Fostering Organizational Change Through a Community-Based Initiative

Sue A. Kaplan, JD
Neil S. Calman, MD
Maxine Golub, MPH
Charmaine Ruddock, MS
John Billings, JD

Program funders and managers are increasingly interested in fostering changes in the policies, practices, and procedures of organizations participating in community-based initiatives. But little is known about what factors contribute to the institutionalization of change. In this study, the authors assess whether the organizational members of the Bronx Health REACH Coalition have begun to change their functioning and role with regard to their clients and their staff and in the broader community, apart from their implementation of the funded programs for which they are responsible. The study identifies factors that seemed to contribute to or hinder such institutional change and suggests several strategies for coalitions and funders that are seeking to promote and sustain organizational change.

Keywords: *organizational change; sustainability; collaboration; institutionalization; health disparities*

As part of a national program to help reduce racial and ethnic disparities in health, the Centers for Disease Control and Prevention (CDC) funded an effort in the southwest Bronx, New York, led by the Institute for Urban Family Health, to reduce morbidity and mortality resulting from diabetes and cardiovascular disease.[1] The coalition that formed to carry out this initiative—Bronx Health REACH—is currently implementing an ambitious program focused on both service delivery and advocacy. Through its community-based initiatives, which include a nutrition and fitness program, a faith-based outreach program, a training program for community health advocates, and a public education campaign, the coalition seeks to create model programs and to understand community needs. Through its mobilization and policy work, the coalition seeks to mobilize the community to press for legislative and regulatory changes that would support the growth and replication of effective programs and eliminate systemic barriers to care (Calman, 2005).

This two-pronged strategy grew out of the coalition's analysis of the obstacles to health in the community. Relying on focus groups with community residents (Kaplan, Calman, Golub, Davis, & Billings, 2006), a review of the literature on health disparities, and the members' own experience in accessing or providing care, the coalition, with the guidance and urging of the CDC, developed program logic models that laid out a strategy for the overall project and each of its initiatives (McLaughlin & Jordan, 1999; Renger & Titcomb, 2002). (The coalition's use of logic models for planning and evaluation is described in detail in Kaplan & Garrett, 2005.) This exercise, which entailed a careful articulation of the program's underlying theories and assumptions, raised concerns early on about the sustainability of the coalition's efforts, given that changes in individual and institutional behavior can take a long time to accomplish. Much of the literature about community coalitions focuses on the challenges of creating partnerships and managing collaborative processes (Mitchell & Shortell, 2000; Sofaer, 2000) and the difficulty of documenting

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The Authors

***Sue A. Kaplan**, JD, is an associate clinical professor at New York University's Robert F. Wagner Graduate School of Public Service and the associate director of the Center for Health and Public Service Research in New York City, New York.*

***Neil S. Calman**, MD, is president of the Institute for Urban Family Health in New York City, principal investigator for the Bronx Health REACH CDC and NIH programs, and clinical professor of family medicine at the Albert Einstein College of Medicine of Yeshiva University in New York City, New York.*

***Maxine Golub**, MPH, is the senior vice president for planning and development at the Institute for Urban Family Health and serves as the project administrator for the Bronx Health REACH program in New York City, New York.*

***Charmaine Ruddock**, MS, is the project director of the Bronx Health REACH program of the Institute for Urban Family Health in New York City, New York.*

***John Billings**, JD, is an associate professor at New York University's Robert F. Wagner Graduate School of Public Service and director of the Center for Health and Public Service Research in New York City, New York.*

their impact on health and well-being (Lasker & Weiss, 2003; Mitchell & Shortell, 2000; Provan & Milward, 2001). Less research has been done to understand what factors contribute to the ability of a coalition to sustain its efforts over time (Altman, 1995; Goodman, McLeroy, Steckler, & Hoyle, 1993; Goodman & Steckler, 1989; Holder & Moore, 2000; Lodl & Stevens, 2002). Indeed, there is some debate about what sustainability means in this context—whether it refers to a particular program, the benefits that result from the effort, the relationships that are formed among the partners, or the capacity and skills that have been developed (Cutler, 2002; Goodman & Steckler, 1989; Hawe, Noort, King, & Jordens, 1997; Jackson et al., 1994; Lodl & Stevens, 2002; Shediac-Rizkallah & Bone, 1998).

