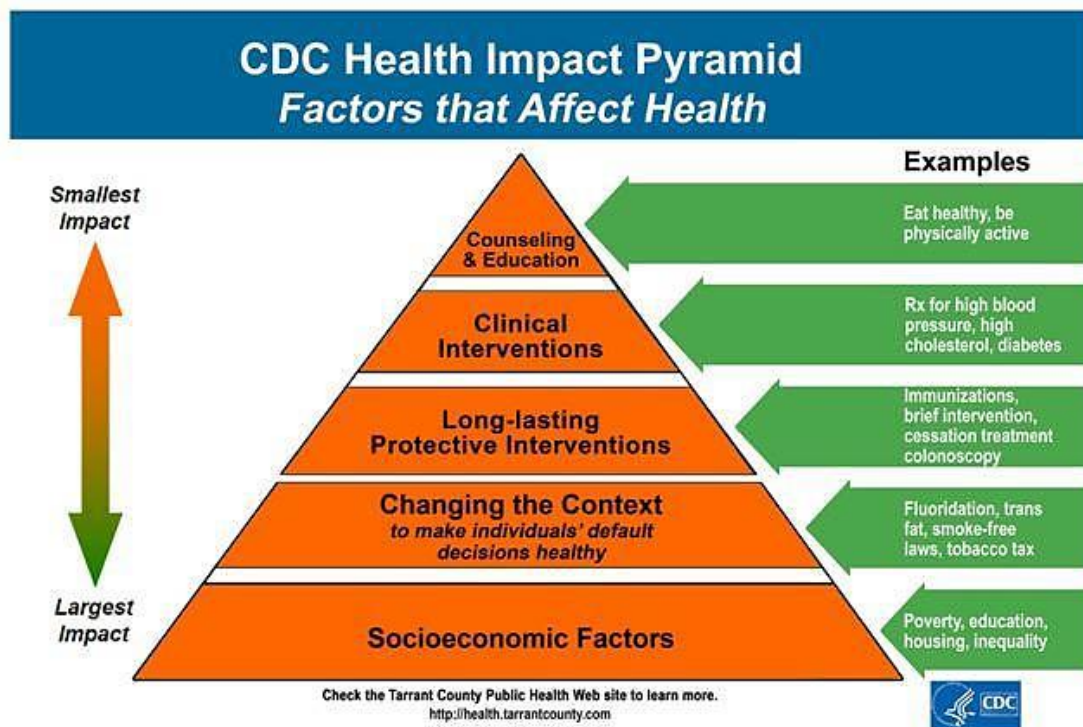


FIGURE 2. CDC Health Impact Pyramid

All data collection activities were conducted in English. All participants were administered oral informed consent in-person for the qualitative research. For the survey, consent was administered through an introductory page for the on-line and paper versions of the survey. For the in-depth IDIs and FGDs, participants were offered a \$25 Visa gift card as reimbursement for their time. Some participants’ organizations prohibited their receipt of compensation for this kind of activity (given its relationship to their professional responsibilities) and in those instances, the gift card reimbursements were donated to the Partnership to support its activities. No reimbursements were provided for participation in the survey, however the study did pay for breakfast or lunch at Partnership meetings where survey recruitment took place.

The research was reviewed by the FHI 360 Office of International Research Ethics and determined to qualify for exemption according to the requirements of 45 CFR 46.101.

Qualitative Research

In-depth IDIs were conducted with past and current co-chairs of the Partnership (i.e., persons serving as committee co-chairs and/or co-chair of the overall Partnership). Focus groups were conducted with current members of the Partnership. Interview and FGD questions were open-ended and discussions centered on obtaining greater understanding of the Partnership's history, vision, and activities. For nine of the IDIs, two FHI 360 research team members jointly conducted the IDIs (with one member primarily providing back-up note-taking); the tenth IDI was conducted by one team member. A moderator and note-taker were present for each of the FGDs. All IDIs and FGDs were digitally recorded and transcribed by a professional transcriptionist using a standardized transcription protocol. Written transcripts were reviewed by FHI 360 research team members who collected the data, to ensure translation accuracy.

