

Multi-stakeholder Partnerships to Promote Access to Primary Health Care for Vulnerable Populations: A Mixed Methods Study

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December 2021

A thesis submitted to McGill University in partial fulfilment of the requirements of the degree of Doctor of Philosophy (PhD) in Family Medicine and Primary Care

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ABSTRACT

Partnerships bring organisations (and individuals) together to achieve outcomes greater than those that can be achieved working alone. Multi-stakeholder partnerships are widely recognised as an important mechanism to tackle complex problems – problems that extend beyond traditional organisational and sectoral divides. Abundant literature from multiple fields describes what constitutes effective versus ineffective partnerships, as well as strategies to enhance partnership processes and increase their effectiveness. In practice, partnerships have a high failure rate. In addition, they are difficult to evaluate, due to the field’s definitional ambiguity and the challenges inherent in measuring complex and evolving collaborative processes. There is a growing need for reliable evidence demonstrating that processes and approaches intended to support partnerships actually achieve the intended outcomes. This doctoral study was conducted between 2016 and 2019 with the aim of understanding partnership processes and how various partnership factors contribute to partnership effectiveness. The focus of the study was on partnerships involving multiple stakeholders working across the boundaries between clinical practice, research, health system management and health care policy – collaborating towards a common goal of transforming primary health care (PHC).

The notion of partnership synergy has recently emerged as an expression of partnership effectiveness. Partnerships are said to be synergistic when they leverage resources successfully and mobilise the complimentary knowledge and expertise of all the partners. Synergy occurs when the combined efforts of partners enhance the outcomes beyond what could be achieved independently by each stakeholder or stakeholder group working towards the same goals, namely when the whole becomes greater than the sum of the parts. The partnership synergy framework was adopted in this doctoral study to examine multi-stakeholder partnerships within the framework of an international research programme entitled “Innovative Models Promoting Access-to-care Transformation (IMPACT)”. The aim of the IMPACT research programme was to implement organisational innovations to promote access to appropriate PHC for vulnerable populations, through a network of six collaborative local partnerships involving decision makers, academic representatives, clinicians, health system administrators, patient partners, and representatives of health and social service organisations providing services to vulnerable populations. The objectives of this doctoral study were: a) to explore the different manifestations of partnership synergy, the types of partnership assets and partnership processes relevant to two multi-stakeholder

partnerships in PHC; b) to determine how well an adapted partnership self-assessment instrument measures partnership processes, partnership assets and the achievement of partnership synergy across five multi-stakeholder partnerships; c) to estimate the associations of partnership assets and partnership processes with the achievement/degree of partnership synergy; and d) to understand how partnership assets and processes contribute to the achievement of partnership synergy in PHC multi-stakeholder partnerships.

These objectives were answered using a two-phase mixed methods sequential exploratory design. Phase I entailed a longitudinal case study of two of the IMPACT local partnerships, in two Canadian provinces, to isolate the dimensions of partnership synergy that manifested and were relevant to these particular partnerships, and to describe the structures and processes that facilitated the work of these partnerships. Document review, non-participant observation of partnerships' meetings (n = 14) and semi-structured in-depth interviews (n = 16) were conducted across both cases. Data analysis involved a cross-case synthesis to compare the cases and framework analysis to identify prominent themes. The qualitative findings then informed the adaptation of the existing Partnership Self-Assessment Tool (PSAT). The instrument was administered to 54 stakeholders embedded in five of the six IMPACT local partnerships, as part of Phase II. Quantitative data analysis entailed examining the metric performance of the instrument and using descriptive and non-parametric bivariate statistics. Qualitative findings and quantitative results were subsequently integrated to obtain a deeper understanding of the multi-stakeholder partnership phenomenon.

Four major themes emerged from the data. Partnership synergy manifested itself in: (1) the integration of resources, (2) partnership atmosphere, (3) perceived stakeholder benefits and (4) partnership's capacity for contextual adaptation. Synergy developed before the intended PHC access outcome could be assessed, and acted both as a dynamic indicator of the health of the partnership and a source of energy fuelling partnership improvement and vitality. The results indicate that the partnership with the highest total partnership synergy score achieved on average the highest scores for partnership functioning on most studied dimensions. Conversely, the partnership with the lowest total partnership synergy score achieved low scores for partnership functioning on all dimensions. However, partnerships with middle-range total partnership synergy scores were more varied in partnership functioning. These findings reflect the complexity in partnership work and suggest that there is more than one way of organising and reaching

partnership synergy. They also suggest that there may be certain partnership dimensions that are still lacking from the analysis.

Synergistic action among multiple stakeholders was achieved through enabling processes at interpersonal, operational and system levels. Among these partnership enabling processes, the dimensions of administration and management and decision-making seemed to be more critical to determining the achievement of partnership synergy. The study findings also support the importance of recruiting partnership stakeholders with varied, but complementary expertise and of benefits to the stakeholders' respective organisations. In conclusion, the partnership synergy framework is useful in assessing the intermediate outcomes of ongoing partnerships when it is too early to assess the achievement of long-term intended outcomes. Enabling processes should be assessed in conjunction with the achievement of partnership synergy, as part of routine partnership assessment. This research adds depth to understanding the processes and approaches that support partnerships, and assesses the relevance of the multi-stakeholder partnership approach in PHC. Equally, this research demonstrates how the application of theoretical frameworks can facilitate a deeper understanding of partnerships.

RÉSUMÉ

Les partenariats rassemblent des organisations (et des individus) pour obtenir des résultats qui seront supérieurs à ceux pouvant être obtenus en travaillant seuls. Les partenariats multipartites sont largement reconnus comme mécanisme important pour s'attaquer à des problèmes complexes, qui dépassent les divisions organisationnelles et sectorielles. Une vaste littérature dans plusieurs domaines décrit les partenariats efficaces ou inefficaces ainsi que des stratégies pour améliorer et accroître l'efficacité des processus des partenariats. Dans la pratique, les partenariats ont un taux d'échec élevé. Ils sont également difficiles à évaluer en raison de l'ambiguïté des définitions du domaine et des défis inhérents à l'évaluation de processus collaboratifs complexes et évolutifs. Il existe un besoin croissant de données fiables qui démontrent que les processus et les approches destinés à soutenir les partenariats atteignent réellement les résultats escomptés. Cette étude de doctorat a été menée entre 2016 et 2019. Elle visait à comprendre les processus de partenariats et déterminer comment divers facteurs peuvent contribuer à l'efficacité du partenariat. L'étude était axée sur des partenariats impliquant de multiples parties prenantes œuvrant au-delà des limites de la pratique clinique, de la recherche, de la gestion du système de santé et de la politique des soins de santé, mais qui collaborent toutes vers un objectif commun de transformation des soins de santé primaires.

La notion de synergie de partenariat a récemment émergé comme l'expression de l'efficacité du partenariat. Les partenariats sont synergiques lorsqu'ils mobilisent avec succès les ressources, les connaissances et l'expertise complémentaires de tous les partenaires. La synergie est atteinte lorsque les efforts combinés des partenaires améliorent les résultats au-delà de ce qui pourrait être réalisé individuellement par chaque partie prenante ou chaque groupe de parties prenantes travaillant à l'atteinte des mêmes objectifs, c'est-à-dire, lorsque tout devient supérieur à la somme des parties. La perspective théorique de synergie de partenariat a été préconisée dans ce projet de doctorat afin d'examiner les partenariats multipartites d'un programme de recherche international intitulé « Modèles innovants favorisant la transformation de l'accès aux soins » (IMPACT). L'objectif du programme de recherche IMPACT était de mettre en œuvre des innovations organisationnelles favorisant l'accès aux soins primaires appropriés pour les populations vulnérables, à travers un réseau de six partenariats locaux collaboratifs. Ces partenariats impliquaient des décideurs, des représentants universitaires, des cliniciens, des administrateurs du système de santé, des patients partenaires et des représentants d'organismes de

services de santé et services sociaux qui offraient des services aux populations vulnérables. Les objectifs de ce doctorat étaient: a) d'explorer les différentes manifestations de synergie de partenariat, les types d'atouts et de processus de partenariat pertinents pour deux partenariats multipartites dans les soins de santé primaires; b) de déterminer jusqu'à quel point un instrument adapté d'auto-évaluation du partenariat mesurait les processus de partenariat, les atouts du partenariat et la réalisation d'une synergie au sein de cinq partenariats multipartites; c) d'estimer les associations des atouts et des processus des partenariats avec la réussite/le degré de synergie du partenariat; et d) de comprendre comment les atouts et les processus de partenariat contribuent à la réalisation d'une synergie dans les partenariats multipartites en soins de santé primaires.

