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

Artist: Eleatta Diver

9/30/2016   FINAL REPORT

Study Team Members:
Kathleen MacQueen, FHI 360, Project Director
Elizabeth Costenbader, FHI 360, Co-Investigator
Marissa Mortiboy, Durham County Department of Public Health, Co-Investigator
Natalie Eley, FHI 360, Qualitative Researcher
Eunice Okumu, FHI 360, Qualitative Researcher
Tom Grey, FHI 360, Data Analyst

fhi360
THE SCIENCE OF IMPROVING LIVES

Partnership for a Healthy Durham

TABLE OF CONTENTS

Building Healthy Communities: Learning from the Partnership for a Healthy Durham

ACKNOWLEDGEMENTS

Cover illustration: "Growing in Health" by Eleatta Diver. This painting was donated to the Durham Community by Duke Health and is on display in the lobby of the Durham County Department of Public Health (DCoDPH). In the artist's words, "this painting depicts the various components of a healthy community as discussed in the 2013 Duke Durham Health Summit. Physical, educational, nutritional and spiritual well-being are represented."

EXECUTIVE SUMMARY

Introduction

The overall purpose of this study was to conduct a descriptive analysis of lessons learned from the Partnership for a Healthy Durham about achieving sustainable integration and effective multi-sector community work. A secondary goal was to provide an evaluation of the constitution and functioning of the current Partnership. The study was conducted by FHI 360 in collaboration with the Partnership for a Healthy Durham with funding from the Family Health International Foundation.

Methods

This was a mixed method, descriptive exploratory study. The study team conducted 10 in-depth interviews and 3 focus group discussions with Partnership leaders and members, a survey of the full membership (conducted both online and in person at Partnership meetings, with 141 respondents), observations at Partnership meetings, and review of publically available Partnership documents and related materials.

Results

Strengths

- Overall, there is agreement that the Partnership has concrete and attainable goals.
- Members viewed the quality of open and frequent communication within the Partnership as a strength.
- Partnership leadership was viewed as strong, with leaders described as having good facilitation skills, being action-oriented, and having an understanding of the big picture.
- The Partnership brings together a broad network of professionals, advocates and engaged community members who are invested in building healthy communities in Durham.
- The Partnership meets a unique need within Durham that cannot be met by any single organization.
- Partnership members perceive a broad range of accomplishments from their collective work.

Challenges
- Some members expressed concern about the extent to which people in the Partnership know and understand the goals.
- Although the openness of communication was viewed as a strength, communication challenges were also frequently noted by members.
- Many members felt a need for the Partnership committees to work more collaboratively together, and noted a tendency toward working in silos.
- Overall levels of commitment, effort, and trust among members were viewed as potentially concerning and in need of discussion.

- Defining membership was viewed as a challenge, especially with regard to balancing the ideal of being open and welcoming to everyone together with clear expectations as to what it means to be a member and how decisions are made regarding use of resources, planning activities, etc.
- Sufficient monetary and people-power resources to achieve the Partnership's goals were seen as major challenges.
- Challenges related to effectively engaging community members were frequently noted.

Recommendations

As requested by the Partnership for a Healthy Durham, the FHI 360 members of the study team provide the following recommendations based upon the study findings presented in this report.

1. <u>Streamline email communications</u>. The email listserv provides a valued means of communication and engagement for all members, regardless of how active they are. However, information-heavy emails tend to be overwhelming and may not get read. Alternative formats should be explored. Specifically, we would suggest altering the format of emails so that they provide short topic headings in the body of the email and then links to connect interested readers to more detailed information online.

2. <u>Continue to use multiple communication channels</u>. Results from both the survey and the interviews clearly indicate that one size does not fit all with regards to the preferred communication channel in the Partnership. Members report using a variety of communication channels to keep themselves and their constituents informed and to stay connected with other members. In light of these results and the large number of members ranging in age and access to and familiarity with different communication platforms and technologies, we would recommend that at present the Partnership maintain all the communication channels currently being utilized in order to reach the broadest audience.

3. <u>Explore the underlying reasons for the mixed views members express about the perceived levels of commitment, effort, and trust</u>. Exploring and coming to understand the extent to which these mixed views reflect structural constraints or barriers as opposed to statements about people will determine how perceived low levels of commitment, effort, and trust among some members can be overcome. For example, do these issues reflect instances of poor fit between Partnership projects/activities and organizational priorities of the members? Do they reflect funding or other resource limitations on effectiveness? Do they reflect instances where committee projects/activities reflect individual priorities rather than a broader committee consensus?

4. <u>Establish a cross-cutting committee or work group to address funding challenges</u>. Many members and their organizations have limited capacity to pursue funding opportunities, lack the required structures to be eligible to receive funding, are prohibited from accepting donations, or have institutional overhead costs that create barriers to managing some of the grants that would

otherwise be viable opportunities to support Partnership projects and activities. Expertise to address these challenges is not available in all of the committees, and some funding opportunities could potentially support cross-cutting committee activities.

5. <u>Develop clearer decision-making guidelines within committees</u>. Everyone recognizes the value and power of the Partnership's open membership. People in general do not want to restrict membership but express concerns about informed decision-making if anyone can vote on issues regardless of their level of previous engagement on those issues. As such, while we would not recommend that the Partnership adopt any criterion for membership eligibility, we would recommend that the Partnership adopt voting eligibility criteria for its membership. Specifically, we would suggest something along the lines of requiring participation in the previous 2 out of 3 meetings in order to vote on an issue within a committee.

6. <u>Seek innovative ways to balance community and organizational representation within the Partnership</u>. Many people noted the challenge of holding meetings at times and in places that work for both grassroots community members and people working in organizations that directly address the Partnership's priorities. Rather than trying to find a one-size-fits-all solution, we recommend that the Partnership consider the different constituency needs and shape multiple strategies to foster leadership, voice, and decision-making roles. Approaches may need to vary in structure, strategy and process for different committees. For example, some committees may be best served by holding meetings alternately in the community and at a central organizational location whereas others may be better served by holding meetings at a regular location. Another example might be to hold semi-annual meetings in community settings in addition to the quarterly full partnership meetings.

7. <u>Make people aware of their process and product accomplishments and celebrate milestones achieved along the way</u>. As evidenced in the survey results, when participants were asked to list key outcomes achieved by their committees, few survey participants articulated key outcomes in terms of impacts at the individual and community-level. Similarly, in the interviews participants discussed the challenges of the long horizon needed in order to see impacts occurring at the community and individual-level. Nonetheless, survey and interview participants did articulate a variety of key outcomes and products that they had achieved in the process of working towards the larger impacts. In order to sustain momentum and motivation among Partnership members, we would suggest that the Partnership leadership find ways to regularly celebrate and disseminate the milestones they have achieved in the process of their collaboration.

8. <u>Make members more aware of the cumulative impacts of their work.</u> People are not always aware of the bigger picture and longer-term successes achieved by the Partnership, especially those outside their own committees or from earlier years. Telling the story of cumulative success may be especially important for mentoring emerging leaders on how to build toward larger goals and accomplishments, and how to overcome challenges such changes in funding.

In summary, the findings of this study indicate that there are various challenge areas to be addressed within the Partnership for a Healthy Durham. The recommendations provided in this report offer suggestions for addressing such challenges. The study findings also highlight that the Partnership has an array of strengths that can be utilized and further developed to support the Partnership's efforts to collaboratively improve the quality of life of the Durham community.

INTRODUCTION

As the Robert Wood Johnson Foundation's[1] County Health Rankings make clear, in many ways, where you live determines your health. By changing the environments in which people live, work, learn, and play, communities can improve multiple health outcomes. FHI 360's Building Healthy Communities project is dedicated to advancing practice and contributing to the evidence on the effectiveness of multi-sector approaches to community health. As part of the Building Healthy Communities project, we sought to learn from the experiences of the Partnership for a Healthy Durham[2], the certified Healthy Carolinians program for Durham County, while also supporting the Partnership's work by providing data to inform and improve its practice. Healthy Carolinians was North Carolina's statewide network of partnerships that address health and safety issues at the community level. Local health departments and Healthy Carolinians partnerships set their health priorities by conducting a community health assessment at least once every four years and by aligning with the Healthy North Carolina 2020 health objectives[3]. The mission of the Partnership for a Healthy Durham is dedicated to collaboratively improving the quality of life of the community with a vision that the people of Durham will enjoy good physical, mental, and social health and well-being.

The overall purpose of the study, *Building Healthy Communities: Learning from the Partnership for a Healthy Durham* was to conduct a descriptive analysis of lessons learned from the Partnership for a Healthy Durham about achieving sustainable integration and effective multi-sector community work and to conduct an evaluation of the constitution and functioning of the current Partnership. The primary objectives for the study were to:

1. Describe the history of the Partnership for a Healthy Durham to understand the context, motivations, approach and challenges to achieving its mission and vision
2. *Describe the activities being supported under the Robert Wood Johnson Foundation (RWJF) Culture of Health Prize*
3. Describe the current structure, processes, functioning and outcomes of the Partnership for a Healthy Durham as they contribute to and impact integration and multi-sector community work
4. Evaluate which aspects of the structure, process and functioning of the Partnership for a Healthy Durham that are reported as working well or needing improvements by its members.

This report describes the methods and findings of the study together with recommendations for consideration by the Partnership leadership.

---

[1] To learn more about the Robert Wood Johnson Foundation, visit http://www.rwjf.org/en.html
[2] For further information about the Partnership for a Healthy Durham, visit http://healthydurham.org/
[3] For details about the Healthy North Carolina 2020 health objectives, visit
http://publichealth.nc.gov/hnc2020/objectives.htm

METHODS

Study Design

This was a mixed method, descriptive exploratory study to learn what has made the Partnership for a Healthy Durham successful, what strategies have facilitated multi-sector community work by Partnership members, what challenges the Partnership has faced in this work and how they are or might be addressed. FHI 360 will use the findings to inform integrated efforts in other communities. The overall approach for this study is best described as community-based participatory research. The research consisted of two phases.

- In Phase 1, the study team conducted qualitative research including participatory observation at public Partnership meetings, reviewed publicly available Partnership documents and related materials, and performed in-depth interviews (IDIs) and focus group discussions (FGDs) with Partnership leaders and members.

- In Phase 2, the study team conducted quantitative research consisting of a survey administered both online and in hard copy paper format with the Partnership members. The survey was developed in collaboration with the Partnership leadership.

Further description of the research framework can be found in a separate report (see Appendix A for details).

Sampling and Recruitment

Study participants included past and present members of the Partnership. Interview, FGD, and survey participants were recruited through an email invitation distributed by the Partnership coordinator. Survey participants were also recruited in-person at five Partnership committee meetings.

Qualitative Research

In Phase I, we conducted in-depth IDIs 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) and FGDs 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. Interviews and FGDs were conducted from August through November 2015. Qualitative data were digitally recorded and transcribed. Transcripts were analyzed by the study team members using NVivo 10 analysis software (QSR International Pty Ltd, 2012) and a thematic analysis (ATA) approach including use of structural, conceptual and content coding, structured codebooks, and inter-coder agreement checks throughout the data analysis process (Guest, MacQueen, & Namey, 2011).