Recognizing that some of its programs might fail and that others would need to adapt in response to changes in the environment or to lessons learned, the coalition focused less on the sustainability of particular programs and more on developing a capacity and commitment among its members, who could then continue to initiate, support, and refine ongoing efforts to reduce health disparities and increase access to care. Sustainability, defined in this dynamic way, is dependent on the coalition members' developing an institutional commitment to the coalition's goals that extends beyond their implementation of a specific funded program (Bracht et al., 1994; Jackson et al., 1994; Shediac-Rizkallah & Bone, 1998). As part of an effort to identify the factors that might facilitate or impede this kind of organizational change, we sought to understand whether, as a result of their participation in Bronx Health REACH, any of the partner organizations have implemented their own institutional changes to support and promote healthy behaviors, particularly those related to diabetes prevention, detection, and management, or to increase access to health care services, apart from their implementation of the Racial and Ethnic Approaches to Community Health (REACH) programs for which they are responsible.

In a sense, these are baseline data. Although many of the partners have begun to make changes in their policies, practices, and procedures, these have been largely a byproduct of their program involvement and not a result of a planned coalition strategy. Moreover, we do not yet know whether or how long these changes will last. With the coalition now beginning to focus more deliberately on fostering institutional change, we plan to return periodically to assess the extent to which these changes are sustained and enhanced and other more targeted or strategic changes emerge.

METHOD

This study of institutional change among the coalition partners is a part of a larger evaluation of the coalition's work (Kaplan, Dillman, Calman, & Billings, 2004; Kaplan et al., 2006). This component utilized qualitative techniques. During the course of a 3-month period, in the 4th year of the coalition's funding, we conducted a total 17 on-site, individual, in-depth interviews with leadership and staff of 10 partner community-based organizations (CBOs). Although the coalition has more than 30 organizational members, we selected these 10 because of their involvement from the early stages of the initiative and their central role in implementing coalition programs. Unlike other organizational members of the coalition, these organizations all received funding (from $3,000 to $34,000 per year) through subcontracts with the lead organization. See Table 1 for a description of the partner organizations.

The research team used semistructured interview protocols to collect data on topics relating to each organization's participation in the coalition. The interview questions were derived from the literature concerning program sustainability and institutionalization (Goodman et al., 1993; Goodman & Steckler, 1989; Shediac-Rizkallah & Bone, 1998) and from our familiarity with the coalition and its goals and the work of the partner CBOs. The interview protocol included questions about service changes, managerial changes (including changes in the

TABLE 1
Partner Organizations

Type of Organization	*Date Joined the Coalition*	*Amount of Subcontract Per Year*	*Size*	*Bronx Health REACH Project*
Institute for Urban Family Health	1999	—	Four sites in the Bronx, serving approximately 12,800 patients.	Provide leadership and staffing to the Bronx Health REACH Coalition.
Community center with supportive housing	1999	$17,000-$18,000	3,200 clients per year in literacy classes, job readiness, placement and support programs, child care and youth programs, family support, and substance abuse treatment; 132 tenants housed in residential building. 25-30 participants in fitness center, 6-8 of whom are REACH clients.	Establish a fitness program for people with or at risk for diabetes. Run a train-the-trainer fitness program for the faith-based coordinators.
Community center	1999	$30,000-$31,000	4,800 clients per year in literacy programs, adult education and job training, community organizing, entitlement assistance, and youth programs, among others.	Employ two part-time community health advocates to provide two to three presentations or workshops a month and one-on-one counseling sessions to community members identified through general outreach or by institute health centers.
After school and day care program	1999	$13,000-$14,000	Serving 182 children in after school and day care.	Hire a nutritionist to develop and implement a nutrition curriculum for the after-school program.
Housing development corporation	1999	$10,500 (1 year only)	Approximately 6,000 tenants.	Supervise community residents to field a door-to-door survey concerning health knowledge, attitudes, beliefs, and behavior.
Community center and housing for seniors	1999	$33,000-$34,000	Job training and placement, adult education, social service programs, advocacy, and youth programs; 1,400 units of housing for low-income and senior citizens.	Employ three part-time community health advocates to provide two to three presentations or workshops a month and one-on-one counseling sessions to community members identified through general outreach or by institute health centers.