Ces objectifs ont été atteints en utilisant un devis séquentiel exploratoire en méthodes mixtes. La première phase comportait une étude longitudinale de cas de deux partenariats locaux du programme de recherche IMPACT, issus de deux provinces canadiennes. L'objectif était d'isoler les dimensions de la synergie partenariale s'étant manifestées et étant pertinentes, puis de décrire les structures et les processus ayant facilité le travail de ces partenariats. Une revue de documents, de l'observation non participante des réunions de partenariats (n = 14) et des entretiens approfondis semi-structurés (n = 16) de deux cas ont été menés. L'analyse des données impliquait une synthèse comparative des cas et une analyse structurelle permettant d'identifier les thèmes importants. Les résultats qualitatifs ont ensuite guidé l'adaptation de l'outil existant d'auto-évaluation du partenariat (PSAT). Lors de la deuxième phase, l'instrument a été utilisé auprès de 54 parties prenantes issues de cinq des six partenariats locaux du programme IMPACT. L'analyse des données quantitatives a impliqué l'examen de la performance métrique de l'instrument et l'utilisation des statistiques bivariées descriptives et non paramétriques. Les conclusions qualitatives et les résultats quantitatifs ont ensuite été intégrés pour obtenir une compréhension plus approfondie du phénomène de partenariat multipartite.

Quatre grands thèmes ont émergé de ces données. La synergie de partenariat s'est manifestée dans: (1) l'intégration des ressources, (2) l'atmosphère du partenariat, (3) les avantages perçus par les parties prenantes et (4) la capacité d'adaptation contextuelle. La synergie s'est développée avant que le résultat d'accès prévu puisse être évalué et a agi à la fois comme indicateur dynamique de la santé du partenariat et source d'énergie favorisant l'amélioration et la vitalité du partenariat. Nos résultats ont indiqué que le partenariat ayant obtenu le score total de synergie le plus élevé a présenté en moyenne les scores les plus élevés au niveau du fonctionnement du

partenariat pour les dimensions de partenariats étudiées. Inversement, le partenariat ayant obtenu le score total de synergie le plus bas a présenté des scores faibles pour le fonctionnement du partenariat pour toutes les dimensions de partenariats étudiées. Cependant, les partenariats avec des scores de synergie totale moyens étaient plus variés au niveau du mode de fonctionnement du partenariat. Ces résultats reflètent la complexité du travail de partenariat et suggèrent qu'il existe plus d'une façon d'organiser et d'atteindre une synergie entre les partenaires. Ils suggèrent également que certaines dimensions de partenariat pourraient encore être absentes de notre analyse.

Une action synergique entre plusieurs parties prenantes a été réalisée grâce à des processus facilitateurs aux niveaux interpersonnel, opérationnel et systémique. Parmi ces processus favorisant le partenariat, l'administration, la gestion ainsi que la prise de décisions semblaient être plus critiques pour déterminer la réalisation de la synergie du partenariat. Les résultats de l'étude ont également mis en évidence l'importance de recruter des parties prenantes de partenariat ayant une expertise variée et complémentaire et des avantages pour les organisations respectives des parties prenantes. En conclusion, le cadre de synergie de partenariat est utile pour évaluer les résultats intermédiaires des partenariats en cours lorsqu'il est trop tôt pour évaluer l'atteinte des résultats escomptés à long terme. Les processus facilitateurs doivent être évalués conjointement avec la réalisation d'une synergie de partenariat, dans le cadre de l'évaluation systématique du partenariat. Cette étude approfondit la compréhension des processus et des approches qui soutiennent les partenariats et permet d'évaluer la pertinence de l'approche de partenariat multipartite dans un contexte de soins primaires. De plus, cette étude démontre comment l'application de cadres théoriques peut faciliter une meilleure compréhension des partenariats.

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LIST OF ACRONYMS

ABCD	Asset Based Community Development
CDC	Centers for Disease Control and Prevention
CHCS	Center for Health Care Strategies
CHRP	Community Health Resources Partnership
COP	Community Outreach Partnership
DL	Distributed Leadership
DSMP	Diabetes Self-management Partnership
HiAP	Helsinki Statement on Health in All Policies
IMPACT	Innovative Models Promoting Access-to-Care Transformation
NAM	National Academy of Medicine
OECD	Organisation for Economic Co-operation and Development
PCCP	Primary Care Connection Partnership
PHC	Primary Health Care
PSAT	Partnership Self-Assessment Tool
RBT	Resource-Based Theory
SLP	Service Linkage Partnership
UN	United Nations
UNDP	United Nations Development Programme
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
VCOSS	Victorian Council of Social Service
WHO	World Health Organization

ACKNOWLEDGMENTS

This journey has been enriching and worthwhile due, in large part, to the contributions of many people who were part of it. Foremost, I wish to express my sincere gratitude to my supervisor Dr. Jeannie Haggerty, for her continuous intellectual and financial support, for encouraging me to look deeper and beyond, and for introducing me to the broader family of researchers and practitioners in family medicine and primary health care. I am deeply thankful to my co-supervisor Dr. Catherine Scott for being close despite being far geographically, for her skilful and gentle guidance and for her ability to see the positive in every situation. I am indebted to my PhD Thesis Committee, including Dr. Susan Law and Dr. Virginia Lewis, for being generous with their time, for their insightful comments, and for showing me what female academic leadership and respectful collaboration looks like.

Thank you to Dr. Haggerty for providing me with office space at St. Mary's Research Centre – a warm and welcoming environment that became my professional home over six years. This research would not have been possible without the support of the IMPACT research programme team and all stakeholders who were involved in this study. Thank you to the IMPACT team members (Dr. Simone Dahrouge, Dr. Darene Toal Sullivan, Dr. Danielle Rolfe, Ryan Mallard, Dr. Emilie Dionne, Dr. Lisa Starr, to name a few) for helping me to deepen my understanding of the programme that was the focus of my study, to look at things differently, and for the friendships that developed along the way. A special thank you to Fatima Bouharaoui, Biostatistician at St. Mary's Hospital Centre, for sharing her statistical expertise and Christine Beaulieu, former IMPACT Research Coordinator, for her support throughout this study. Thank you to my colleagues at St. Mary's Research Center (Dr. Sylvie Lambert, Mona Magalhaes, Manon De Raad, Lydia Ould Brahim, Cindy Ibberson, Nicole Mike, Isabelle Crepeau, Eric Belzile) for strengthening my appreciation for team work and for welcoming me, an outsider, into their professional worlds with open arms. A special thank you to my office mates Dr. David Loutfi and Dr. Ting Yu, for all the stimulating conversations and for fuelling my motivation to produce only the best.

I would like to recognise the invaluable support of the Department of Family Medicine and McGill University in general, for providing us, graduate students, with an exceptional selection of graduate courses, a wonderful academic environment and optimal conditions for our ideas to flourish. Thank you for encouraging us to attend relevant conferences and for providing us with

financial support to do so. Thank you to my study group colleagues (Dr. Ilja Ormel, Dr. Shinjini Mondal, Dr. Svetlana Puzhko, to name a few) for the helpful exchanges regarding manuscript and thesis preparation and for sharing the latter part of the PhD journey.