Additionally, we conducted participatory observations at public Partnership meetings to help familiarize the study team with the Partnership's meeting structure, membership, and activities. Throughout the study, we also conducted document review of publically available information from online sources such as meeting

notes, annual reports, news articles, and similar documents available on the websites of the Partnership for a Healthy Durham, Durham County Department of Public Health, Robert Wood Johnson Foundation and other sources. The document review process was used to enhance our understanding of information provided in the IDIs and FGDs and to address information gaps for the study team. Further details on the qualitative methodology can be found in a separate report (see Appendix A for details).

Quantitative Research

In Phase 2, we conducted a survey designed to evaluate which aspects of the structure, process and functioning of the Partnership for a Healthy Durham were viewed as working well and which its members viewed as needing improvements. The survey was conducted from February through April 2016 and included approximately 50 questions divided into seven sections. The sections pertained to membership demographics, organizational sectors and relationships, Partnership Committee affiliations, Partnership and community engagement, and a series of questions to assess characteristics of cross-sector collaboratives (using the Wilder Collaboration Factors Inventory) (Mattessich, Murray-Close, & Monsey, 2001). Expanded detail on the quantitative research methodology can be found in a separate report (see Appendix A for details).

Member-checking

Preliminary study findings were shared and discussed at the April 20, 2016 full Partnership quarterly meeting, and at the June 20, 2016 Partnership Steering Committee meeting. Draft versions of this report were also shared with the Partnership leadership for comment and feedback.

RESULTS

Data presented in this section are derived from all sources and are presented with qualitative findings interwoven with the survey findings. Of note for the survey data, we included five categories of factors from the Wilder Collaborative Inventory and each factor had one to three survey items, resulting in a total of 20 questions on the survey. 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, interpretation of factor scores are as follows:

- Scores of **4.0 to 5.0** – strengths that don't need attention
- Scores of **3.0 to 3.9** – issues of borderline concern that deserve discussion
- Scores of **1.0 to 2.9** – concerns that should be addressed

Factor scores are graphically displayed on the following color-coded scale (score indicated with a star) together with the scale items and percent of respondents agreeing or strongly agreeing with each scale item included in that factor.

5   4   3   2   1

Participants

Demographics

A total of 141 individuals completed an evaluation survey; 31 individuals completed paper surveys at the committee meetings and 110 individuals completed the survey electronically. As shown in Table 1, a demographically diverse sample of members participated in the survey and there were no statistically significant differences in the demographics of the electronic and paper survey participants.

We conducted ten in-depth IDIs with current and former co-chairs and three FGDs with Partnership committee members. There were a total of eleven participants across the three FGDs. We did not collect separate demographics on participants in the qualitative component.

Table 1: Demographic Characteristics of Survey Participants	Electronic n = 110 n (%)	Paper n = 31 n (%)	Total N= 141 N (%)
Age			
18 - 34	25 (23%)	13 (42%)	38 (27%)
35 - 44	31 (28%)	10 (32%)	41 (29%)
45 - 54	25 (23%)	2 (7%)	27 (19%)
55 or more	28 (25%)	6 (19%)	34 (24%)
Missing	1 (1%)	0	1 (1%)
Gender			
Male	34 (31%)	10 (32%)	44 (31%)
Female	74 (67%)	21 (68%)	95 (68%)
Missing	2 (2%)	0	2 (2%)
Hispanic or Latino Ethnicity			
Yes	12 (11%)	2 (7%)	14 (10%)
No	95 (86%)	28 (90%)	123 (87%)
Missing	3 (3%)	1 (3%)	4 (3%)
Race			
Black or African-American	34 (31%)	12 (39%)	46 (33%)
White or Caucasian	64 (58%)	14 (45%)	78 (55%)
Multiracial	6 (5%)	3 (10%)	9 (6%)
Asian	0	1 (3%)	1 (1%)
American Indian or Alaskan Native	2 (2%)	0	2 (1%)
Missing	4 (4%)	1 (3%)	5 (4%)
Durham County Resident			
Yes	83 (75%)	23 (74%)	106 (75%)
No	25 (23%)	8 (26%)	33 (23%)
Missing	2 (2%)	0	2 (2%)
Attend as:			
Community Member	16 (15%)	1 (3%)	17 (12%)
Organizational Representative	39 (35%)	19 (61%)	58 (41%)
Both	44 (40%)	9 (29%)	53 (38%)
Missing	11 (10%)	2 (7%)	13 (9%)

Response Rate

The survey was launched and initial invitations to participate were emailed by the Partnership coordinator on February 1, 2016. At that time, the Partnership listserv contained the email addresses of 603 individuals

who, at a minimum, had requested to receive email notifications and updates about the Partnership. Four subsequent reminders were sent by the coordinator to all of the individuals on the listserv over the following six-week period. During this time, several new individuals and organizations also joined or expressed interest in the Partnership resulting in a total of 7 new email addresses being added to the listserv and 610 total email addresses to which the survey was sent. Also during this time 7 email addresses were found to be undeliverable or incorrect and 29 were duplicates. The total number of individuals invited to participate was thus 603 + 7 new - (7 failed + 29 duplicate) = 574. The resulting survey response rate was 24% (141/574).

While a 24% response rate is notably lower than what is typically considered a desirable response rate for surveys with individuals, it should also be noted that the number of survey participants (N= 141) was greater than the number of organizations listed on the Partnership website at that time as active members of Partnership committees (N = 83). In addition, it has been documented that surveys of organizations typically receive substantially lower return rates than surveys of individuals; 15% return rates sometimes reach a level of acceptability for organizational surveys (Baldauf, Reisinger, & Moncrief, 1999; Tomaskovic-Devey, Leiter, & Thompson, 1994). It has also been shown that because organizational surveys are usually completed in a work environment, factors such as preoccupation with work, confidentiality of information, or workplace rules and policies contribute to low survey response rates (Greer, Chuchinprakarn, & Seshadri, 2000). As such our 24% participation rate is very similar to the average rate observed for online surveys recruited via email (Hager, Wilson, Pollak, & Rooney, 2003).

Activity Level

The frequency with which survey participants attended meetings in the past year varied with 12% not having attended any meetings and about a quarter reporting they had attended more than five meetings in the past year (Table 2). Of note, a third of those completing electronic surveys did not answer this question. Those who completed the survey on paper at a Partnership meeting were significantly more likely to have attended 6 or more meetings than those who completed the electronic survey. Roughly half of all survey participants indicated that they were part of a committee but paper respondents were significantly more likely to indicate such membership.

Table 2: Participation Activity Level of Survey Participants	Electronic n = 110 n (%)	Paper n = 31 n (%)	Total N= 141 N (%)
Frequency of meeting attendance past year *			
No meetings	11 (10%)	6 (19%)	17 (12%)
Just one meeting	18 (16%)	1 (3%)	19 (13%)
2 to 5 meetings	26 (24%)	5 (16%)	30 (21%)
6 or more meetings	19 (17%)	17 (55%)	37 (26%)
Missing	36 (33%)	2 (6%)	38 (27%)
Part of a Committee *			
Yes	47 (43%)	21 (68%)	68 (48%)
No	38 (35%)	7 (23%)	45 (32%)
Missing	25 (23%)	3 (10%)	28 (20%)
			*p < .10, ***p < .01

Given the significant differences in meeting attendance and committee participation between responses to the paper and the electronic versions of the survey, we subsequently chose to further explore differences between members based on their activity levels within the Partnership. Specifically, we divided participants in to more and less active members; defining the more active members as those who were part of a committee and who attended more than one meeting per year. **With the exception of one factor, scores on the Wilder inventory were uniformly more positive and indicated fewer issues of concern among the survey participants who were more active in the Partnership.**

History

Historical context was provided by some participants during qualitative data collection, however to fully grasp the history of the Partnership the study team reviewed publically available documents accessible through online sources. Figure 1 below depicts key milestones in the development of the Partnership for a Healthy Durham. Additional details about Partnership-related milestones can be found in a separate report (see Appendix A for details).
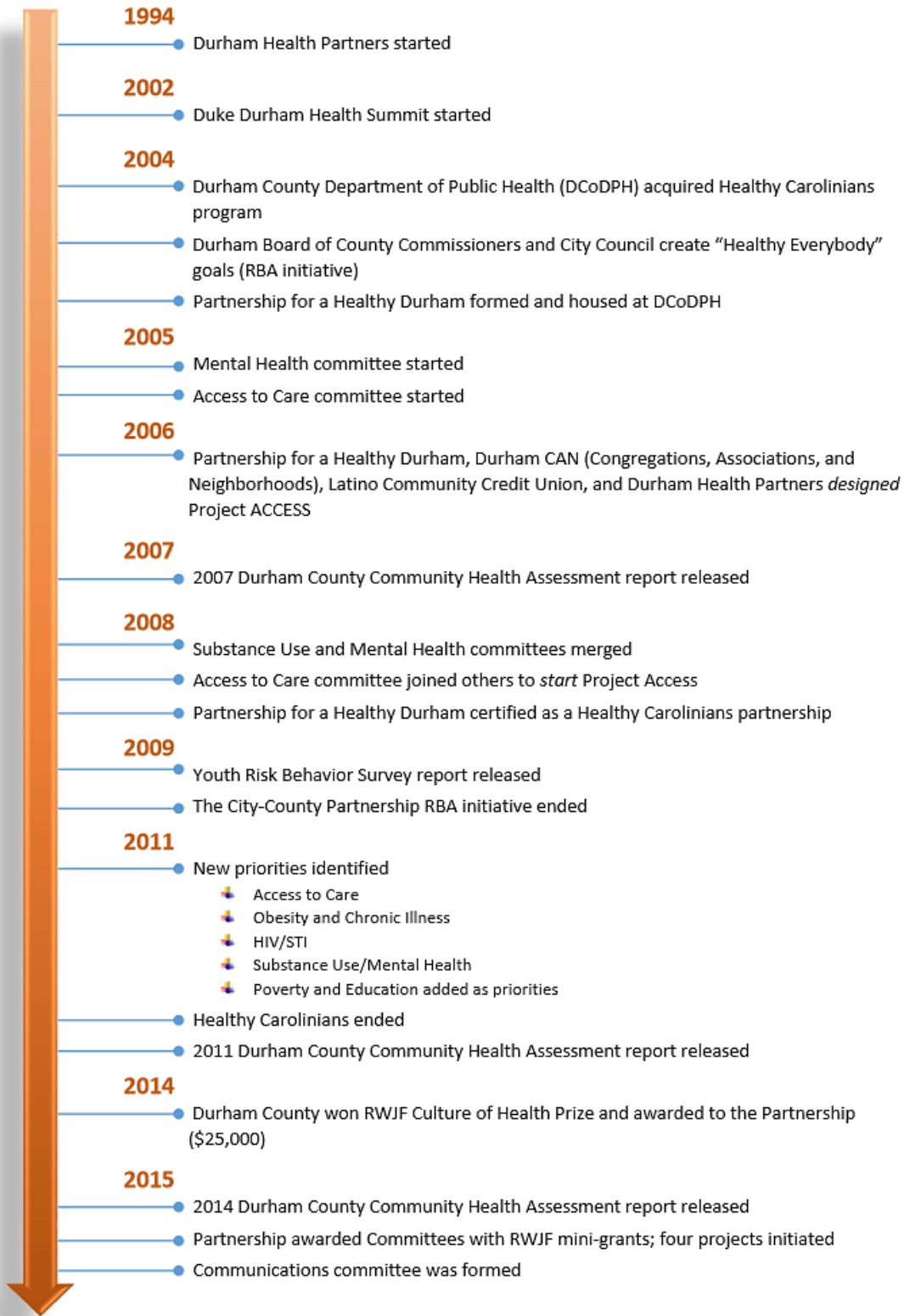
1994
- Durham Health Partners started