Using NVivo 10 software for qualitative data analysis (QSR International Pty Ltd, 2012), we applied a thematic analysis approach including use of structural, conceptual and content coding, structured codebooks, and intercoder agreement checks throughout the data analysis process. We applied 1) structural coding to map the transcript text to elements of the data collection process; 2) conceptual coding to help us align the evidence from our data with theoretical models that seek to explain how and why integrated development contributes to the well-being and health of communities; and 3) the iterative strategy of content (or emergent) coding to support summary descriptions of themes and meaning in the data.

Quantitative Research

In Phase 2, we administered a survey to evaluate what aspects of the Partnership for a Healthy Durham's structure, processes, and functioning that its membership perceived to be working well and aspects needing improvement. The survey consisted of approximately 50 questions divided into seven sections. The first section of questions pertained to membership demographics in an effort to describe the diversity and levels of participation among the Partnership members. The second set of questions pertained to the organizations that each participant represented (if any) and were included in an attempt to understand how organizations in different sectors are connected to each other through different types of relationships. The third set of questions focused on the work being done by participants in the Partnership committees.

For the fourth, fifth and sixth set of questions, we used items from the Wilder Collaboration Factors inventory, a tool developed for and used to help groups see where they stand on factors that have been shown to be critical to the success of cross-sector collaboratives (P. Mattessich & Rausch, 2013; P. W. Mattessich, Murray-Close, & Monsey, 2001). We chose this inventory because the factors included in it were developed through a systematic review of empirical studies of collaboration. Six categories of factors are included on the inventory: environment, membership characteristics, process and structure, communication, purpose, and resources. We chose to include factors from five of the six categories; we excluded the environment category based on input from the steering committee and initial analyses of the qualitative data which indicated that this factor was not a concern for the Partnership. Each of the five categories of factors had one to three survey items, resulting in a total of 20 questions on the survey from the Wilder inventory.

The inventory question response options were Likert scales that ranged from 5 = strongly agree to 1= strongly disagree. According to the developers of the Wilder scale items, factors that receive scores of 4.0- 5.0 are strengths that don't need attention; factors that receive scores of 3.0 to 3.9 are considered issues of borderline concern that deserve discussion; and factors that receive scores of 1.0 to 2.9 are concerns that should be addressed.

The final section of the survey was a series of open-ended questions soliciting feedback from the Partnership membership about how to increase participation from the full membership and engagement with the community.

We used simple descriptive frequencies, and calculated inventory factor scores to summarize the survey responses. During survey analysis, we looked at similarities and differences in responses among participants whom we classified as more or less active members of the Partnership based on their role in committees and attendance at meetings. Since survey participation was not based on a random sample, we used tests for the statistical significance of any differences with caution.

We used a combination of self-administered paper and internet surveys. We used Qualtrics (Provo, UT, USA) to administer and manage the internet survey. The option of completing a paper survey was provided because not all Partnership members have easy access to or are comfortable with using the internet. All Partnership members with email addresses were contacted via email and provided with the information needed to complete the online version of the survey. The email invitation was forwarded to the Partnership members by the Partnership coordinator along with brief instructions and a link to the survey. Four subsequent reminders were also sent to all of the individuals on this listserv over the following six-week period. Paper surveys were distributed and completed at Partnership committee meetings. We calculated a minimum response rate based on the number of surveys completed electronically and on paper divided by the total number of surveys sent out. We calculated a maximum response rate based on the number of surveys completed divided by the total number of surveys sent out. We tracked the proportion of responses that resulted in refusals. We also tracked the number of email invitations returned as "dead" email accounts and the number of individuals who completed a survey online versus paper format at a meeting. We used a combination of software programs for this descriptive analysis, including reporting functions within Excel and SAS and Pajek and Ucinet for network visualizations and calculations.

The findings resulting from this study can be found in a separate report (see Appendix A).

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APPENDICES

Appendix A: List of Study-Related Reports

Listed below are study-related reports provided to the Partnership for a Healthy Durham by FHI 360 members of the study team. These reports include a main study report along with four supplemental reports containing expanded details on study methods, the history of the Partnership, descriptions and accomplishments of the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize mini-grants, and additional study findings (i.e., analysis of conceptual frameworks).

1. Building Healthy Communities: Learning from the Partnership for a Healthy Durham
2. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Expanded Study Methods
3. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Partnership History
4. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – RWJF mini-grant descriptions and accomplishments
5. Building Healthy Communities: Learning from the Partnership for a Healthy Durham – Partnership Framework