(continued)

TABLE 1 (continued)

Type of Organization	*Date Joined the Coalition*	*Amount of Subcontract Per Year*	*Size*	*Bronx Health REACH Project*
Church	2001	$3,000	Approximately 830 members.	Assign one coordinator from each faith-based organization to attend monthly meetings, sponsor health-related activities at his or her organization, and serve as a liaison to congregants.
Church	2001	$3,000	Approximately 300 members.	
Church	2001	$3,000	Approximately 160 members.	
Church	2001	$3,000	Approximately 2,000 members.	

organizational chart, supervision and evaluation of staff, programs for staff), diffusion of information or programs within the organization, skills development, funding (internal and external), relationships with other organizations (within and outside the coalition), compatibility with mission, and likelihood of program continuation. We also asked the key informants to reflect on the factors that aided or impeded their participation in the coalition and in their implementing changes within their organizations.

Each interview lasted approximately 1.5 hours. Extensive notes were taken and then coded by themes, which were verified with the interviewees, and analyzed (Rubin & Rubin, 1995). The analysis focused on whether, as a result of participation in Bronx Health REACH, the organization had made any changes in (a) its policies, practices, or procedures relating to its clients or members; (b) its policies, practices, or procedures for its staff; and (c) its function in the community in terms of the scope its mission and the role of its leadership. We also identified the barriers and facilitating factors that were articulated by the interviewees or were implicit in their explanations.

Following our analysis of the interview data, we presented our preliminary findings for discussion at a full coalition meeting, shared the draft with all interviewees, and then had more in-depth discussions with 6 of the key informants and the coalition's staff and principal investigator.[2] This participatory process was intended to enrich our understanding and to help the coalition develop strategies and identify potential levers for change (Minkler & Wallerstein, 2003).

FINDINGS

The coalition comprises a wide range of organizations—social service agencies, health care providers, a housing development corporation, an after-school program, and 14 churches. Several of these organizations worked together previously on other health projects, including the development of three community health centers in the Bronx with the Institute for Urban Family Health. Other members of the coalition, particularly many of the churches, had never before participated in any health-related activities or partnerships. The member institutions vary by size (from a housing development corporation with 6,000 tenants to an after-school program serving 182 children) and by type of service provided (health care, religious guidance, adult education, and social services). The role played by the partners in the coalition has also varied, with some providing services specified by contract (e.g., a certain number of presentations each month) and others working in a less prescribed manner (e.g., general liaison services; see Table 1). Not surprisingly given this variation, participation in the coalition affected the partners in a different ways and to different degrees, and various aspects of the coalition's work resonated differently within each organization.

Changes in Policies, Practices, and Procedures for Clients or Members

As a result of participating in the coalition, several partner organizations have begun to make changes to the policies, practices, and procedures affecting their

clients or members. The Institute for Urban Family Health, which initiated the coalition's effort to identify systemic disparities in access to health care services, sought to make sure that its own house was in order as it began to take a public role in critiquing how care is organized and accessed in New York City. In an effort to create a single system of care for its uninsured and insured patients, it has begun to restructure its Care for the Homeless program and its free clinic (the two main programs for uninsured patients) so that people entering the system through those doors have the same access to specialty and other services as the Institute's insured patients. In the case of the Care for the Homeless program, the Institute is implementing a plan to upgrade the program's physical space and create a new specialty care coordinator to assist patients in scheduling and keeping specialty appointments. The model of care for the free clinic was also changed. Instead of providing a separate system of care by supervised, rotating medical students, the clinic was redesigned to serve as an entry point to the Institute's main system of care.