2002
- Duke Durham Health Summit started

2004
- Durham County Department of Public Health (DCoDPH) acquired Healthy Carolinians program
- Durham Board of County Commissioners and City Council create "Healthy Everybody" goals (RBA initiative)
- Partnership for a Healthy Durham formed and housed at DCoDPH

2005
- Mental Health committee started
- Access to Care committee started

2006
- Partnership for a Healthy Durham, Durham CAN (Congregations, Associations, and Neighborhoods), Latino Community Credit Union, and Durham Health Partners *designed* Project ACCESS

2007
- 2007 Durham County Community Health Assessment report released

2008
- Substance Use and Mental Health committees merged
- Access to Care committee joined others to *start* Project Access
- Partnership for a Healthy Durham certified as a Healthy Carolinians partnership

2009
- Youth Risk Behavior Survey report released
- The City-County Partnership RBA initiative ended

2011
- New priorities identified
  - Access to Care
  - Obesity and Chronic Illness
  - HIV/STI
  - Substance Use/Mental Health
  - Poverty and Education added as priorities
- Healthy Carolinians ended
- 2011 Durham County Community Health Assessment report released

2014
- Durham County won RWJF Culture of Health Prize and awarded to the Partnership ($25,000)

2015
- 2014 Durham County Community Health Assessment report released
- Partnership awarded Committees with RWJF mini-grants; four projects initiated
- Communications committee was formed

FIGURE 1 KEY DATES IN THE DEVELOPMENT AND FUNCTION OF THE PARTNERSHIP FOR A HEALTHY DURHAM

Structure, Processes and Functioning

Overall Structure

The Partnership structure is minimally hierarchical (Figure 2). The Durham County Department of Public Health (DCoDPH) employs one full-time staff member to serve as the overall Partnership Coordinator to coordinate meetings and communication. The Partnership is guided by a Steering Committee consisting of 16 individuals who include two overall Partnership co-chairs, the Partnership Coordinator, co-chairs of committees or action groups, leadership from DCoDPH and a past overall co-chair of the Partnership.

FIGURE 2 CURRENT STRUCTURE OF THE PARTNERSHIP FOR A HEALTHY DURHAM (AS POSTED ON THE PARTNERSHIP'S WEBSITE)
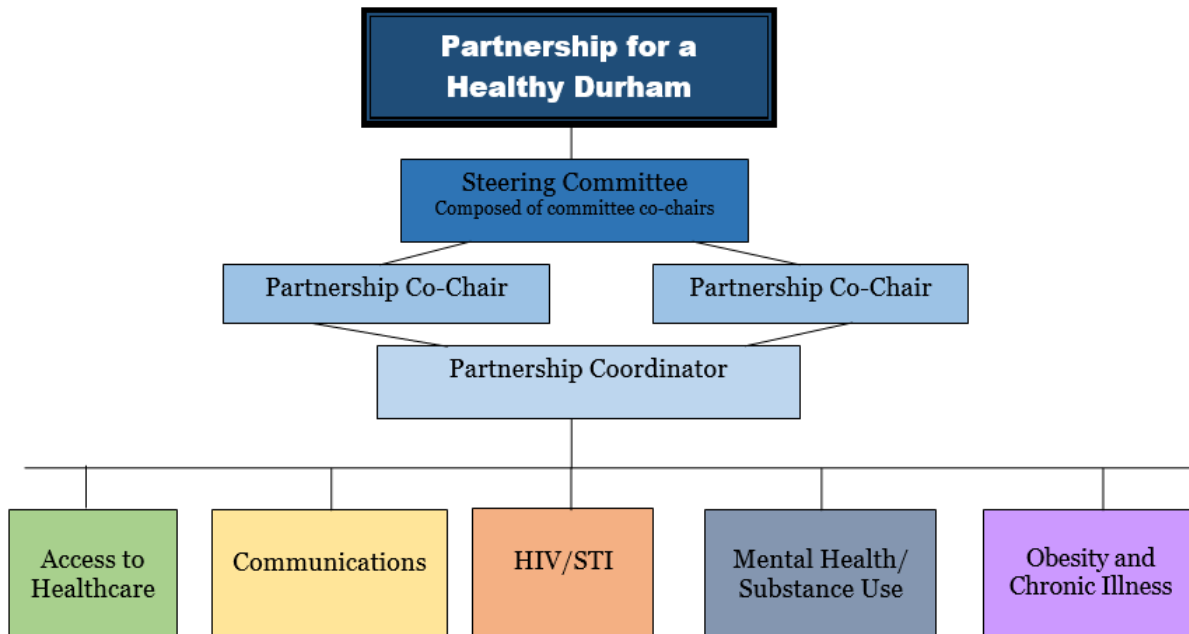
Currently the Partnership is divided into five committees:

- **Access to Care**: Advocates for legislative changes that will affect health care coverage for residents and develops community and agency-based strategies to make measurable improvements in access to medical and dental care for the uninsured and underinsured residents of Durham.

- **Obesity and Chronic Illness**: Provides a community-based approach to address the growing problem of overweight and obesity, and chronic illnesses, such as diabetes.

- **HIV/STI**: Brings together community members and agencies to focus on strategies to prevent the spread of syphilis and HIV/AIDS, which disproportionately impacts people of color.

- **Substance Use/ Mental Health**: Advocates on local issues related to treatment and prevention of substance abuse and addiction illnesses. Seeks to increase public awareness of mental illness and access to mental health services.

- **Communications**: This newly formed committee (2015) aims to improve internal and external communications and branding of the Partnership. Since formation, the committee has focused on looking for different options for *"improving communications between"* organizations, including *"working on a resource guide."*

In general, the Partnership committees reflect priority health concerns identified through a Community Health Assessment together with epidemiologic data:

> *"SO EVERY THREE YEARS WE DO A HEALTH ASSESSMENT… AND BASED ON THAT HEALTH ASSESSMENT WE CHOOSE WHAT COMMITTEES WE'RE GONNA HAVE, SO THEY'RE OUR TOP HEALTH PRIORITIES IN THE CITY." (IDI PARTICIPANT)*

> *"…HIV AND STIS WEREN'T IDENTIFIED BY THE COMMUNITY AS AN IMPORTANT ISSUE, BUT THE DATA SAYS IT'S A HUGE ISSUE IN DURHAM, AND OUR NUMBERS ARE WAY WORSE THAN THE STATE. SO LIKE AS THE EXPERTS, WE KIND OF OVERRODE WHAT THE COMMUNITY SAID, AND SAID THIS IS STILL A PRIORITY AND WE WANT TO KEEP THIS COMMITTEE." (IDI PARTICIPANT)*

More than half of survey participants generally agreed that the Partnership has concrete and attainable goals, making this an issue of borderline concern that deserves discussion.

Extent to which the Partnership for a Healthy Durham is viewed by members as having concrete and attainable goals

Wilder inventory statements	% who agree or strongly agree
I have a clear understanding of what the Partnership for a Healthy Durham is trying to accomplish	70%
People in the Partnership for a Healthy Durham have established reasonable goals	65%
People in the Partnership for a Healthy Durham know and understand our goals	52%
5 4 ⭐ 3 2 1	

Factor score = 3.7 (borderline concern)

Leadership and its Characteristics

The Partnership co-chairs and the co-chairs of the committees are elected by the members of the Partnership. Partnership voting normally takes place annually using a free online survey tool to enable those who do not attend meetings to vote. Throughout the IDIs and FGDs, descriptions were provided of the characteristics of the Partnership leadership (past and current Partnership chairs, committee co-chairs, and coordinators) that the study participants felt most contributed to the Partnership structure, functioning, and successes. The three most salient characteristics that were attributed by participants to the success of leaders in the Partnership were having good facilitation skills, being action-oriented and having an understanding of the big picture. Leaders were commended for doing a good job at facilitating meetings, coordinating tasks between meetings, connecting people to one another, and encouraging and engaging people to participate in the Partnership committees.

> *"The first chair of [committee] when I started coming was... amazing... you didn't want to look up from the table because if you looked up, you knew she was gonna call you to do something. (Group laughter) But she had everyone around the table because they were all actively participating and they felt valued." (FGD participant)*

Leaders were described by IDI participants in terms that suggested they were seen as action-oriented ("able to move work forward") and working collaboratively.

> *"I think apart from the [health department] staff, the others [co-chairs] have provided key leadership... made significant investments to the work of the Partnership in facilitating meetings and writing articles and presenting ideas, working with the staff to make sure that strategies were being implemented." (IDI Participant)*

> *"THIS IS REALLY THEIR PASSION AND THEY [ARE] ABLE TO DO SOMETHING AND BE CREATIVE ABOUT IT AND KEEP MOVING WITH IT. THAT'S WHAT I SEE A LOT OF... THEY BRING EVERYBODY TOGETHER FOR A GOOD CAUSE. THEY JUST GET THE WORK DONE. THERE'LL BE A LOT OF CONFUSION AT TIMES, BUT THEY GET IT DONE THOUGH... WE END UP AGREEING ON ONE ACCORD... AND AGREEING AND DISAGREEING, BUT IT COMES OUT... IT'S REALLY A BEAUTIFUL THING... ALL OF THEM ARE BEAUTIFUL, BEAUTIFUL PEOPLE. I MEAN THEY GOT THAT HEART." (IDI PARTICIPANT)*

It was noted that for some of the Partnership leaders the work that they are doing outside of the Partnership aligns closely with their work inside the Partnership.

> *"WE'RE ALSO VERY LUCKY TO HAVE A COUPLE REAL MOVERS AND SHAKERS WHO ARE ABLE TO IMPLEMENT THE COMMITTEE'S GOALS WITHIN THEIR OWN ORGANIZATION." (FGD PARTICIPANT)*

Lastly, leaders were characterized as having an understanding of the "big picture" (e.g. about Durham and how public health issues connect with other sectors). For example, the Partnership coordinator was highlighted as a gatekeeper role for dissemination of information and determining what information gets shared across committees and to the Partnership at large. Other leaders were noted as well.