My deepest gratitude to my husband, Professor Kristian Waters, for guiding me as I navigated the complex world of academic publishing, for helping me to overcome formatting and software challenges, for being the main bread winner for so many years, and for his relentless encouragement to persevere even when I felt that I could go no further. A sincere thank you to my wonderful daughter Emilia, who was born as I was just embarking on this PhD journey. I admire her enormously, for the passion with which she embraces new projects and for her amazing strength in conquering new heights, be it in sports or in other activities. Thank you to my family, for their patience, free child care, gentle reminders that being a perpetual student has to stop at a certain point, and for demonstrating that life outside of academia could be fulfilling as well. Thank you to my friends who, unknowingly, helped me to hone the skill of describing in one sentence what I actually do for a living. Finally, thank you to my late and present cats, Ali, Cosmo, Monty and Nola, for warming my lap (and my laptop) as I was writing my manuscripts, and for all the laughs and cuddles throughout the years.

FUNDING ACKNOWLEDGEMENTS

This research was undertaken within the framework of a larger programme of research entitled IMPACT. IMPACT was supported through joint funding from the Australian Primary Health Care Research Institute, the Canadian Institutes of Health Research (CIHR) and the Fonds de recherche du Québec – Santé (FRQS). I would like to acknowledge funding of a doctoral stipend through the IMPACT research programme (2015-2018). I am also deeply grateful for the following funding that I received to present findings from this research at conferences: travel awards from the Department of Family Medicine and the Post-Graduate Students' Society of McGill University, as well as the CIHR Institute Community Support (ICS) Travel Award with the Institute of Health Services and Policy Research.

PREFACE

CONTRIBUTION OF AUTHORS

This is a manuscript-based dissertation that includes three research manuscripts. All manuscripts have been published in academic journals. The work presented in this dissertation was undertaken within the framework of a multi-year Canada-Australia research programme entitled “Innovative Models Promoting Access-to-Care Transformation” (IMPACT), co-led by Drs. Haggerty, Scott and Lewis, among others (Levesque et al., 2013). The PhD candidate did not have a direct role in contributing to the objectives of the IMPACT programme, but rather led a spin-off project focussed on studying the evolution of the multi-stakeholder partnerships that were the conduit of the IMPACT programme activities. The candidate was responsible for all components of the research presented here, including the conception and design of the study, data collection, data management, analysis and interpretation, and preparing the manuscripts and this thesis. This work also entailed a number of participatory research components, including soliciting, at the early stages of the project, the input of project stakeholders regarding research objectives. All co-authors of the manuscripts consented to their inclusion in this dissertation (see Appendix A).

Manuscript 1:

Loban, E. (EL), Scott, C. (CS), Lewis, V. (VL), Law, S. (SL), & Haggerty, J (JH). (2021). Improving primary health care through partnerships: key insights from a cross-case analysis of multi-stakeholder partnerships in two Canadian provinces. *Health Science Reports*, 4(4), 397. <https://doi.org/10.1002/hsr2.397>

EL designed the study, conducted the data collection, analysed and interpreted the findings and wrote the manuscript. JH facilitated the recruitment of interview participants and provided input regarding study design, interpretation of findings and manuscript preparation. CS verified the coding of qualitative data and provided input regarding the interpretation of findings and manuscript preparation. VL and SL provided feedback on the interpretation of findings and critically appraised the manuscript. All authors read and approved the final manuscript.

Manuscript 2:

Loban, E. (EL), Scott, C. (CS), Lewis, V. (VL), & Haggerty, J. (JH). (2021). Measuring partnership synergy and functioning: Multi-stakeholder collaboration in primary health care. *PLOS One*, 16(5), e0252299. doi:10.1371/journal.pone.0252299

EL adapted the assessment tool, administered the survey, analysed and interpreted the results and wrote the manuscript. JH verified the adapted instrument and provided guidance regarding data analysis. JH, CS and VL facilitated the recruitment of participants and provided input regarding the interpretation of results and manuscript preparation. Based on their involvement in a longitudinal developmental evaluation of the partnerships that ran parallel to this study, CS and VL contributed data through independent content ranking of partnerships that were part of this investigation. All authors read and approved the final manuscript.

Manuscript 3:

Loban, E. (EL), Scott, C. (CS), Lewis, V. (VL), Law, S. (SL), & Haggerty, J. (JH). (2021). Activating Partnership Assets to Produce Synergy in Primary Health Care: A Mixed Methods Study. *Healthcare*, 9(8), 1060. doi:10.3390/healthcare9081060

EL conducted the analysis, interpreted the findings, and wrote the manuscript. JH, CS, VL and SL contributed to interpretation and writing. All authors read and approved the final manuscript.

CHAPTER 1. Introduction

1.1 INTRODUCTION

Partnerships involving multiple stakeholders are a powerful mechanism for tackling difficult problems that transcend the ambits of single organisations and for bringing about broader systemic change. A multi-stakeholder partnership is defined as a complex human system based on voluntary collaborative relationships between stakeholders who agree to work together towards a common purpose, to combine competencies, resources and responsibilities, and to share risks and benefits (adapted from United Nations General Assembly, 2003). Multi-stakeholder partnerships are useful for stimulating more innovative approaches to problems, overcoming traditional divisions of power, improving communication and access to information, optimising resource utilisation and helping to avoid a wasteful duplication of effort (Audit Commission, 1998; McQuaid, 2005, 2010). Other benefits include developing more coherent services, contextualising policy and enhancing the relevance of research findings through direct involvement of end users (Hunter & Perkins, 2014; Sibbald, Kang, & Graham, 2019; Wildridge, Childs, Cawthra, & Madge, 2004). The concept of “partnership” recognizes that organisations (and individuals) often need to work together to achieve outcomes greater than those that can be achieved by each organisation working alone.

In health care, the partnership approach enjoys widespread endorsement in disease prevention, health promotion, service redesign and system change (Lasker, Weiss, & Miller, 2001; Verma, Peterson, Samis, Akunov, & Graham, 2014). In the environment of increasing demands and limited resources, rapid technological change and a progressively complex patient population, partnerships offer a more meaningful way of tackling complex health care system problems than efforts undertaken by individual agents (Zuckerman, Kaluzny, & Ricketts, 1995). Indeed, partnerships have become a popular strategy for delivering better outcomes to service users and care providers.

There is a considerable body of literature in multiple fields, including health and social care, regarding what constitutes an effective as opposed to ineffective partnership, as well as approaches and strategies to enhance partnership processes and to increase their effectiveness (e.g., Centers for Disease Control and Prevention, 2008; Health Research & Educational Trust, 2016; Human Service Partnership Implementation Committee, 2009; Kegler, Steckler, McLeroy, & Malek, 1998; Kreuter, Lezin, & Young, 2000; Larkan, Uduma, Lawal, & van Bavel, 2016;

Mitchell & Shortell, 2000; Ramaswamy, Kallam, Kopic, Pujic, & Owen, 2016). In practice, however, partnerships frequently fail and those that survive are often unable to achieve the intended change in systems and/or health outcomes (Bleeke & Ernst, 2003; Drahota et al., 2016; Hunter & Perkins, 2012; Jones & Barry, 2011a; Lasker & Weiss, 2003; Lasker et al., 2001; Mitchell & Shortell, 2000). In addition, they are difficult to evaluate, due to the field's definitional ambiguity and the challenges inherent in measuring complex and evolving collaborative processes (Butterfoss & Francisco, 2004). There is a growing need for evidence demonstrating the link between the implementation of processes that contribute to partnership effectiveness and the achievement of intended outcomes.

The notion of “partnership synergy” has recently been proposed to explain the link between partnership structures and processes on the one hand and achieving the intended health and health system goals on the other (Lasker et al., 2001). Partnership synergy is the combined effect of complementary tangible and intangible partnership assets and enabling collaborative processes that gives partnerships unique advantages over the work of individual people or organisations working towards the same goals (adapted from Lasker et al., 2001). It is achieved when partnership assets are leveraged to produce outcomes that are greater than those that would be expected from individual players. Partnership intangible or “soft” assets include human, informational and organisational resources such as knowledge, competencies, connections, culture, data and information, whereas tangible assets include material and financial resources such as space and funding (Hart, 1995). Partnership enabling processes include leadership, administration and decision-making, as well as the degree to which a partnership optimises the involvement of its partners (Lasker et al., 2001; Weiss, Anderson, & Lasker, 2002). The importance of these collaborative processes lies in their ability to contribute to partnership synergy which, in turn, determines the likelihood of achieving the ultimate long-term partnership outcomes. These processes have been studied in many contexts but less is known about how they are applied and how they interact both with each other and with partnership assets to promote and solidify partnerships in the context of primary health care (PHC).