Participation in the coalition also led the Institute to approach other aspects of patient services with a heightened awareness. By participating in the analysis of the coalition's early focus groups with community residents and through discussions with community partners, the Institute's leadership became acutely aware of the communication barriers between patients and providers and patients' mistrust of the medical system. In implementing its new electronic medical record system, the Institute saw an opportunity to address some of these issues, designing the electronic record to serve as a "shared tool that patients and doctors use together to manage prevention and treatment of illness." To facilitate this patient-doctor interaction, they installed flat computer monitors and printers in every examination room at considerable additional expense and have encouraged staff to use the new system to serve as a communications tool. Similarly, participation in the coalition created pressure to maintain a costly diversity training program for all staff members. Senior staff believe that this program "might well have been eliminated during tough economic times" had it not been for the Institute's participation in Bronx Health REACH and the "understanding that gave us of this issue and its importance in achieving high quality care."

Several of the churches that are part of the coalition's faith-based initiative also changed practices and procedures that affect their members in ways that extend beyond the funded initiative. Many of the pastors routinely incorporate health messages into their weekly sermons, and many of the churches include clippings and other health-related materials (some provided by the coalition and some from other sources) in the weekly church bulletins. In addition, on their own initiative, nine faith-based culinary committees are meeting monthly to learn how to cook with less salt and fat, how to modify traditional recipes, and how to prepare healthy and tasty vegetables. Several of the churches are now tackling the problem of how to ensure that the culinary committees are part of the menu planning process for events sponsored by other ministries. As one key informant explained, "We need to provide them with enough information and authority so that they can defend their position about healthy food preparation." One of the churches has changed the free food it provides through its Hunger Ministry, and several have substantially cut back and, in one case, eliminated all fried foods from church banquets and other events (Kaplan, Calman, Golub, Ruddock, & Billings, 2006).

The after-school program, which implemented a nutrition curriculum for children as part of Bronx Health REACH, also altered its policies and practices for how it provides food to all of the children and staff at the day care and after-school center. Because the center administrator found that it was impossible to purchase commercially prepared, healthy meals, the center now prepares its own food and routinely submits those menus for government approval. This change in practice resulted in additional expenses that were not funded through the REACH program, including the purchase of a commercial freezer, the creation of a code-compliant pantry, and the training of staff to prepare the food and maintain the kitchen. All food is now served family style so that children (and staff) learn about portion size and develop the socialization skills of communal eating. In addition, the center has sought grant funding to cover the costs of child care so that parents can attend workshops on nutrition, and the center's director is working to create a food purchasing coop and family exercise program.

Other partner organizations have done little to change the policies, practices, and procedures affecting their clients beyond the direct implementation of the REACH program. One seniors program invited their community health advocates to make presentations to their clients and residents, and another community center incorporated the coalition's statewide advocacy agenda into its citizenship classes, using a letter-writing campaign to elected officials to teach people how to participate in government. But neither organization has made health education part of its curricula or regular programming or developed any client screening mechanisms to help facilitate access to care or preventive health services. In the case of the seniors program, program leadership found it difficult to connect to other parts of the agency

because of staff turnover, "turf" issues, and competing priorities. In the case of the community center, the coalition's broad approach and its community health advocate model did not fit easily into its very local, grassroots philosophy and structure. The center's current leadership, who were not involved in the original design of their REACH program, are skeptical about the ability of their community health advocates, who have low levels of education and little work experience, to serve as emissaries for the program.

Two of the larger coalition partners (the housing development corporation and the community center with supportive housing) have passed information along to residents and clients, but neither has undertaken any other efforts to foster healthy behavior among clients or residents or to change the curricula or the food served in children's programs. In both of these organizations, their REACH programs are a very small and discrete piece of a much larger operation.

Changes in Policies, Practices, and Procedures for Staff

Although the coalition did not sponsor or support any programs or initiatives directed at staff, the program administrators in all of the partner organizations recognized the need for their employees to be better informed about health issues and to develop healthy eating and exercise habits. Many expressed concern about their employees' health status. As one program director said, "In my years here, I have watched the health of the staff deteriorate due to stress, poor nutrition, lack of knowledge." Growing out of their work in the coalition, many of the organizations instituted programs to address this issue.