> *"ONE OF THE BEST ADVOCATES IN PUBLIC HEALTH WAS [PERSON]. AND SO, YOU KNOW, AS A POSITIVE FOR THE GROUP, SHE ALWAYS WAS GREAT ABOUT PAINTING THE BIG PICTURE, AND THIS IS HOW THIS GROUP INTERACTS WITH OTHER GROUPS, WITH THE COMMUNITY, WITH THE STATE OF THE HEALTH. YOU KNOW, THIS IS HOW WE CAN AFFECT POLICY, AFFECT HOW, YOU KNOW, THINGS ARE VIEWED. SO SHE WAS ALWAYS GREAT AT DOING THAT." (IDI PARTICIPANT)*

Communication

Committees meet on a monthly basis and full Partnership meetings are held on a quarterly basis. The coordinator sends out a monthly email update to the listserv. The Partnership also maintains a website, a Facebook page and a Twitter account. In the qualitative IDIs, participants indicated a broad awareness of the range of communication channels, specifically noting Partnership meetings, emails, Partnership website, media coverage, Facebook, Twitter, flyers, online polls and informal communication as existing modes of communication used by the Partnership.

Across the domain of survey questions on **communication channels**, the average score for this factor was 3.6, indicating that communication channels are an issue of borderline concern that deserve discussion.

Extent to which the Partnership for a Healthy Durham indicated satisfaction with communication channels as well as whether there was a mechanism to communicate concerns or grievances

Wilder inventory statements	% who agree or strongly agree
The committee updates are sufficient to keep everyone informed about what each subcommittee is working on	57%
The Partnership website is useful for obtaining information about what is happening in the Partnership	44%
When I have concerns or grievances about the Partnership I feel there is a mechanism by which I am able to share my concerns	37%
The Partnership social media pages (Facebook and Twitter) are useful for obtaining information about what is happening in the Partnership	29%
5 4 ⭐ 3 2 1	

Factor score = 3.6 (borderline concern)

Partnership meetings were mentioned by participants in one of the three FGDs and by seven out of the ten IDI participants, as a key mode of communication where members share information about what they are working on. Three kinds of Partnership meetings were mentioned by the participants, which included eight annual Steering committee meetings ("*for the co-chairs*"), Quarterly meetings (*"open to anyone and everyone"),* and monthly committee meetings. The role of meetings as a mechanism for sharing information broadly was noted.

> *"…THE OTHER THING WE DO AT THE BIG MEETING IS IF AGENCIES HAVE ANYTHING TO ANNOUNCE THAT MAY BE OF IMPORTANCE OR IMPACT TO THE BIGGER GROUP, THERE'S ALWAYS TIME AT THE END FOR THAT OPPORTUNITY AS WELL." (IDI PARTICIPANT)*

The **Partnership's website** was mentioned by two IDI participants and participants from one of the three FGDs as a source of information. Both IDI participants mentioned that they always encourage people (Partnership and community members) to go to the Partnership's website to learn more about what the Partnership is doing, the specific committee activities, and what else is happening in Durham as a whole.

> *"WOW, I CAN GET THE STATISTICS ON DURHAM AND THE FAILURE RATES IN THE PUBLIC SCHOOL AND… ALL [THE] GEOSPATIAL MAPPING [THAT] HAS BEEN DONE TO DETERMINE WHICH ZIP CODES HAVE HIGHER OBESITY RATES, WHICH HAVE HIGHER SCHOOL DROPOUT RATES. AND YOU CAN FIND ALL THIS STUFF ON THAT WEBSITE…" (IDI PARTICIPANT)*

One IDI participant felt that the amount of information that could be included on the website was very limited, and stated that plans were underway to get a "*more modern one with more control.*" As of the writing of this report, the new website has now been launched.

Email as a means of communication was mentioned by seven IDI participants and participants in two of the three FGDs as *"the primary mode"* of *"keeping a wide variety of people informed"*, including those who *"don't come to the meetings"*. The listserv maintained by the Partnership coordinator was noted as a tool for communicating with people who may not be actively attending meetings.

> *"I'VE BEEN PLEASED AS A NEW CO-CHAIR THAT, [THE COORDINATOR] SENT ME AN EMAIL LIST OF ABOUT A HUNDRED AND FIFTY PEOPLE WHO ARE TO GET NOTICES OF THE MEETINGS OF [MY] COMMITTEE. I WAS AMAZED WHEN I LEARNED THAT THERE WERE THAT MANY PEOPLE ON THE LIST BECAUSE WE TYPICALLY MAYBE HAVE FIFTEEN OR TWENTY OR TWENTY-FIVE PEOPLE ATTENDING THE MONTHLY MEETINGS IN MY EXPERIENCE." (IDI PARTICIPANT)*

Like announcements at the quarterly meetings, the monthly emails sent out by the coordinator to all Partnership members also serve as a mechanism for organizations to share information.

> *"[THE COORDINATOR] SENDS OUT A MONTHLY EMAIL, AND SO IF YOU WANT [TO SHARE] INFORMATION ABOUT YOUR ORGANIZATION... YOU KNOW, IF YOU'RE PUTTING ON A HEALTH FAIR OR DOING SOMETHING OR NEED VOLUNTEERS, YOU CAN SEND INFORMATION TO HER AND SHE'LL SEND IT OUT ON A CERTAIN DAY OF THE MONTH." (IDI PARTICIPANT)*

One FGD participant mentioned that the email updates make her feel connected to the Partnership even when she is unable to attend meetings:

> *"I HEAR YOU GUYS [IN THE FGD] SAYING THAT BECAUSE PEOPLE AREN'T PHYSICALLY PRESENT, YOU FEEL LIKE THEY'RE NOT CONNECTED NECESSARILY. BUT I CAN TELL YOU, I DO READ THE EMAILS THAT COME ACROSS, AND I'M ACTUALLY STILL A PART OF [COMMITTEE]. I GET THEIR EMAILS AS WELL. SO I APPRECIATE THE INFORMATION. ALTHOUGH I'M NOT SITTING IN THE ROOM AT THE TABLE, I DO FEEL LIKE I'M SORT OF CONNECTED TO THE CONVERSATION AND SEE SOME OF THE PROJECTS. I FEEL LIKE THIS COMMITTEE IS RESOURCEFUL FOR ME AND PROVIDES INFORMATION TO ME, ALTHOUGH I'M NOT PHYSICALLY AT THE TABLE EVERY MEETING." (FGD PARTICIPANT)*

On a more negative note, three IDI participants and one FGD participant complained about the format of the emails, stating that they are often too long and detailed, which discouraged them from reading the information and noting that they subsequently delete them. One of the IDI participants noted that the Partnership coordinator is *"trying to streamline it [emails]."*

One IDI participant mentioned that the Partnership's "**Facebook page** *is for everybody*", and one FGD participant reported that she is "*always trying to get people to like*" the page by emailing people she knew. However, some FGD participants were unsure whether the broader community was accessing the Partnership Facebook page.

Regarding **media coverage**, participants in three IDIs and one FGD reported that the Partnership seeks to maintain relationships with media houses and local newspaper to share information with the public,

including writing op-ed sections on the local newspapers. Media houses (radio and TV) were mentioned by other participants as a means for sharing information about ongoing events in the community.

Although the survey responses indicate that there is room for improvement with regards to utilization of and satisfaction with specific channels of communication, survey participants nonetheless rated the **quality of open and frequent communication across Partnership members** as a strength that does not need attention (average score = 4.0).

Extent to which participants indicated their satisfaction with the communication channels being open and frequent across Partnership members

Wilder inventory statements	% who agree or strongly agree
People in the Partnership for a Healthy Durham communicate openly with one another	67%
The people who lead the Partnership for a Healthy Durham communicate well with the members	68%
The Partnership Coordinator is responsive to emails and other requests for information	75%
I am informed as often as I should be about what goes on in the Partnership for a Healthy Durham	65%
The Partnership does a good job of communicating progress and celebrating our successes	55%
5　　　　　　　3　　2　　1	

Factor score = 4.0 (strength)

Committee Collaboration

Just over half of survey participants agreed that there is a need for more **collaboration across the committees** indicating this is an area of borderline concern that deserves discussion.

Extent to which the Partnership for a Healthy Durham indicated concern about committees' collaboration

Wilder inventory statement	% who agree or strongly agree
There is a need for Partnership committees to work more collaboratively together	53%
5　　4　　3　　2　　1	

Factor score = 3.7 (borderline concern)

In the IDIs, three out of ten participants stated that the committees work in silos, including around the coordination of events. For example, one participant noted:

> *"I don't actually see, other than coming to the larger steering committee meetings, where any of these groups are actually working together… I think they're separate entities… I think that together component is at the steering committee level…" (IDI Participant)*

Working in silos also emerged in other sections of the IDIs, with five additional IDI participants and participants in one of the three FGDs mentioning that members are often unaware of activities in other committees or sub-committees that they are not members of.

> *"…There's so much going on here, but again, people don't know what's going on, and we don't know what's going on between each other, too. So lots of people are working in silos, or things get reinvented and efforts, you know, get repeated when they don't have to be." (IDI Participant)*

Commitment and Trust

Among the factors shown to be critical to the success of a collaborative and included on the Wilder inventory are having a **sufficient level of commitment and effort** among the members and **mutual respect and trust** among its members. Although survey participants' responses were mixed in terms of the percent who agreed with the statements relating to these factors, the average survey score for these factors were 3.6 and 3.7, respectively, indicating that both are issues of borderline concern that deserve discussion.

Extent to which participants indicated a sufficient level of commitment and effort were critical for Partnership success

Wilder inventory statements	% who agree or strongly agree
Everyone who is a member of the Partnership for a Healthy Durham wants this effort to succeed	76%
The level of commitment among the Partnership for a Healthy Durham participants is high	45%
The organizations that belong to the Partnership for a Healthy Durham invest the right amount of time in our collaborative efforts	31%
5 4 ⭐ 3 2 1	

Factor score = 3.6 (borderline concern)

Extent to which participants indicated a sufficient level of mutual respect and trust among members were critical for Partnership success

Wilder inventory statements	% who agree or strongly agree
People involved in the Partnership for a Healthy Durham *always* trust one another	27%
I have a lot of respect for other people involved in the Partnership for a Healthy Durham	81%
5 4 ★ 3 2 1	

Factor score = 3.7 (borderline concern)

This mixed response is reflected in the qualitative data. For example, two IDI participants discussed the relationship between members of the Partnership and the community, which was perceived to include trust and the willingness of members to collaborate on activities and for the community to get involved in Partnership events. But two other IDI participants noted the perception of mistrust between community members and institutional representatives within the Partnership.

> *"… THEY (COMMUNITY) DON'T TRUST THE UNIVERSITY SYSTEMS. YOU KNOW, THEY COME AND DO THEIR RESEARCH. THEY LEAVE. DON'T UPDATE THEM ON WHAT THEY'VE DONE. THEY DON'T LEAVE THEM WITH ANY KIND OF SUSTAINABILITY." (IDI PARTICIPANT)*

> *"[WITHIN THE PARTNERSHIP] THERE'S JUST A RESISTANCE TO PEOPLE FROM THE OUTSIDE …THERE EXISTS A LEVEL OF NON-TRUST AND CONCERN ABOUT I DON'T KNOW WHAT." (IDI PARTICIPANT)*

On the other hand, one IDI participant noted the way relationships built within the Partnership made collaboration stronger.