This mixed methods doctoral study was conducted between 2016 and 2019 with the aim of understanding partnership processes and how various factors contribute to partnership's ability to achieve intended outcomes. The focus of the study was on partnerships involving multiple stakeholders working across the boundaries between clinical practice, research, health system

management and health care policy – collaborating towards a common goal of transforming PHC. The study unfolded within the framework of an international research programme entitled “Innovative Models Promoting Access-to-care Transformation (IMPACT)”. The IMPACT research programme aimed at implementing organisational innovations to promote access to appropriate PHC for vulnerable populations through six local partnerships that involved multiple stakeholders.

1.2 STATEMENT OF RESEARCH OBJECTIVES

The objectives of this research were as follows:

- a) To explore the different manifestations of partnership synergy, the types of partnership assets and partnership processes relevant to two multi-stakeholder partnerships in primary health care (qualitative);
- b) To determine how well an adapted partnership self-assessment instrument measures partnership processes, partnership assets and the achievement of partnership synergy across five multi-stakeholder partnerships (quantitative);
- c) To estimate the associations of partnership assets and partnership processes with the achievement/degree of partnership synergy (quantitative);
- d) To understand how partnership assets and processes contribute to the achievement of partnership synergy in primary health care multi-stakeholder partnerships (mixed methods).

1.3 THESIS STRUCTURE

This is a manuscript-based thesis, comprised of nine chapters and 13 appendices. The structure of the thesis can be summarised as follows:

Chapter 2. Review of the literature contains an overview of the history and importance of partnerships and how partnerships, and in particular effective partnerships, are conceptualised. It also details the benefits and challenges of partnerships and identifies the knowledge gap.

Chapter 3. Epistemological influences, theoretical frameworks and research approach describes the thesis epistemology and theoretical frameworks that guided the investigation.

Chapter 4. Methodology describes the research approach, the study design, the specific research methods employed, the ethical considerations and the study context.

Chapter 5. Manuscript 1 provides an in-depth qualitative description of the different manifestations of the partnership synergy phenomenon in two evolving multi-stakeholder partnerships working towards enhancing the accessibility of PHC to vulnerable populations. In addition, it outlines the processes that enabled stakeholders from different organisations to achieve synergistic action, and introduces the refined model of partnership synergy. It expands the original partnership synergy framework to demonstrate holistically the inter-connections between partnership inputs, mediating processes and partnership outcomes, and highlights the influence on partnerships of their contexts.

Chapter 6. Manuscript 2 presents results from a survey administered to five partnerships within the framework of the IMPACT programme of research. It demonstrates the feasibility of using a partnership self-assessment tool, developed in the field of health promotion, in assessing certain dimensions of partnership functioning and partnership intermediate outcomes in PHC. Based on the findings of Manuscript 1, it identifies gaps in the tool and provides preliminary evidence supporting the utility of a modified partnership synergy scale.

Chapter 7. Manuscript 3 integrates the qualitative findings from Manuscript 1 and quantitative results from Manuscript 2 to obtain a deeper understanding of partnership synergy and the multi-stakeholder partnership phenomenon. Inconsistent findings revealed additional nuances in relation to some of the partnership dimensions studied as part of the qualitative and quantitative investigations.

Chapter 8. Discussion details the contributions to original knowledge, study limitations and suggestions for future lines of inquiry.

Chapter 9. Conclusions details the overall conclusions of this doctoral work.

CHAPTER 2. Review of the Literature

This chapter provides a comprehensive overview of the literature on the importance and conceptualisations of multi-stakeholder partnerships, in particular, effective partnerships. It also details the benefits and challenges of partnerships and identifies the knowledge gap. The review is based on more than 200 sources from academic and grey literature. While it draws upon partnership concepts from various fields, most of the literature referred to in this chapter comes from the area of health and social care, where a substantial amount of research on partnerships has been undertaken. This review served as the foundation for the various manifestations of multi-stakeholder partnerships that were the focus of this doctoral work. As the doctoral analysis progressed, a need emerged to deepen the understanding of what was observed with the help of additional theoretical frameworks from strategic management. These frameworks are discussed in Chapter 3 (*Epistemological Influences, Theoretical Frameworks and Research Approach*), along with the partnership synergy framework that has guided this investigation since the beginning.

2.1 HISTORY AND IMPORTANCE OF PARTNERSHIPS

Partnerships involving stakeholders from different organisations are an important mechanism for addressing complex issues that transcend the ambits of single organisations (Goddard, 2006; Green, Daniel, & Novick, 2001; Huxham & Macdonald, 1992; Miller & Ahmad, 2000). The interest in partnerships is driven by the proposition and accumulating evidence that “wicked” societal problems (Rittel & Webber, 1973) will be more adequately addressed by pooling the expertise and resources of different organisations (Hunter & Perkins, 2014; Schulz, Krieger, & Galea, 2002; Wildridge et al., 2004). It is fuelled by the desire to reduce system fragmentation and ensure better and more sustainable outcomes for the end users (Audit Commission, 1998; Glasby & Dickinson, 2008; Hunter & Perkins, 2014). Furthermore, partnerships offer a more meaningful way to contain expenditures and accelerate innovation (Dees, Emerson, & Economy, 2002; Horton, Prain, & Thiele, 2009). The recent example of the COVID-19 vaccine development demonstrates that rapid and effective response to a health crisis can be achieved when organisations and governments work together.

Partnerships are not a recent phenomenon: laws governing business partnerships can be traced back to the Code of Hammurabi (Mayer, Warner, Siedel, & Lieberman, 2012), a Babylonian

legal document which is considered to be the oldest written legal code (Garner & Black, 2009). Commercial partnerships were recognised as legal entities and regulated as part of Roman law (Mayer et al., 2012), which influenced the development of legal constructs of modern civil law (Garner & Black, 2009). During the Middle Ages, partnerships were an integral part of international commercial law and started to be referred to more broadly, to encompass relationships between entities with a goal of effecting social change (Mayer et al., 2012). It has been argued that partnerships have been an integral feature of English public policy since the Poor Law (Powell & Glendinning, 2002) social reforms of the Tudor era that preceded England's modern welfare system. The British "New" Labour Government, elected in 1997, embraced the collaborative discourse, and in particular the partnership approach to governance that transcended the traditional divides between the state and the market (Clarke & Glendinning, 2002; Dickinson & Glasby, 2010; Hunter & Perkins, 2014). The new discourse characterised attempts to improve linkages between governments at different levels, statutory services, the private sector and civil society. This emphasis on collaboration transpired within a broader discourse of changing relationships between different players across sectors, from hierarchies and centralised provision of services to markets and subsequently to networks (Powell & Glendinning, 2002).

These developments were not confined to England. For example, partnerships were a popular business vehicle in the United States of America (USA) in the nineteenth century (Mayer et al., 2012). More recently, given the partnership's appeal, the governments of Organisation for Economic Co-operation and Development (OECD) countries have invested sizable amounts of financial resources to support collaborative arrangements (Butterfoss, Goodman, & Wandersman, 1996). Governments and funding agencies now promote and even mandate partnerships as an essential element of the programmes and initiatives that they support (Canadian Institutes of Health Research, 2012; Eisinger & Senturia, 2001; Green et al., 2001; Thibault & Harvey, 2013; Victorian Council of Social Service (VCOSS), 2009). Creating and sustaining intersectoral partnerships is also an important element of approaches of intergovernmental organisations. Within the United Nations (UN) system, specifically following the 2002 Johannesburg World Summit on Sustainable Development that promoted partnerships as the preferred vehicle for sustainable change, multi-stakeholder partnerships have become *a modus operandi*; such UN entities as the UNDP and UNICEF now consider it their core practice (Malena, 2004).