Two of the partner organizations independently sought out grant funding to enable them to put health and wellness programs in place for their staff. One community center received a grant from its parent organization to create a holistic health program that supports staff workshops on preventive health, including yoga and nutrition. The other organization received a small grant that allowed them to provide the staff with free membership and extended hours in its fitness center and supported workshops on healthy eating. This program has remained in place even after the grant period ended.

Other efforts to change staff health habits are beginning to occur in some of the partner organizations. In addition to staff discussions and workshops about nutrition, the agency responsible for the fitness program changed the food that is served at managers' meetings and, for a period, offered healthier choices in the office vending machines. (With a new vendor, this arrangement now needs to be renegotiated.) Growing out of the REACH survey of community grocers, staff of one community center persuaded a nearby deli to offer healthy foods. The after-school program requires that the staff be present to supervise the children when the nutrition classes are held, thereby deliberately exposing the staff to this curriculum and to the healthier food now offered by the program. The Institute for Urban Family Health has provided financial support for a staff Weight Watchers program, in part because it was "perennially embarrassing for the leadership to be involved in REACH and to be overweight." Although outreach to Institute staff has been quite limited, materials about diabetes and nutrition are now included in staff mailings, and the staff of one of the health centers have developed their own fitness and nutrition program, setting goals and timelines.

Neither the housing corporation nor the seniors program has initiated any health programs for their employees, although some referrals have been made for staff with diabetes-related problems, and in neither organization have staff been made aware of the coalition's work. In the case of the housing corporation, which has only sporadically undertaken activities for Bronx Health REACH, the director believes that "there is not enough activity level [within the organization] to draw attention to program." At the seniors program, the primary problem seems to be an overstretched staff and concerns about program turf.

Changes in Mission and Leadership

The coalition's focus on eliminating racial and ethnic disparities in access to high-quality health care has resonated with some of the partners and has begun to transform how the leadership sees their organization's mission and role. For a number of the churches, exposure to the issues of racial and ethnic disparities in health has, as one pastor put it, been "an illumination," providing "a new way of seeing the world" and, as a result, a new way of seeing the role of the church in the community. The coalition's emphasis on community organizing around access to care and equal treatment struck a cord with the pastors, who have roots in or identify with the history of the Civil Rights Movement, and with one of the faith-based coordinators, who has a background in liberation theology in Latin America. Several of the pastors have become spokespersons on the issue of health disparities, bringing this perspective and passion to other activities, including membership in local and national associations of religious leaders and, in one case, the community board of a hospital. Similarly, the leadership of the Institute for Urban

Family Health has become increasingly outspoken about the role that race and ethnicity play in health and health care, and its reputation and professional identification with these issues has grown within the city and state and on the national level. The Institute's leadership brings this perspective to bear in its participation in professional organizations, speaking engagements, testimony, grand rounds, and local and national advisory groups.

A number of community leaders, however, have not felt ready or comfortable with the notion of bringing the disparities message back to their organizations or integrating this perspective into their work. Several stated that they did not feel knowledgeable enough about the problem of racial and ethnic disparities to speak to staff members or clients. Others felt that this issue would not resonate within their organizations or with their constituencies. One coalition member commented that it is not easy to discuss issues of race and discrimination in our society.

For several of these partners, the coalition's health messages, particularly those concerning the importance of nutrition and exercise, have had a greater impact on the organization's sense of its role in the community. The integration of health issues into an organization's mission in some cases grew out of a recognition that the problems faced by clients or residents are complex and, as one person said, "Solutions need to be complex and interrelated too." For some, this connection between health issues and other socioeconomic problems was a new insight. For example, one program administrator noted that, "When this project first started, I couldn't understand how it fell into a social work department. But now it is part of me. All of these issues are linked by the needs of the people we serve."

One partner organization had been operating a number of small health programs in addition to its work with Bronx Health REACH, but always in a way that had been, as one key informant stated, "external to its core operations." With their work as part of the coalition, they have come to recognize the centrality of health issues to their clients. These programs have now reached a critical mass and have begun to "migrate to the core" to form a new organization-wide health initiative, with its own database for health-related referrals (parallel to the database they have already for social service referrals).