> *"…IF A GRANT COMES ALONG… WE'RE READY TO JUMP AND ALREADY START WORKING TOGETHER, AND WE CAN WORK TOGETHER WELL BECAUSE WE'VE ALREADY ALL BEEN WORKING TOGETHER, … WE ALREADY HAVE THOSE RELATIONSHIPS BUILT AND THE TRUST IS ALREADY THERE." (IDI PARTICIPANT)*

Organizational Membership

On the survey, participants representing organizations were asked to indicate in **which sector or sectors their organization provided services to Durham county residents**. They were also asked to indicate **what skills or sectors were currently most lacking from the Partnership**. As shown in Figure 3 below, 10% or more of the Partnership members who participated in the survey indicated that, in thinking about the range of expertise, skills and sectors that the members of the Partnership currently have, the skills that are currently most lacking in the Partnership are those in the legal, financial, transportation, criminal justice and housing sectors. In fact, fewer than 10% of the participants reported that their organizations provided

services in those sectors. The sectors most frequently reported as already present in the Partnership by the participants were health care, education, non-profit, human services and mental health services.
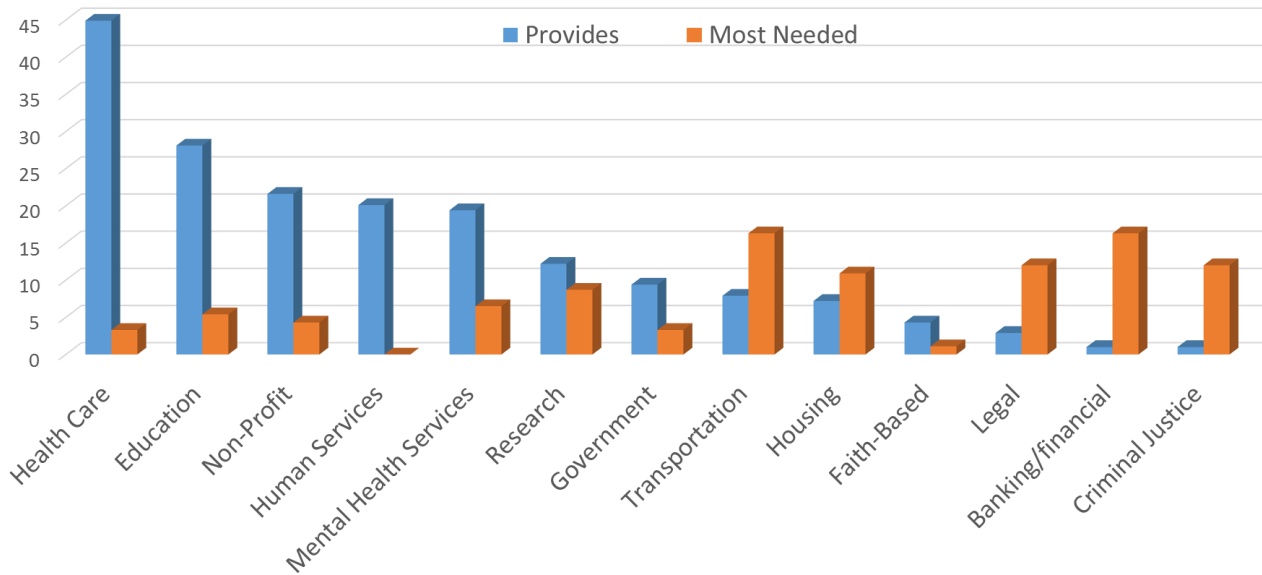
FIGURE 3. Sectors of services provided by organizational members and perceived as most lacking among organizational members.

Survey participants were asked in two separate questions to list the names of other Durham area organizations with whom they shared two types of relationships; **coordinated** and **integrated**, and up to ten organizations with whom they shared each type of relationship. In addition, they were asked to name up to ten cross-sector collaborative projects or initiatives with which their organization was currently involved. Unfortunately, only 64 survey participants (45%) provided the name of their own organization and only 40 of these organization (28% of all study participants) named any other Durham area organizations or initiatives on any of these three questions. As such, our analysis of the relationships that exist between the organizations that participate in the Partnership for a Healthy Durham and other organizations in the Durham area was limited to the data provided by 28% of all study participants. Nevertheless, from the 40 participants that provided both the name of their organization and the names of one or more other area organizations, 175 other local organizations (or collaboratives) were named as those with whom they have some type of coordinated or integrated relationship.

Coordinated relationships were defined as intentional efforts to enhance each other's capacity for the mutual benefit of programs. Examples of coordinated relationships that were given included formal or

established processes by which clients are referred from one organization to the other or jointly conducting community assessments or forums on targeted issues. Integrated relationships were defined as acts of creating and using unified centers of knowledge, funding and programming to support work in related content areas. Examples of integrated relationships given were developing and utilizing shared client lists or shared funding streams/sources.

Across this analytic subset of 40 participating organizations, a total of 254 coordinated relationships between their organizations and 122 other organizations were reported. When asked about organizations with whom their organization had relationships in which they engaged in integrated activities, 26 organizations responded and 94 integrated relationships were reported. Given the low response rate to these questions, the results presented here describe only a subset of the potential relationships encompassed by the Partnership members.

Reported integrated relationships are shown in Figure 4, which shows organizations color coded by the sector of services which they primarily provide and arrows showing the direction of the relationships reported (i.e., who named whom). The clustered structure of relationships in this sociogram (i.e., diagram of social relationships between the organizations) largely results from a few participating organizations such as the Lincoln Community Health Center naming a large number of other organizations with whom they have integrated relationships. In network terms, the other organizations or people that participants name are referred to as outdegree nominations. On this survey all organizations could list up to 10 outdegree nominations. Lincoln Community Health center has the highest outdegree because they named the largest number of integrated relationships with other organizations in this network. In-degree is defined as the count of nominations received from other organizations responding to the survey. In this case, the Early Childhood Outreach (EChO) initiative/project received the largest number of in-degree nominations from other organizations in the network.

Also notable in this network are the fact that some of the organizations around the periphery are connected to one or two other organizations through integrated relationships but remain isolated (i.e., disconnected) from the rest of the organizations in the network. Encouragingly there appears to be a good mix of sectors across this network with organizations providing medical care connected to those providing education, human and social services etc. Notably however there were only two faith-based and one legal services sector organization that appeared in this network. Visible also is the fact that several organizations (i.e., the Boys and Girls club and the Department of Social Services) play a key role bridging disparate clusters in the network that would otherwise be disconnected.
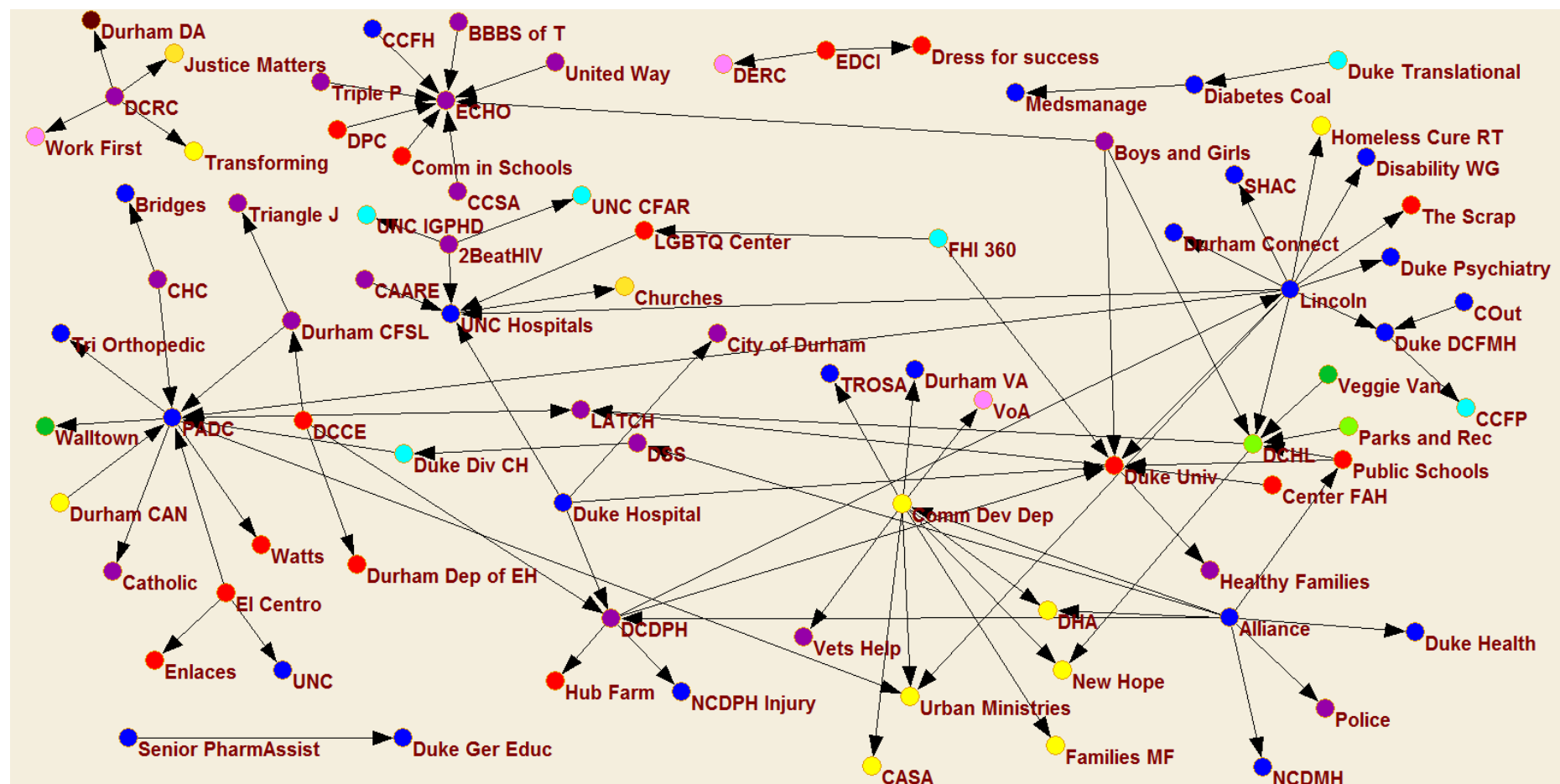
Figure 4: Sociogram depicting 94 reported integrated relationships between Durham area organizations. Colors indicate the primary sector of services provided by each organization as follows: Dk Blue = Medical Care, Lt Blue = Research, Red (on this looks pink) = Education, Purple = Human and Social Services, Green = Nutrition and Fitness, Bright Yellow = Housing, Dk Yellow = Faith-based and Brown = Legal services.

Accomplishments/Successes

Results of the Wilder collaborative inventory show that the factors that survey participants currently perceive to be the biggest strength of the collaborative were that the Partnership has a **unique purpose** (average score = 4.0) and that the members of the Partnership feel that **collaboration is in their self-interest** (average score = 4.0).