Partnerships involving stakeholders from different organisations are ubiquitous. They are implemented across multiple disciplines and spheres, including management and organisation development, public policy and administration, international development, science and technology, agricultural research, public health and health promotion (Drahota et al., 2016; Horton et al., 2009). In health care, a partnership approach to system change and service redesign has enjoyed widespread endorsement, given evidence over time regarding improvements for service users and care providers (Lasker et al., 2001; Verma et al., 2014). It has increasingly been acknowledged that the complexity of social processes that influence health requires the combination of a wide range of skills, diverse resources, influence and knowledge (Schulz et al., 2002). The World Health Organization (WHO) has highlighted intersectoral action as a central element in health promotion, the achievement of health equity, and the realisation of health as a human right (World Health Organization, 2013). The emphasis on creating and sustaining intersectoral partnerships has been reflected in many WHO frameworks, strategies and resolutions, including the 1978 Alma Ata Declaration on Primary Health Care and more recently the Helsinki Statement on Health in All Policies (HiAP) (World Health Organization, 1978, 2013). In the USA, two think tanks - the National Academy of Medicine (NAM) and the Center for Health Care Strategies (CHCS) - have stressed the importance of collaboration across an array of medical and social service providers, governments and community partners, as a way to improve health outcomes and reduce health care costs (Dzau et al., 2017). In Canada, the federal and provincial governments have increasingly promoted addressing the question of improving the quality of health care provided to the Canadian population through a means of collaborative models (Verma et al., 2014). This trend can also be observed in other countries within the context of health and welfare services (El Ansari, Phillips, & Hammick, 2001; Lasker et al., 2001).

When it comes to PHC, partnerships have been proposed as one of the paths to tackle its complex challenges that include: fragmentation across the system; limited patient involvement; important gaps in equitable access; poor communication and information sharing; limited meaningful collaboration between governments, institutions and the research community; as well as limited ability to scale up innovation (Canadian Institutes of Health Research, 2010; World Health Organization, 2008). The emphasis on partnerships in PHC has recently increased as health systems globally have focussed on strengthening the sector (Keleher, 2015b).

2.2 THE CONCEPT OF PARTNERSHIP

Partnerships exist in varied contexts and are formed for a variety of reasons. The five main reasons to develop partnerships include: 1) to tackle complex issues; 2) to deliver coordinated services to individuals; 3) to reduce the impact of organisational fragmentation; 4) to bid for, or access, new resources; and 5) to meet a statutory requirement (Audit Commission, 1998). Partnerships differ on a number of dimensions, summarized in Table 2-1 below. In broad terms, partnerships can be differentiated according to the following aspects: the scale and boundaries of the partnership; membership; the links between members; and the wider context within which the partnership operates (Ling, 2000).

Table 2-1. Main dimensions differentiating partnerships (adapted from Ling, 2000; McQuaid, 2010; Wildridge et al., 2004)

Main Dimension	Sub-dimension	Considerations
Scale and boundaries	Scope	Whether the partnership is strategic or project driven
	Type	Facilitating, co-ordinating or implementing
	Purpose	What the partnership is trying to accomplish
	Timing	Stage of development
Partnership members	Stakeholders	The types of actors who are involved and level of stakeholder engagement
Links between members	Structure	Partnership structure (e.g., horizontal or vertical integration)
	Form	The form adopted (e.g., joint venture, joint R&D)
	Agreement	Types of agreements that bind stakeholders together
	Implementation mechanisms	How activities are carried out
Context of partnership	Reach	The geographical location of activities (local/ national/ global)
	Existing institutional architecture	Whether the partnership is reinforcing it or undermining it
	Resources	Financial and other resources
	Broader political and economic context	Exerting influence over the partnership

There is no universally applicable and accepted definition of the term “partnership”, and the likelihood of ever developing one is relatively low (Drahota et al., 2016; Horton et al., 2009; Institute for Public Policy Research, 2001). A review of academic and grey literature on joint working reveals the term’s multi-disciplinary theoretical roots and that it is used to describe a large array of relationships (Gray & Stites, 2013; Osborne, 2000). The term’s definitional diversity has been extensively documented (Dowling, Powell, & Glendinning, 2004; Horton et al., 2009;

Wildridge et al., 2004; Williams & Sullivan, 2010). Indeed, the field of partnerships has been criticised for its “methodological anarchy and definitional chaos” (Ling, 2000, p. 82). It has been suggested that “partnership” has become “the "buzz word" to sprinkle liberally through any funding application in order to improve its chances of success” (Osborne, 1998, p. 290).

The term “partnership” has been loosely applied to any form of organisational interaction with outside players. It is frequently used interchangeably with such terms as “collaboration”, “coalition”, “alliance”, “joined-up working”, “joint planning”, “multi-agency working”, “inter-organisational relations” and “collective impact initiatives”, just to name a few (Hunter & Perkins, 2014; Kania & Kramer, 2013). It has been used to denote relationships between public and private entities, collaboration between different public sector bodies to deliver services, linkages between members of interprofessional health teams, and work between academic and community institutions (McQuaid, 2010). It could pertain to a formal relationship between two parties within the same sector or an international agreement between multiple stakeholders representing such entities as businesses, non-governmental organisations, governments of several countries and international organisations coming together for a common purpose. These relationships have been characterised with an extensive range of partnership labels (and accompanying acronyms). There are public-private partnerships (PPPs) (Clarke & Glendinning, 2002; Osborne, 2000); intersectoral partnerships (Corbin, Jones, & Barry, 2018); interprofessional health and social service partnerships (IHSSPs) (Butt, Markle-Reid, & Browne, 2008); community-academic partnerships (CAPs) (Brush, Baiardi, & Lapides, 2011; Drahota et al., 2016); community health partnerships (CHP) (Mitchell & Shortell, 2000); public-policy partnerships between universities and communities (Cortes, 1998); research community partnerships (RCPs) (Brookman-Frazee et al., 2016); local strategic partnerships (LSPs) (Halliday, Asthana, & Richardson, 2004; Hunter & Perkins, 2012); clinic and social service agency partnerships (Henderson et al., 2020), etc. It has been suggested that the absence of precision in definitions can be helpful as it makes the concept flexible and malleable to suit all types of circumstances, thereby facilitating responsiveness to local challenges (Glendinning, Dowling, & Powell, 2005; Hunter & Perkins, 2014). Conversely, this conceptual “fuzziness” (Hunter & Perkins, 2014, p. 4) can undermine collaborative ways of working and complicate comparisons, measuring success, and determining the novelty of an approach (Glendinning et al., 2005; Scott & Thurston, 2004).

In light of these conceptual challenges, a number of definitions to characterise working in partnership have been articulated. The paragraphs below contain some of the most frequently cited definitions.

Glendinning et al. (2005) have described partnerships (in public policy) as:

“[...] involving two or more organisations, groups or agencies that together identify, acknowledge and act to secure one or more common objective, interest or area of interdependence; but where the autonomy and separate accountability arrangements of the partner organisations are in principle retained.” (Glendinning et al., 2005, p. 370).

According to Brinkerhoff (2002) working in the field of public administration:

“Partnership is a dynamic relationship among diverse actors, based on mutually agreed objectives, pursued through a shared understanding of the most rational division of labour based on the respective comparative advantages of each partner. Partnership encompasses mutual influence, with a careful balance between synergy and respective autonomy, which incorporates mutual respect, equal participation in decision-making, mutual accountability, and transparency.” (Brinkerhoff, 2002, p. 216).

The Public Health Agency of Canada has provided the following definition in its core competencies document:

“Partnerships: Collaboration between individuals, groups, organizations, governments or sectors for the purpose of joint action to achieve a common goal. The concept of partnership implies that there is an informal understanding or a more formal agreement (possibly legally binding) among the parties regarding roles and responsibilities, as well as the nature of the goal and how it will be pursued.” (Public Health Agency of Canada, 2007, p. 12).