The coalition's health messages also resonated with the clergy members of the coalition. Many of the church leaders view health in a religious context and as a core tenet of their church's mission. As one pastor stated, "We can't separate our Christian lives from how we treat our bodies." The theme of the "body as the temple of the Lord" has emerged in sermons, written materials, prayers that begin meetings, and conversations with the participants.

By contrast, neither the coalition's health nor its disparities agenda has taken hold at the housing corporation, despite the fact that health is nominally part of the organization's "comprehensive approach." Over the years, this organization has participated in a number of health-related initiatives, but they have never integrated them into their main line of business: "providing safe and affordable housing." The director reports that they are eager to participate in a Bronx Health REACH initiative, but because their "core activity" is providing housing and not "health advocacy," they are looking to the "professionals" on the coalition staff to design a program they can "plug into." Although the housing corporation has access to many residents and runs several programs that could participate in the coalition's work (e.g., the after-school program, the youth development program), the coalition has not yet found a way to tap into this resource, and the housing corporation has not seen participation as integral to its mission or fitting with its entrepreneurial, go-it-alone style.

DISCUSSION

In this work, we have sought to understand the extent to which, as a result of their participation in the Bronx REACH coalition, the partner organizations have changed their policies, practices, and procedures—their way of doing business—and their role in the community. In other words, we have sought to understand what are the collateral "organizational legacies" (Lodl & Stevens, 2002) that have resulted from the coalition's work to date and what it is about the organizations and their relationships to and role in the coalition that has facilitated this kind of change.

One limitation of this study is that it only addresses the early signs of change among the organizational partners. This kind of institutionalization of program goals may be necessary but not sufficient to sustain an organization's commitment during the long term. We do not yet know if these changes will be sustained or if other changes will occur during the next few years. For this reason, we plan to periodically assess the policies and practices of the partner organizations, supplementing key informant interviews with surveys of staff.

In addition, this study looked solely at organizational change and not the impact of organizational change on the behavior of community residents, which is the ultimate goal of the initiative. Other components of the program evaluation are exploring whether, as a result of the coalition's activities, people learn more, behave differently, pass information along to friends,

neighbors, and relatives, and even live longer and healthier lives.

Third, because the changes we observed were an unplanned byproduct of coalition activities and not part of its initial strategic plan, we had no preexisting matrix for measuring them and assessing their value. Indeed, the changes ranged all over the lot, from fairly significant modifications in operating procedures (e.g., the Institute's reengineering of its free clinic), to more minor but still hard-fought changes (e.g., persuading the local deli to offer healthier food choices). They varied not just in terms of size and potential impact but also in terms of focus, with some organizations addressing the issue of access to care and others focused on healthy behaviors. Our goal was to catalogue and understand the changes retrospectively and to begin to identify the factors that seemed to facilitate their occurrence.

Despite these limitations, we learned several key lessons that will guide the coalition's future work and may help other partnerships and funders that are seeking to promote organizational change. First, it is important from the start to encourage the partner organizations to take an active role in defining the coalition's mission and developing its programs. Those Bronx Health REACH partners that have begun to make organizational changes were ones in which, from the start, the leadership played a strong part in shaping the coalition's agenda and in defining the nature of their organizations' participation. For example, the Institute for Urban Family Health, several of the churches, and the after-school program all took leadership roles in developing the coalition's mission statement and action plan and then developed their projects to fit with their own institutional missions and play to their organizational strengths. In contrast with a more top-down, one-size-fits-all approach, this kind of collaboration provides an opportunity for the partner organizations to shape the initiative in a way that furthers their institutional goals and is in keeping with their operational style. Those partners that were less active in the program development stage found that the projects they were to implement did not always fit neatly with their organizational models or worldview or with their management priorities. Without such a match, it appears unlikely that the organization's project will have spillover effects to other aspects of its work or structure or that the partner will have an expansive sense of commitment to and responsibility for the overall enterprise.