Extent to which the Partnership perceives its biggest strength to be its unique purpose

Wilder inventory statements	% who agree or strongly agree
What we are trying to accomplish with the Partnership for a Healthy Durham would be difficult for any single organization to accomplish by itself	81%
No other organization in the community is trying to do exactly what the Partnership is trying to do	50%
5 ⭐ 3 2 1	

Factor score = 4.0 (strength)

Extent to which the Partnership feels that collaboration is in its self-interest

Wilder inventory statement	% who agree or strongly agree
My organization will benefit from being in the Partnership for a Healthy Durham	78%
5 ⭐ 3 2 1	

Factor score = 4.0 (strength)

Key Accomplishments

Survey participants were asked to "describe/list up to 3 key outcomes (i.e., most important things) that you feel your committee has accomplished during your time on the Partnership." Forty-six participants responded to this question and listed a total of 102 outcomes. While 15 of the outcomes offered were not specific enough to code, we categorized the remaining 87 outcomes as one of three types:

- Product (n=59) – outcomes framed as a specific service or product achieved; these included things like developing or contributing to the development of discrete products or activities such as Project Access or a report on the health of the community
- Process (n=15) – outcomes achieved as part of the working process, such as building relationships in the community

- Impact (n=13) – outcomes that were framed in terms of their impacts on individuals and the community such as an increase in the number of children on Medicaid who see a dentist that referenced an actual impact on the community that was achieved

Figure 5 provides a word cloud made up from all of the 102 outcomes noted by survey respondent. The word cloud provides a visual representation of the outcomes giving prominence to words that were more frequently mentioned. Table 3 is a detailed listing of the specific outcomes described, organized by category.

Figure 5. Word cloud generated from key outcomes that survey participants said they felt their committee had accomplished during their time on the Partnership.

Table 3. Categorized list of key outcomes (i.e., most important) that participants said they felt their committee had accomplished during their time on the Partnership.

Product Accomplishments (n=59)

- **Development of or contribution to all of the following:**
  - Project Access, LATCH, Durham Knows Campaign, Healthy Aisles, Double-bucks substance abuse center, Healthy miles trails, CJRC Recovery and World AIDS Day celebrations
  - Brochures for Department of Disability, Medical Options and Disability, Transportation, and Reports on Health of the community and oral health
  - Respite model for People without Homes, Diabetes kidney workshops, financial support for community abuse and feeding center, north Durham farmers market plans, progress toward new online database
  - Identification of HIV testing and condom distribution sites, Coordination of testing events, Initiation of new LGBTI services, Increased the range of sexuality-based topics covered in the school system
  - ACA enrollment activities, Articles for Herald-Sun, Durham Public School Wellness Policy creation, Communication Survey Results, Community resources listings

Process Accomplishments (n = 15)

- **Conducted or completed:** research on I&R, Focus groups through faith centers, mini-grant applications
- **Began or established:** health literacy strategy, social media education presence, building relationships/infrastructures, clear community relevant goals, coordination/connection of similarly-focused organizations across the community, Learning about evolving issues in insurance & CMS programs, Councils to address issues, Resource information gathering
- **Worked with:** Hispanic community, Durham Schools
- **Also:** "Clarified difficult to decipher information" and "Respected the voices of its committee members"

Impact Accomplishments (n=13)

- **Increases in:**
  - child Obesity Awareness, acceptance of naloxone, awareness & prevention of suicide prevention, # of children in Medicaid who see a dentist, # persons in permanent supportive housing who were formerly homeless or low-income, access to food/nutrition services, Opioid abuse prevention, access to safe and free walking trails
- **Improvements in:**
  - awareness and sensitivity about resources related to care access, coordination of services, transportation, availability of HIV testing, teen substance use

Within the IDIs and FGDs, four major themes emerged as accomplishments of the Partnership:

- addressing access to health care issues in the Durham community;
- involving community members in leading the Partnership agenda;
- developing a resource guide (provider referral directory); and
- work done on the RWJF mini-grants and related-activities

Three of the ten IDI participants and one FGD participant discussed how the Partnership had helped to address **access to health care issues**. Two specific projects noted as having an impact in Durham were Project LATCH[4] and Project Access of Durham County (PADC).[5]

> *"IT'S A CREDIT TO OTHER LEADERS WITHIN THE PARTNERSHIP THAT PROGRAMS LIKE PROJECT LATCH AND PROJECT ACCESS AND EFFORTS TO REALLY MAKE SURE THAT LOW INCOME PEOPLE HAVE ACCESS TO SPECIALTY HEALTH CARE HAVE BEEN PUT IN PLACE." (IDI PARTICIPANT)*

Project LATCH was founded in 2002 with funding from the Healthy Communities Access Program (HCAP), US Health Resources and Services Administration (HRSA). Project LATCH essentially serves a care management and navigation role for uninsured and underinsured residents of Durham County. A unique aspect of the HRSA funding was that "grants were given only to consortia of local providers, not to individual institutions."[6] Thus the HRSA funding was an early impetus in the founding of the Partnership. In 2006 the HRSA program was defunded and fiscal responsibility for the Durham LATCH program was picked up by the Duke University Health System. It is currently housed in the Duke Division of Community Health, which provides services to uninsured and under-insured residents of Durham County. Project Access of Durham County (PADC) is an organized system of health care provided to low income uninsured Durham County residents on a voluntary basis at no charge by physicians and other health care practitioners, hospitals, laboratories, pharmacies, and other health service providers. The Partnership was one of the original partners that came together in 2006 to advocate for improved healthcare access for the uninsured in Durham County. An IDI participant also mentioned that the Access to Care committee has developed

> *"SOME MEDICAL RESPITE FOR HOMELESS PEOPLE WHO ARE HOSPITALIZED AND THEN HAVE NO HOME TO GO TO WHEN THE HOSPITAL IS READY TO DISCHARGE THEM, …WHICH IS… A SIGNIFICANT CHALLENGE FOR MANY COMMUNITIES." (IDI PARTICIPANT)*

One IDI participant described **engaging the community** in the Partnership leadership as a success in that one of the committees has a co-chair who was a community volunteer. This participant also noted "*WE'VE*

---

[4] For more information about Project LATCH, visit https://sites.duke.edu/latch/
[5] For more information about Project Access of Durham County, visit http://www.projectaccessdurham.org/
[6] See program description provided by NORC at the University of Chicago at
http://www.norc.org/Research/Projects/Pages/healthy-communities-access-program-community-coalitions.aspx

DONE THE COMMUNITY HEALTH ASSESSMENT. WE'RE FOCUSING OUR VISION AND OUR OBJECTIVES OVER WHAT THE ASSESSMENT SAID ABOUT COMMUNITY." Relatedly, a FGD participant perceived that one of biggest strengths of the Partnership and the reason it is able to engage the community is because of its inclusiveness:

> *"I THINK ANOTHER STRENGTH [OF THE PARTNERSHIP] IS THAT LIKE ANYONE CAN COME, AND THAT'S KIND OF NICE IF YOU DON'T HAVE TO FEEL LIKE YOU NEED PERMISSION AHEAD OF TIME... ANYONE FROM THE COMMUNITY IS WELCOME AT ANY TIME TO BRING THEIR IDEA OR JUST SIT IN AND LEARN WHAT WE'RE TALKING ABOUT." (FGD PARTICIPANT)*

However, it should be noted that the issue of community engagement nonetheless emerged in both the qualitative and survey data as an important challenge to be addressed.

Another area of success described by two FGDs participants was that the Partnership, in collaboration with other organizations, has developed a **resource directory/guide** with consolidated information on where to access different health care services in Durham, serving as a good resource to providers and the community at large.

Four interview respondents specifically talked about the value-added of the $25,000 Durham County **Robert Wood Johnson Foundation Culture of Health Prize** that was used to fund Partnership committee activities. The Partnership leadership developed a mini-grant process after receiving the funding:

> *"ROBERT WOOD JOHNSON FOUNDATION GAVE [DURHAM] $25,000. WE [PARTNERSHIP FOR A HEALTHY DURHAM] USED THAT MONEY TO FUND DIFFERENT GRANTS OR PROJECTS THAT WERE SUBMITTED WITHIN THE PARTNERSHIP... SO STI/STDS, ACCESS TO CARE [COMMITTEE]... EVERYBODY WOULD SUBMIT A GRANT PROPOSAL." (IDI PARTICIPANT)*

> *"...WE DECIDED AS A CONDITION OF THE MINI-GRANTS, NOT JUST TO MAKE IT OPEN TO ANYONE, BUT THIS WOULD BE A REWARD FOR THE PARTNERSHIP. SO [APPLICANTS] HAD TO BE A [PARTNERSHIP] MEMBER FOR AT LEAST A YEAR AND THEN WHATEVER PROJECT THEY APPLIED FOR HAD TO ALIGN WITH THE COMMITTEE ACTION PLAN AND SO THESE PROJECTS ARE COMING OUT [OF] WHAT THE COMMITTEES ARE ALREADY ADDRESSING AND WORKING ON..." (IDI PARTICIPANT)*

Further detail regarding the RWJF mini-grant projects, their provisions/scope and the accomplishments of each are provided in a separate report (see Appendix A for details).

Challenges or Areas for Growth

The biggest challenge identified by survey participants was the issue of **having sufficient monetary and people power resources**. The overall factor score for resource sufficiency was 2.9 indicating that it was an area of concern for the Partnership.

Extent to which the Partnership sees having sufficient monetary and people power resources as its biggest challenge

Wilder inventory statements	% who agree or strongly agree
The Partnership for a Healthy Durham has adequate "people power" to do what it wants to accomplish	20%
The Partnership for a Healthy Durham has adequate funds to do what it wants to accomplish	12%
5 4 3 ⭐ 2 1	

<p align="center">Factor score = 2.9 (concern)</p>

Funding

Important funding sources that helped to establish the Partnership in the early 2000s have disappeared. In addition to the HRSA funding previously described, two IDI participants talked about previously receiving Results-Based Accountability (RBA) mini-grants from the state to perform Partnership tasks. However, that RBA funding stream is no longer available, a change that prompted at least some in the Partnership to seek other sources of funding:

> *"…WE APPLIED … FOR A MINI GRANT TO PROVIDE AFTER-SCHOOL SNACKS… THIS WAS A MINI GRANT THROUGH THE RBA PROCESS THAT WE APPLIED FOR. AND SO NATURALLY THE QUESTION IS WHEN THE RBA PROCESS SORT OF WENT AWAY, THE COUNTY FELT … THEY NO LONGER NEEDED TO CONTINUE IT… WE THEN AS A GROUP BEGAN TO LOOK FOR OTHER FUNDING STREAMS BECAUSE THESE WERE INTERVENTIONS THAT WE VALUED." (IDI PARTICIPANT)*

Sustainable funding to support projects and activities is an ongoing challenge. One interview participant highlighted that although the Partnership received the $25,000 RWJF Culture of Health Prize award and committees received mini-grants from that award, the funding is not a renewable stream of support for committee activities. *"[IT'S] MORE OF A ONE-TIME KIND OF FUNDING SOURCE THAN ANY KIND OF ONGOING FUNDING FOR SPECIFIC ACTIVITIES OF VARIOUS COMMITTEES."* Nonetheless, the RWJF monies offer the potential for leveraging other resources. As noted previously, one participant reported that the HIV/STI committee received additional funding from North Carolina Central University's Campus Community Coalition, Substance Abuse and Mental Health Services Administration (C3 SAMHSA) project as that project's community partner. This funding from the US Department of Health and Human Services' SAMHSA will be used to supplement the committee's activities.