In the context of international agricultural research for development, partnership is defined as:

“[A] sustained multi-organizational relationship with mutually agreed objectives and an exchange or sharing of resources or knowledge for the purpose of generating research outputs (new knowledge or technology) or fostering innovation (use of new ideas or technology) for practical ends.” (Horton et al., 2009, p. 13).

One of the legal definitions of a partnership highlights profit and loss-sharing and refers to the Uniform Partnership Act that regulates business partnerships in the USA:

“A voluntary association of two or more persons who jointly own and carry on a business for profit. Under the Uniform Partnership Act, a partnership is presumed to exist if the persons agree to share proportionally the business’s profits or losses.” (Garner & Black, 2009, p. 1230).

In an attempt to arrive at some common understanding, a number of scholars (e.g., Hutchinson & Campbell, 1998; Wildridge et al., 2004) have isolated aspects that are common to different partnership definitions. These aspects include: working across organisations, groups, agencies, or disciplines; a common aim or aims, vision, mission, goals, or interests; a strategy to achieve these aims; sharing of resources, skills, responsibilities and risks; new structure(s) and processes; and mutual benefit (Hutchinson & Campbell, 1998; Wildridge et al., 2004). In addition, partnerships could involve a formal agreement, in some instances legally binding, outlining, *inter alia*, the roles and responsibilities of the parties, for example, a memorandum of understanding, terms of reference, or a partnership agreement (Valaitis, 2012; Victorian Council of Social Service (VCOSS), 2009). Finally, in the area of health and social services, it would typically involve a service delivery focus (Victorian Council of Social Service (VCOSS), 2009).

Furthermore, there have been efforts to generate typologies of different ways in which people work together. Figure 2-1 below depicts one of the typologies that is frequently cited in the literature, demonstrating that the ways of working together cover a wide range of structures and levels of engagement (Hemmati, 2002). Each one of these relationships may be more or less appropriate depending on the specific circumstances and the goals of an undertaking (Himmelman, 2002).

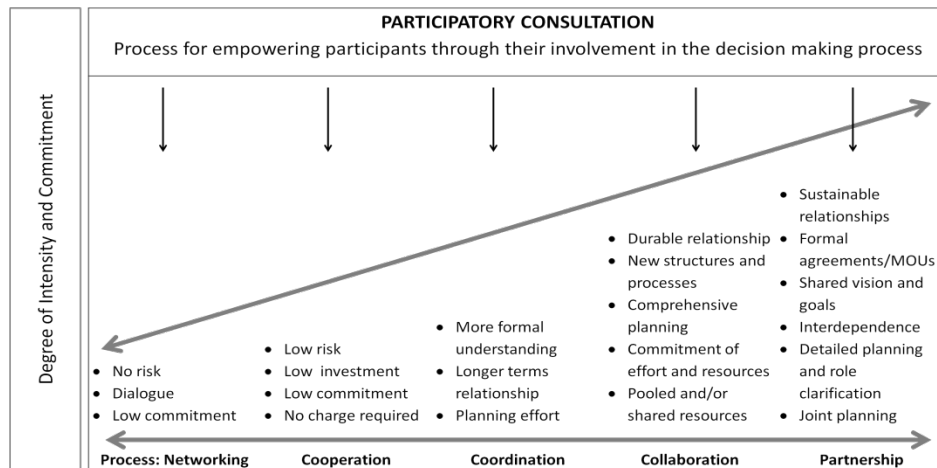


Figure 2-1. Continuum of joint effort. Adapted from Success Works (2002) (Victorian Council of Social Service (VCOSS), 2009)

This doctoral study has used the following definition of partnership:

A complex human system based on voluntary collaborative relationships between stakeholders who agree to work together towards a common purpose, to combine competencies, resources and responsibilities, and to share risks and benefits. (adapted from United Nations General Assembly, 2003).

This project conceptualised partnerships as being located at the far end of the collaborative spectrum denoting the highest level of commitment to a joint venture and a shared purpose and agenda (Victorian Council of Social Service (VCOSS), 2009).

Finally, stakeholders were defined as “[i]ndividuals, groups or organizations [...] who have a specific interest in, have some influence on, or are affected by, a given policy, program, regulatory initiative or service” (Health Canada and the Public Health Agency of Canada, 2016, p. 32). The influence that stakeholders exercise “can be felt in the form of accelerating change, slowing it down, altering its course or preventing it altogether” (Grundy, 1997, p. 50).

The focus of the current doctoral project was on partnerships involving multiple stakeholders – actors from different stakeholder groups, each bringing their own, unique, perspective, who were working towards a common goal of transforming one dimension of PHC for a vulnerable population group in their region. These multi-stakeholder partnerships have the potential to achieve significantly more than individual organisations working independently.

2.3 BENEFITS OF PARTNERSHIPS

“Genuine partnerships are not an end in themselves – they are practiced and promoted in order to strengthen the capacity of the partners and ensure that the results of the partnership will be both relevant to target groups and sustainable in the long term.” (Blagescu & Young, 2005, p. 2).

There are a number of benefits associated with well-designed and adequately-resourced partnerships. The sub-sections below describe the key expected benefits that characterise effective partnerships.

2.3.1 Combining and leveraging non-tangible resources

Arguably the main rationale for entering into a multi-stakeholder partnership is that “two heads are better than one” (Gray, 1989, p. 5). Partnerships are formed to combine and leverage the non-tangible resources of complementary perspectives, capabilities and practices from multiple organisations in order to arrive at appropriate, effective and sustainable solutions (Hazlewood, 2015; McQuaid, 2010). Partnerships allow partners to not only increase the scale but also the types of intangible resources available, which are not all available in a single organisation (McQuaid, 2005, 2010). Examples of intangible resources include particular expertise or access to hard-to-reach populations. This sharing of resources allows organisations to expand the reach, diversity and quality of their services (McQuaid, 2010). In the private sector, strategic partnerships are commonly used to obtain access to valuable resources (such as technological know-how) of other firms that cannot be obtained in other ways, with the objective of increasing competitive advantage (Das & Teng, 2000). Indeed, it has been suggested that in today’s brutally competitive environment driven by globalisation, companies must learn to collaborate in order to remain competitive (Bleeke & Ernst, 2003). The do-it-alone strategies are proving to be increasingly costly, lengthy and ineffective in terms of providing appropriate access to markets (Bleeke & Ernst, 2003). In comparison with mergers and acquisitions, strategic partnerships allow organisations to have access to precisely those resources that are needed, bypassing the non-desired ones (Das & Teng, 2000). In addition, partnerships allow organisations to retain valuable but under-utilised resources, whereby instead of laying these individuals off, organisations engage them in projects to be carried out in collaboration with other organisations (Das & Teng, 2000).

2.3.2 Pooling of tangible resources

Partnership-based approaches have the potential to increase the level of physical, technological and financial resources available to tackle a particular problem (Das & Teng, 2000; McQuaid, 2010). Using pooled financing mechanisms, involving the mobilisation and combination of diverse sources of funding, has demonstrated positive influence in partnerships for development purposes (Hazlewood, 2015). In addition, partnerships allow to maximise the impact of existing resources (McQuaid, 2010). For example, blended finance approaches, whereby public dollars are used to mobilise private funding through partnerships, have proven to be important for increasing the impact of grant funding (Hazlewood, 2015). Furthermore, the pooling of resources provides more predictable multi-year funding commitments (Hazlewood, 2015).

2.3.3 Capacity building

Partnerships are valuable for capacity development within an organisation, for they involve the sharing of knowledge and practice across areas of expertise embedded in other organisations (McQuaid, 2010). Capacity building can encompass specific technical know-how (such research, grant writing, monitoring and evaluation or new techniques), “soft skills” such as leadership and change management, or, more broadly, the capacity to partner and to innovate (Hall, 2005; Horton et al., 2009). Partnerships can also open possibilities for new ways of working – both jointly and within an organisation – and can help organisations to access more stable long-term funding (McQuaid, 2010). Strengthening capacity can be referred to explicitly in partnership documentation, or arise as an unintended consequence of collaborative work.