Second, institutional change seemed more likely to occur when the partner's funded activity was open ended rather than a discrete program with specified deliverables and required time frames. For example, in many of the churches and in the after-school program, the line between institutional change and program implementation was blurred, and it was not always clear what was part of the funded program and what was not. In the case of churches, neither the staff nor the leadership is quite sure whether the culinary effort is part of the funded activity or something that grew organically out of it. Similarly, in the after-school program, is the change in how food is served part of the REACH-funded nutrition program or a result of it? Those organizations in which program funding supported the delivery of a set of specified services or activities (e.g., presentations or fitness or educational sessions) made fewer changes in their policies, practices, and procedures, and the impact of the program on the organization's role in the community was minimal. Highly prescriptive, deliverable-based contracting, although producing a quantifiable output, may undermine the opportunity for a single project to evolve into more substantial institutional change.

This approach creates a number of management challenges and tradeoffs, however. The ability of an organization to participate in program design and to implement an initiative in a flexible and creative manner requires strong leadership and management. Those partners that were hampered by turf issues or weak administration did not participate in program development and settled for a more deliverable-based model. Moreover, supporting partner engagement in designing the initiative and managing these more fluid processes requires the coalition leadership and staff to be responsive and flexible and to develop a range of tools for monitoring performance. It is an ongoing challenge for the Bronx Health REACH staff and management to balance their need for accountability against the need for local input and control.

Third, institutional change was more likely to occur when the funded program achieved some minimum degree of visibility and level of activity within the partner organization. In several of the partners, the leadership felt that their REACH project was too discrete and small to have any impact on the organization's policies or practices. Conversely, the organizational impact of the REACH program was greatly enhanced if the project was viewed as a success. For example, the faith-based initiative has been highly visible and is seen by coalition members, staff, and funders as a very strong component of the coalition's work. This has reinforced the churches' efforts, creating a sense of energy and enthusiasm for the initiative, which has continually expanded beyond its original scope. By contrast, the community health advocate program, implemented by two of the partner organizations, has had difficulty developing an effective service model and finding clients. Participation in the coalition has had much less of an impact on those partner organizations policies, practices, or sense of purpose.

Fourth, it is often assumed that coalitions work best when the partners are on the same page and motivated by the same goals and objectives. Certainly, this can provide focus and coherence to a coalition's work. Yet our work with the Bronx Health REACH coalition suggests that there are advantages to a coalition's having more than one page in its book. Different partners have different organizational imperatives and may seize on and internalize different aspects of a coalition's mission. In this case, some are motivated by an interest in racial and ethnic disparities in access to care and others by the community's dire need for disease prevention and management. Here again, to encourage engagement and foster institutional change within the partner organizations, a coalition may need to strike a balance, keeping a focus for the initiative's work while taking into account the strengths, interests, and motivations of the partners.

Finally, advice for program funders: As all of the key informants pointed out when reviewing these findings, many of the organizational changes that have been implemented already have substantial costs associated with them, whether these are capital costs for new equipment (e.g., a freezer) or training costs for staff and volunteers. Some organizations are willing to incur these costs, either because they have more flexible resources and infrastructure or because their mode of operating is to implement a program first and then backfill with grant funding or donations. But others have less capacity or (like the housing corporation) operate more from a business model in which programs must be self-supporting, with designated funded lines. Finding supplemental funding, even small amounts, is often the key to fostering institutional change.

The duration and flexibility of the funding is also critically important. The long-term funding for the REACH program, and the CDC's flexibility and support of the program participants' self-reflection, allowed the Bronx Health REACH coalition to consider issues of sustainability throughout its program development and implementation. This kind of support from a funder is vital if the work of a partnership is to result in true organizational change within community institutions. As we continue to identify the program ingredients that have fostered institutional change, the coalition plans to develop a strategy for promoting and coordinating organizational change among all of its members and to periodically assess its impact.

NOTES

1. This initiative is part of the Centers for Disease Control and Prevention's Racial and Ethnic Approaches to Community Health (REACH) 2010. This community is made up of four contiguous zip codes (10452, 10453, 10456, and 10457) and includes the neighborhoods of Highbridge, Morrisania, West Tremont, and Morris Heights.

2. The draft was shared with all key informants. Three shared their thoughts at the coalition meeting. Six were interviewed separately over the telephone. The remainder offered no comments.

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