Three interview participants noted that the Partnership is housed within the DCoDPH and the coordinator's position is supported within the County's budget. One noted that this was "*SOMETHING NEW FOR US 'CAUSE … WE HAD A COORDINATOR BEFORE, BUT … I DON'T THINK IT WAS PARTICULARLY IN THE BUDGET [IN THE PAST].*" Another noted that targeted government funding is sometimes available, stating that "*THERE ARE SOME FUNDS AVAILABLE FROM THE STATE, LIKE … A FEW THOUSAND DOLLARS AVAILABLE EVERY YEAR, BUT IT'S ONLY AVAILABLE FOR LIKE OBESITY AND CHRONIC ILLNESS-RELATED THINGS.*" It was also noted that Partnership members have access to "*THINGS THAT THE HEALTH DEPARTMENT STAFF AND COUNTY STAFF DO, TRAININGS AND OPPORTUNITIES [TO PURSUE] ADDITIONAL FUNDING.*"

One participant reported that the Partnership is seeking a Duke Endowment grant that would allow it to hire additional staff for the Partnership in order to assist with evaluating Partnership activities. "*WE WANT SOMEONE WHO'S LIKE AN EVALUATOR/QI [QUALITY IMPROVEMENT] PERSON,*" this person said, "*TO LOOK AT THE BIGGER [PARTNERSHIP] PICTURE, THEN LOOK AT PROJECTS, … AND DEVELOP TOOLS, … BUT THEN ALSO DO A QI.*" One IDI participant mentioned that they relied on funding donations and donated meeting space to support an annual event in the community. "*ONCE WE GOT THE FIRST COUPLE OF EVENTS DONE, THEN WE HAD SOME CARRY-OVER MONEY THAT WE USED,*" this person said. "*THEN AS PART OF THE EVENT WE WOULD CONTACT LOCAL PROVIDERS AND ASK FOR A DONATION … WE HAD SOME THAT WOULD … JUST GIVE THEM SOME [PRO BONO] MEETING SPACE. SO THAT'S WHAT FUNDED THE EVENT.*"

Two IDI participants said the Partnership is currently looking into writing more grants in order to get funding to support their activities "*BECAUSE WE KNOW THAT WE NEED THAT TO SUPPORT OUR VISION.*" The OCI committee was specifically noted in discussions of grant writing, based on their membership's expertise and affiliation with organizations that are constantly writing grants.

> "*… WE APPLIED FOR A LOT OF MINI GRANTS THROUGH OBESITY AND CHRONIC ILLNESS COMMITTEE. AND WE WERE USED TO APPLYING FOR MINI GRANTS BECAUSE THAT'S WHO WAS IN OUR GROUP. WE HAD RESEARCHERS IN OUR GROUP AS WELL, WHO ARE USED TO APPLYING FOR MONEY. WE HAD JUST SOME OF THE FOLKS WHO ARE POSITIONED IN THEIR ORGANIZATIONS [AND] WERE USED TO APPLYING FOR MONEY… IF ONE FUNDING SOURCE DRIES UP, WELL, LET'S IDENTIFY ANOTHER FUNDING SOURCE. THAT WASN'T THE CULTURE WITHIN SOME OF THE OTHER GROUPS.*" (IDI PARTICIPANT)

Some participants however cited challenges in applying for funding that grew out of the Partnership's being housed within the County government. Bureaucratic impediments at both the State and County level can lead to delays in implementation, and some funding (e.g., donations from local businesses) cannot be funneled through these government channels to support activities. The decline in State and County funding combined with these impediments have increased reliance on Partnership member organizations as funding conduits to support activities and projects. However, many organizations lack the resources to lead the way in seeking and managing resources to specifically support Partnership work. Those that have such capacity generally also have overhead costs that many funding sources will not cover.

> "*SO THERE'S SOME GRANTS THAT WE CAN'T APPLY FOR, ONE OF OUR PARTNERS HAS TO APPLY FOR, YOU KNOW, WHICH AT TIMES IT'S OKAY BUT THEN, … SOMETIMES IT COULD PRESENT SOME DIFFICULTIES.*" (IDI PARTICIPANT)

Membership Challenges

Regarding other areas for growth, survey participants indicated that the Partnership could benefit from **developing more clear roles and guidelines and in attracting a more appropriate cross-section of members** to the collaborative. In terms of roles and guidelines, less than half of the participants agreed or strongly agreed with the inventory statements around understanding of roles, processes and timelines, indicating that this was an issue of borderline concern that deserves discussion.

Extent to which members feel the Partnership for a Healthy Durham could benefit from developing more clear roles and guidelines

Wilder inventory statements	% who agree or strongly agree
Members of the Partnership have a clear sense of their roles and responsibilities	39%
There is a clear process for making decisions among Partnership members	42%
Members of the Partnership have a clear understanding of tasks that they are expected to complete and timelines for completing those tasks	41%
5　　　4　　★3　　2　　1	

Factor score = 3.3 (borderline concern)

Similarly, the average score across the two statements about **membership representativeness** was 3.5, indicating that this also was an issue of borderline concern that deserves discussion.

Extent to which the Partnership sees membership representativeness as a concern

Wilder inventory statements	% who agree or strongly agree
All the organizations that we need to be members of the Partnership for a Healthy Durham have become members of the group	23%
The people involved in the Partnership for a Healthy Durham represent a cross section of those who have a stake in what we are trying to accomplish	69%
5　　　4　★3　　2　　1	

Factor score = 3.5 (borderline concern)

Clarification of membership was also noted as an area for development. During study data collection, the Partnership did not have a specific definition of what was required to be considered a member. Any individual who expressed an interest or attended a meeting could add his or her name to the Partnership membership listserv and all individuals in attendance at a given meeting were allowed to vote regardless of their previous level of activity or attendance. A FGD participant stated that one is considered a member so long as s/he is still active on the Partnership listserv.

> *"…I ACTUALLY ASKED THE CHAIR IN THE LAST MEETING THAT WE HAD BECAUSE I HAD BEEN INACTIVE FOR A LITTLE BIT, AND SHE SAID BASICALLY… UNLESS YOU TELL ME YOU WANT TO BE OFF OF THE EMAIL LIST AND THAT YOU DON'T WANT TO PARTICIPATE ANYMORE, YOU'RE STILL CONSIDERED A MEMBER." (FGD PARTICIPANT)*

Only 34% of the survey participants responded yes to the survey question, "Do you think it would benefit the Partnership to have a specific definition of membership?" though less than half of these participants provided concrete suggestions for what the definition of membership should be (see Table 4). Among the roughly 15% of participants who provided concrete suggestions, eight people mentioned that the definition of membership should be determined by meeting a minimal attendance requirement.

One IDI participant stated that discussions have been held about whether to have members attend a particular number of meetings in order to vote on any Partnership agenda are underway. "*IT'S KIND OF AN ISSUE IF PEOPLE COME AND GO,*" this participant said. "*WE'VE TALKED ABOUT [REQUIRING] VOTING MEMBERS [TO] HAVE TO [ATTEND] A CERTAIN NUMBER OF REQUIRED MEETINGS. LIKE ANYONE CAN ATTEND, BUT TO VOTE ON WHAT IS CHOSEN ON OUR ACTION PLAN, YOU HAVE TO… COME TO SEVENTY-FIVE PERCENT OF THE MEETINGS OR SOMETHING LIKE THAT.*"

Table 4: Three types of membership definition suggestions provided by participants and an example of a suggestion given for each category.[1]	
	N (%)
Demonstration of greater commitment to goals of the Partnership	10
Example: Membership should reflect the contribution towards a committee or the goal of the organization to foster participation in outcomes	
Attendance at a certain number or percentage of meetings	8
Example: Attend certain number of meetings annually or subcommittee meetings	
Members should pay dues	1
Example: "I think paying dues also helps – maybe $5 a year, just something that helps solidify commitment to meetings"	

[1] Four others provided suggestions that were vague and therefore could not be categorized.

Engaging Community

On the survey, participants were asked the open-ended question, "What are some ways that the Partnership could do a better job **engaging the community** in its activities?" and were allowed to provide up to two suggestions in response. About half of the survey participants answered this question (47%). We categorized the responses of those who responded into six categories of suggestions (see Table 5). About one-third of the suggestions provided pertained to advertising/marketing and outreach/recruitment.

Table 5: Percent of all survey participants providing different categories of suggestions of ways to improve community engagement and one example of a suggestion given for each category.	
Category	N (%)
Advertising or Marketing	**17 (12%)**
Example: Work with the City to get information out, e.g. through water bills, about events and initiatives.	
Outreach or recruitment	**17 (12%)**
Example: Invite community support groups to participate.	
Miscellaneous specific suggestions	**14 (10%)**
Example: Provide transport to meetings for community persons.	
Changing meeting times and/or locations	**9 (6%)**
Example: I think if we want to engage more in the community, trying different locations in the community may help.	
Communication content	**6 (4%)**
Example: Provide better updates/descriptors of events and goals for each group	
Funding	**3 (2%)**
Example: Offer more grants	

In the IDIs, the time and location of meetings were mentioned by six of the ten IDI participants as determining factors for meeting attendance. It was generally recognized that those who attend the Partnership as community representatives and work full-time have difficulty finding the time to attend Partnership meetings. One participant talked about the possibility of holding meetings in the evening in community centers in an effort to increase community attendance, but also noted that this would then create challenges for the working professionals attending such meetings as part of their job:

> *"...WE'VE HAD A HARD TIME GETTING PEOPLE FROM THE COMMUNITY TO THE MEETINGS, AND SOME OF IT'S THE TIME OF DAY BECAUSE THE MEETINGS ARE HELD DURING THE WORKDAY, SO IT'S HARD FOR VOLUNTEERS TO GET THERE. THEY'RE HELD AT THE HEALTH DEPARTMENT, SO ... IT'S NOT IN THE COMMUNITY. BUT IT'S A BALANCING ACT. I'VE BEEN AT OTHER MEETINGS WHERE THEY HAVE IT IN THE EVENING IN THE COMMUNITY BECAUSE THEY WANT TO GET COMMUNITY MEMBERS, BUT THEN THEY DON'T HAVE ANY OF THE PROFESSIONALS THAT DEAL WITH THE ISSUE. SO IT'S REALLY HARD TO FIND THAT SPACE WHERE WE CAN GET COMMUNITY MEMBERS AT THE MEETINGS AND PARTICIPATING AS WELL..." (IDI PARTICIPANT)*

Another IDI participant mentioned the idea of faith-based community members playing a dissemination role in engaging with the community.