2.3.4 Facilitating innovation

Beyond capacity building, working with people from different organisations and sectors brings new perspectives and gives partnerships the potential to facilitate and scale up innovation, through experimentation involving testing new approaches (McQuaid, 2010). Partnerships also allow partners to discard unsuccessful approaches more easily, with fewer investments and risks (McQuaid, 2010). From a single organisational perspective, partnerships offer organisations the opportunity to pivot and adapt in an ever-changing environment. Examples may include companies working in partnership with academic institutions, allowing to blend the practice and the latest research in a specific area.

2.3.5 More comprehensive response to complex, multi-dimensional problems

Despite the differences between partnerships in terms of their goals, composition and the form that they take, they all have in common the realisation that “... in today’s environment, most objectives related to [complex problems] cannot be achieved by any single person, organization or sector working alone” (Lasker et al., 2001, p. 179). The health and social care environment is characterised by chronic underfunding, focus on efficiency, rapid technological and scientific progress, an aging and increasingly complex patient population, and higher patients’ expectations (Jackson, 2010; Lasker et al., 2001). Problems related to health (including poverty, social exclusion, obesity, addictions) and the delivery of health and human services tend to involve many inter-related factors and players (Kania & Kramer, 2013). These problems are “difficult to define, usually have no clear solutions, are inter-dependent and multi-causal, are socially complex, and rarely sit within the boundaries or responsibilities of any single organisation.” (Hunter & Perkins, 2012, p. 45). Addressing any one aspect of the problem is unlikely to generate successful, sustainable solutions (Kania & Kramer, 2013; McQuaid, 2005, 2010). In addition, solutions to these problems go beyond the authority, capabilities and resources of a single organisation (Lasker & Weiss, 2003). Partnerships across organisations, sectors and levels of the government are therefore essential, for they allow harnessing and aligning a range of inputs from multiple stakeholders, resulting in more coordinated services for the target population and more effective tackling of the wider variables that are likely to influence the outcomes (Boydell, Hoggett, Rugkasa, & Cummins, 2008; McQuaid, 2005; Victorian Council of Social Service (VCOSS), 2009).

2.3.6 Improving efficiency and accountability

Partnerships can enhance the efficiency of undertakings by achieving economies of scale, and reducing system fragmentation and duplication of effort (Hazlewood, 2015; McQuaid, 2010). For example, partnerships can overcome fragmentation between service providers working with the same target group through improved communication and better understanding of the capabilities of each participating organisation (Glendinning et al., 2005; McQuaid, 2010). Partnerships can also increase efficiency by reducing transaction costs and ensuring more flexible, targeted and faster support to groups and areas most in need (Hazlewood, 2015). Working in partnership can

also improve accountability to partnership's stakeholders (including the intended beneficiaries), each other, and the respective stakeholders of each partner (Blagescu & Young, 2005).

2.3.7 Engagement and shared ownership

Funding agencies and partnership scholars and practitioners have come to accept that ignoring or minimising community members' perspectives can undermine otherwise well-designed interventions (Kreuter et al., 2000). The involvement of community-based stakeholders allows partnerships to access local knowledge (Drahota et al., 2016; McQuaid, 2010). It also helps partnerships to gain buy-in and mobilise support for policy or programme changes, which is particularly relevant in areas that have a history of strained relationships or mistrust towards public institutions (Kennedy, Vogel, Goldberg-Freeman, Kass, & Farfel, 2009; McQuaid, 2010; Mitchell & Shortell, 2000). Engaging local partners allows generating a sense of shared ownership, which can also facilitate sustainability following the withdrawal of grant-driven resources (Cargo & Mercer, 2008). Sustainability can either take the form of continuing the programme or intervention, or modifying them to suit evolving community needs (Bracht et al., 1994).

2.4 PARTNERSHIP CHALLENGES

“[P]artnership working is difficult to do well and making partnerships work effectively is one of the toughest challenges facing public sector managers” (Audit Commission, 1998, p. 5).

Despite the widespread endorsement and use of the partnership approach across many fields and the abundant literature stating that partnerships are “a good thing” (Popay & Williams, 1998) there is substantial evidence that they generate a great deal of frustration, and frequently struggle to achieve measurable, significant (beneficial) outcomes (Bleeke & Ernst, 2003; Drahota et al., 2016; Hunter & Perkins, 2012; Jones & Barry, 2011a; Lasker & Weiss, 2003; Lasker et al., 2001; Mitchell & Shortell, 2000). “[W]orking together to achieve common objectives is an ideal that all may aspire to but few achieve” (Popay & Williams, 1998, p. 410). Large numbers of cross-border alliances are failing (Bleeke & Ernst, 2003). Estimates suggest that only half of partnerships succeed and among those that do survive many are confronted with challenges with developing plans or the implementation of interventions (Bleeke & Ernst, 2003; Lasker & Weiss, 2003; Lasker et al., 2001).

There are a number of reasons why partnerships fail or are not sustainable, including: the challenges of bringing together people who have never collaborated before; significant time and resource commitments; burnout; problems with governance and leadership; conflicting interests and mistrust; lack of necessary skills; insufficient recognition; and the perennial political challenges (Butterfoss & Francisco, 2004; Drahota et al., 2016; Kania & Kramer, 2013). In addition, partnerships often suffer from collaborative inertia, where the rate of output is much slower than expected (Huxham & Vaugen, 2000). The sub-sections below consider some of these key challenges.

2.4.1 Differences in organisational practices and perspectives

Multiple stakeholders entering a partnership will inevitably bring their own perspectives, cultures, philosophies, ways of doing things and regulatory requirements (Bindler, Richardson, Daratha, Wordell, & Project, 2012; Goodyear-Smith, Jackson, & Greenhalgh, 2015). As documented above, some of these differences can be considered a strength; conversely, they could be a source of tension (Vangen & Huxham, 2010). The differences will manifest in the partners' working practices (Vangen & Huxham, 2010). One of the examples is integrating contractual obligations - a common feature in private management practice - into a partnership that involves public sector players (McQuaid, 2010). Views on the necessity of contractual coordination versus less formal partnership arrangements differ (Mitchell & Shortell, 2000). While contracts, involving rules and defined procedures, may be necessary from the perspective of accountability and clarity in responsibilities, they can also stifle innovation (Butterfoss et al., 1996; McQuaid, 2010). Another example is conflicting priorities over the most appropriate use of financial resources (McQuaid, 2010).

Stakeholders representing different sectors may inadvertently reinforce a siloed (sectoral) and project-driven approach in partnerships that aim to address broader societal and developmental goals and require systemic change that is more appropriately addressed through a programmatic approach (Hazlewood, 2015). In addition, more powerful players (typically those who control resources) may impose approaches to strategies, priority setting, procedures, and implementation modalities that are at odds with the practices and approaches in other organisations (Hazlewood, 2015). Another area where differences may manifest themselves is in stakeholder interactions. The

differences in language, specific jargon, disciplinary approaches and communication etiquettes can compromise understanding between partners (Bindler et al., 2012; Vangen & Huxham, 2010).

2.4.2 Conflict over goals

One of the major causes of partnership failure cited in the literature is the lack of clear, specific goals or aims (Hunter & Perkins, 2014; McQuaid, 2010). This is perhaps not surprising, for the aims expressed by members are strongly influenced by the aims of their respective organisations (Vangen & Huxham, 2010). While partners may have agreed upon broad goals at the start, the details may be unclear or partners may have differing understandings of what the goals mean (McQuaid, 2010). These issues can undermine the benefits of partnerships and lead to misunderstanding, conflict and lack of coordination (McQuaid, 2010). In addition, some partners may have undeclared or “hidden” agendas which may complicate the situation even further (McQuaid, 2010; Vangen & Huxham, 2010).