> *"THERE HAS BEEN AN ONGOING DISCUSSION ABOUT THE TIME OF THE MEETINGS...COMMUNITY PEOPLE CAN'T COME BECAUSE OF THE TIME. BUT SO THE QUESTION HAS BEEN CAN WE MOVE THE MEETING AROUND IN THE EVENING TO DIFFERENT PLACES? THAT HAS NOT HAPPENED. AND I THINK... I THOUGHT THAT THE INVOLVEMENT OF THE FAITH COMMUNITY WAS SUPPOSED TO ASSIST [WITH] THAT IN SOME REGARD SO THAT YOU WOULD HAVE, YOU KNOW, FAITH COMMUNITY MEMBERS WHO ARE OUT THERE WHO COULD PROVIDE THE INFORMATION ABOUT WHAT'S HAPPENING ON THE SUB-COMMITTEE, SO THAT THE COMMUNITY WOULD BE INVOLVED." (IDI PARTICIPANT)*

It was also noted that holding meetings in the evening would require additional resources. For example, one IDI participant said, "*IF YOU HAVE A MEETING THAT STARTS AT 5:00 AND IT'S GONNA GO TO 6:30, AND YOU'RE NOT PLANNING ON FEEDING PEOPLE, THAT'S ROUGH.*"

On the survey, participants were asked the question, "Would you like to see the Partnership rotate its meetings to hold them alternately in different locations?" Of 105 survey participants who answered this question, 23 participants or 22% of responding participants responded affirmatively. Of these, 13 provided responses to the open-ended question which asked for suggestions of where future meetings should be held (see Table 6).

Table 6: Suggestions provided by 13 survey participants for specific places to hold future meetings	
Locations	**N**
Hold meetings in a location in the community or "in the neighborhoods that we are looking to assist"	4
Hold meeting in the library	3
Hold meeting in the offices of member organizations All of the following specific locations were mentioned by one or more participants: FHI 360 building, CAARE, Inc., W.D. Hill Community Center, Durham Public Library, South Durham, the Durham Center for Senior Life, Holton Career Center, Lincoln Community Health Center meeting rooms, Lyon Park, and El Centro Hispano.	6

Structural changes in the Partnership and stigma related to committee focus areas (i.e., substance abuse, mental health, HIV/STIs, obesity) were mentioned as additional challenges to engaging the community. With regard to structural changes, one IDI participant noted that "*ONE OF THE THINGS WE LOST GOING FROM PROJECT STRAIGHT TALK TO THE PARTNERSHIP FOR A HEALTHY DURHAM WAS REAL COMMUNITY INPUT… THERE WERE MANY MORE PEOPLE WITH HIV WHO WERE THERE, THERE WERE GRANNIES. THERE WERE WOMEN WHOSE HUSBANDS WERE INFECTED. WHO WERE STAKEHOLDERS IN THAT THEY WERE INFECTED OR THEIR HUSBANDS WERE INFECTED. SO WE LOST THAT GOING [TO] THE PARTNERSHIP BECAUSE I THINK THAT IT WAS HARDER FOR THEM TO HAVE A VOICE BECAUSE WE WERE HAVING TO MAKE THESE FIVE-YEAR PLANS … THEY WANTED TO TELL THEIR STORY, AND THAT PLATFORM HAD KIND OF BEEN LOST FOR THEM.*" *(IDI participant)* Stigma was cited as a perceived reason for some of the committees within the Partnership lacking community members' involvement. As one person noted, "*NOBODY WANTS TO BELONG TO THE OBESITY GROUP OR …HIV AND AIDS. I MEAN, … IT'S TOUGH TO GET THE COMMUNITY'S SUPPORT.*" *(IDI participant)*

Three IDI participants suggested counteracting these additional challenges by having Partnership members that are working in the community to actively recruit community members into various committees on the Partnership.

> "*…I DON'T WANT TO JUST INVITE ANYBODY, BUT DO WE HAVE AN ACTUAL SET GUIDELINE THAT WE WANT TO MAKE SURE WE'RE MEETING? LIKE, OH, YOU KNOW, ARE THEY A LEADER? YOU KNOW, ARE THEY INVOLVED WITH THE COMMUNITY? … BECAUSE YOU CAN INVITE SOMEBODY THAT'S IN ACADEMIA, BUT NEVER STEPPED FOOT IN THE COMMUNITY. THEY'RE NOT GONNA REALLY DO MUCH FOR US… YOU'LL DO STUFF FOR US, BUT MAYBE, YOU KNOW, INVOLVED IN THE COMMUNITY, YOU WON'T REALLY BE THAT HELPFUL.*" *(IDI participant)*

Study Limitations

Our study was not without limitations. As a result of study timeline and funding constraints, data was collected at one point in time therefore limiting our ability to examine changes over time or make any statements about causal relationships in the data. Only about a quarter of all individuals whose email addresses were on the Partnership listserv at the time of this study participated in either the survey or the in-depth interviews. As with any study relying on small sample sizes, the generalizability of our findings is limited. In addition, this limited rate of participation is likely to have resulted in non-response and sampling biases in our data. For instance, there exists the possibility that members who chose not to participate in the survey may be those who participate less regularly in Partnership activities and therefore have systematically different viewpoints about its functioning. The non-response bias both in participating in the survey and in responding to certain sections of questions on the survey limits our ability to accurately determine the breadth of individual demographics, and organizational sectors and relationships represented on the Partnership. Finally, due to the condensed nature of this evaluation this study was purely exploratory and we were not able to collect data to confirm the data's support of a specific theory or model.

RECOMMENDATIONS

As requested by the Partnership for a Healthy Durham, the FHI 360 study team provide the following recommendations based upon the study findings presented in this report.

1. Streamline email communications. The email listserv provides a valued means of communication and engagement for all members, regardless of how active they are. However, information-heavy emails tend to be overwhelming and may not get read. Alternative formats should be explored. Specifically, we would suggest altering the format of emails so that they provide short topic headings in the body of the email and then links to connect interested readers to more detailed information online.

2. Continue to use multiple communication channels. Results from both the survey and the interviews clearly indicate that one size does not fit all with regards to the preferred communication channel in the Partnership. Members report using a variety of communication channels to keep themselves and their constituents informed and to stay connected with other members. In light of these results and the large number of members ranging in age and access to and familiarity with different communication platforms and technologies, we would recommend that at present the Partnership maintain all the communication channels currently being utilized in order to reach the broadest audience.

3. Explore the underlying reasons for the mixed views members express about the perceived levels of commitment, effort, and trust. Exploring and coming to understand the extent to which these mixed views reflect structural constraints or barriers as opposed to statements about people will determine how perceived low levels of commitment, effort, and trust among some members can be overcome. For example, do these issues reflect instances of poor fit between Partnership projects/activities and organizational priorities of the members? Do they reflect funding or other resource limitations on effectiveness? Do they reflect instances where committee projects/activities reflect individual priorities rather than a broader committee consensus?

4. Establish a cross-cutting committee or work group to address funding challenges. Many members and their organizations have limited capacity to pursue funding opportunities, lack the required structures to be eligible to receive funding, are prohibited from accepting donations, or have institutional overhead costs that create barriers to managing some of the grants that would otherwise be viable opportunities to support Partnership projects and activities. Expertise to address these challenges is not available in all of the committees, and some funding opportunities could potentially support cross-cutting committee activities.

5. Develop clearer decision-making guidelines within committees. Everyone recognizes the value and power of the Partnership's open membership. People in general do not want to restrict membership but express concerns about informed decision-making if anyone can vote on issues

regardless of their level of previous engagement on those issues. As such, while we would not recommend that the Partnership adopt any criterion for membership eligibility, we would recommend that the Partnership adopt voting eligibility criteria for its membership. Specifically, we would suggest something along the lines of requiring participation in the previous 2 out of 3 meetings in order to vote on an issue within a committee.

6. <u>Seek innovative ways to balance community and organizational representation within the Partnership</u>. Many people noted the challenge of holding meetings at times and in places that work for both grassroots community members and people working in organizations that directly address the Partnership's priorities. Rather than trying to find a one-size-fits-all solution, we recommend that the Partnership consider the different constituency needs and shape multiple strategies to foster leadership, voice, and decision-making roles. Approaches may need to vary in structure, strategy and process for different committees. For example, some committees may be best served by holding meetings alternately in the community and at a central organizational location whereas others may be better served by holding meetings at a regular location. Another example might be to hold semi-annual meetings in community settings in addition to the quarterly full partnership meetings.

7. <u>Make people aware of their process and product accomplishments and celebrate milestones achieved along the way</u>. As evidenced in the survey results, when participants were asked to list key outcomes achieved by their committees, few survey participants articulated key outcomes in terms of impacts at the individual and community-level. Similarly, in the interviews participants discussed the challenges of the long horizon needed in order to see impacts occurring at the community and individual-level. Nonetheless, survey and interview participants did articulate a variety of key outcomes and products that they had achieved in the process of working towards the larger impacts. In order to sustain momentum and motivation among Partnership members, we would suggest that the Partnership leadership find ways to regularly celebrate and disseminate the milestones they have achieved in the process of their collaboration.

8. <u>Make members more aware of the cumulative impacts of their work.</u> People are not always aware of the bigger picture and longer-term successes achieved by the Partnership, especially those outside their own committees or from earlier years. Telling the story of cumulative success may be especially important for mentoring emerging leaders on how to build toward larger goals and accomplishments, and how to overcome challenges such changes in funding.

In summary, the findings of this study indicate that there are various challenge areas to be addressed within the Partnership for a Healthy Durham. The recommendations provided in this report offer suggestions for addressing such challenges. The study findings also highlight that the Partnership has an array of strengths that can be utilized and further developed to support the Partnership's efforts to collaboratively improve the quality of life of the Durham community.

"I THINK [THE PARTNERSHIP LEADERS] … ARE COMMITTED TO A HEALTHIER DURHAM AND A HEALTHIER COMMUNITY, AND THEY RECOGNIZE THAT IT DOES TAKE A VILLAGE. IT TAKES A LOT OF PEOPLE WORKING TOGETHER, PUTTING THEIR SHOULDERS TO THE WHEEL TO MAKE POSITIVE CHANGE, AND THAT POSITIVE CHANGE TAKES TIME.

IT TAKES A LOT OF WORK." (IDI PARTICIPANT)

REFERENCES

Baldauf, A., Reisinger, H., & Moncrief, W. C. (1999). Examining motivations to refuse in industrial mail surveys. *International Journal of Market Research, 41*(3), 345.

Greer, T. V., Chuchinprakarn, N., & Seshadri, S. (2000). Likelihood of participating in mail survey research: Business respondents' perspectives. *Industrial Marketing Management, 29*(2), 97-109.

Guest, G., MacQueen, K. M., & Namey, E. E. (2011). *Applied thematic analysis*: Sage.

Hager, M. A., Wilson, S., Pollak, T. H., & Rooney, P. M. (2003). Response rates for mail surveys of nonprofit organizations: A review and empirical test. *Nonprofit and Voluntary Sector Quarterly, 32*(2), 252-267.

Mattessich, P. W., Murray-Close, M., & Monsey, B. R. (2001). *The Wilder Collaboration Factors Inventory: assessing your collaboration's strengths and weaknesses*: Wilder Pub. Center.

QSR International Pty Ltd. (2012). NVivo qualitative data analysis software.

Tomaskovic-Devey, D., Leiter, J., & Thompson, S. (1994). Organizational survey nonresponse. *Administrative Science Quarterly*, 439-457.

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