Partnerships are also highly susceptible to external influences beyond the stakeholders’ respective organisations. For example, governments commonly exercise influence over partnerships, either mandating collaboration or exerting power over partnerships through policy or local priorities (Vangen & Huxham, 2010). Changes in government priorities and policies may lead to a redefinition of partnership goals, or may mean that the specific concerns driving the partnership have ceased to exist altogether (Huxham & Vaugen, 2000). Moreover, where the partnership is internally aligned on the goals, the external community may not be ready to accept them, thereby thwarting the ability of the partnership to achieve measurable results and sustainability (Mitchell & Shortell, 2000). Partnerships that have a service delivery focus may draw resources away from mainstream services or lead to confusion in the minds of service users (McQuaid, 2010). Integrating the fruits of the partnership into mainstream services may pose challenges in the short and long-run (McQuaid, 2010). For example, the lack of involvement of frontline practitioners in the partnership may result in the disconnect between the strategic level and the implementation of activities (Hunter & Perkins, 2012).

2.4.3 Resource commitments

Partnerships are expensive (Audit Commission, 1998). They require a considerable (typically more than anticipated) investment of time, energy and resources, including staff time and effort to

deliberate, arrive at conclusions and consult with a broader range of stakeholders (Hunter & Perkins, 2014; Huxham & Macdonald, 1992; Israel et al., 2006; McQuaid, 2010; Scott & Thurston, 2004). Community-based participatory research (a partnership approach aimed at improving the health and well-being of community members through equitable engagement of diverse partners) is particularly time-consuming, as it involves establishing, and a long-term commitment to nurturing, relationships with community stakeholders (Israel et al., 2010; Israel, Schulz, Parker, & Becker, 1998). Partnerships are frequently “add-on” undertakings, not part of an organisation’s core business, putting an additional strain on organisation’s limited resources and time (Williams & Sullivan, 2010). Resource costs tend to be higher in instances where the partnership is inefficient or where stakeholders do not agree on objectives (McQuaid, 2010). Even when a partnership is working well, the costs involved may outweigh the benefits that accrue from partnership activities (Kreuter et al., 2000). Unfortunately, the full extent of the costs involved in partnership work is rarely known as few partnerships monitor them systematically (Audit Commission, 1998; Hunter & Perkins, 2014).

2.4.4 Governance and management challenges

Partnerships are notoriously difficult to manage (Mitchell & Shortell, 2000) and raise unique governance and management challenges, given that stakeholders represent diverse organisations and tend to collaborate voluntarily. Different types of partnerships will require different forms of monitoring and control, mechanisms of accountability and methods of decision-making (Mitchell & Shortell, 2000). For example, health and community partnerships will tend to rely on social-control mechanisms, including the internalisation of norms, whereas business partnerships will tend to be governed by contracts and legal sanctions (Mitchell & Shortell, 2000). Connections and accountability towards stakeholders external to the partnership (e.g., funders) add to the complexity of partnership governance and management (Mitchell & Shortell, 2000).

2.4.5 Under-investment in evaluation

Even when the most appropriate form of governance and control is adopted, many partnerships suffer from lack of shared measurement systems and weak monitoring and evaluation (Hazlewood, 2015). Despite the availability of literature on best practices involving needs assessment, shared objectives, logic models and evaluation approaches, the complexity of these planning and

assessment tasks and the resource requirements may prevent partnerships from implementing them (Butterfoss & Francisco, 2004; Centers for Disease Control and Prevention, 2008; Kreuter et al., 2000). Partnership funds are more likely to be spent on interventions, leaving evaluation inadequately funded or not built into the plans at all (Butterfoss & Francisco, 2004). Moreover, given that partnerships are complex and dynamic (Huxham & Vaugen, 2000), their evaluation is inherently challenging due to problems of causality and attribution (Butterfoss & Francisco, 2004; Dowling et al., 2004; Keleher, 2015a; Sullivan & Skelcher, 2002). “Distinguishing between cause and effect or what percentage of the outcome can be attributed to which [partnership] activity is often difficult” (Butterfoss & Francisco, 2004, p. 111).

2.4.6 Lack of partnership-building skills

Partnerships require skills that are different from the skills that are honed and rewarded in stakeholders’ mainstream jobs (Lasker et al., 2001; Williams & Sullivan, 2010). Partnerships require boundary-spanning skills (Lasker et al., 2001) that entail “networking activities to build collaborative cultures, based on effective interpersonal relationships, trust and reciprocity, brokering to bring people together to deliver win-win solutions, entrepreneurial activities to promote innovative approaches to ‘wicked problems’, organisational skills to convene and coordinate collaborative processes, and mediation processes to align the different cultures, viewpoints and aspirations of diverse stakeholders.” (Williams & Sullivan, 2010, p. 10). The lack of these skills can hinder partnership development and implementation (McQuaid, 2010).

Too often, partnership tasks are assigned to individuals based on their seniority or status in an organisation (Williams & Sullivan, 2010). However, despite the widespread acknowledgement that the ability and willingness to collaborate is the best predictor of organisational success (Bleeke & Ernst, 2003), training and professional development budgets continue to be used for traditional managerial and professional development and not for competencies required for collaborative work (Williams & Sullivan, 2010). Individuals who are given partnership tasks are expected to either “sink or swim” as they lack this important training and may have had limited exposure to collaborative experiences (Hunter & Perkins, 2014). Similarly, in the academic environment researchers are rarely exposed to the skills required for collaboration during graduate training (Bindler et al., 2012).

2.4.7 Multiple layers of accountability

Given that partnerships involve a variety of actors, accountability may be complicated because of different interests and specific accountability requirements of each participating organisation (Horton et al., 2009). In addition, partnerships are accountable to the intended beneficiaries, other external stakeholders (e.g., funders) and all interest groups represented in the partnership. Many partnerships find that satisfying accountability to all these stakeholders is extremely difficult, and at times impossible to achieve, particularly in light of shifting priorities and changing partnership membership (Huxham & Vaugen, 2000). Challenges can also arise in instances where no single partner feels fully accountable for the actions (and problems) of the partnership or, if there is a lead organisation, other stakeholders may be unclear as to who is in charge (Hunter & Perkins, 2014; McQuaid, 2010).

2.4.8 Power imbalances and loss of control

Unequal power constitutes an important challenge in partnerships involving multiple stakeholders. Even with careful attention to group dynamics and continuous nurturing of collaborative relationships, real and perceived power imbalances will be inevitable (Vangen & Huxham, 2010). Ultimately, partners who control resources will have more influence in the partnership (McQuaid, 2010). Examples include academics or health system players controlling financial resources in partnerships with the community (Kennedy et al., 2009). Achieving equal participation and power may be difficult and may not be realistic; some partners may legitimately have greater power, for example due to their privileged access to a local community (Cargo & Mercer, 2008; McQuaid, 2010). Power imbalances may lead stakeholders who do not control resources into believing that they need to invest more personal time and energy into the partnership (Kennedy et al., 2009). In addition, even well-intentioned stakeholders may lapse into viewing stakeholders who do not control resources as less capable partners (Kennedy et al., 2009).

Another documented challenge in partnership work is the loss of control. Individual organisations participating in the partnerships will inevitably lose control to act independently (Hudson, Hardy, Henwood, & Wistow, 1999). In addition, individual organisations have to share the credit for partnership achievements with other organisational players or even cede the glory to another organisation (Huxham & Macdonald, 1992). These developments may result in turf protection or in the withdrawal from the partnership altogether.

2.4.9 Lack of meaningful engagement of community stakeholders

There is widespread realisation of the importance of involving community stakeholders in health and human services partnerships (Chaskin & Abunimah, 1999; Schulz et al., 2002). Governments and funding agencies increasingly mandate community collaboration as a strategy to increase the relevance and sustainability of partnership activities (Butterfoss & Francisco, 2004; Butterfoss et al., 1996; Canadian Institutes of Health Research, 2012; Eisinger & Senturia, 2001; Green et al., 2001). However, despite ample literature documenting how community engagement should be approached (e.g., Centers for Disease Control and Prevention, 2008; Health Research & Educational Trust, 2016; Israel et al., 1998; World Health Organization, 2017) many partnerships struggle to form and sustain community relationships (Lasker & Weiss, 2003; Mitchell & Shortell, 2000). Specific obstacles include, but are not limited to: lack of trust and respect between community and non-community stakeholders (e.g., researchers); differences in perspectives, beliefs and language; conflicts over the management of funds; different emphases placed by stakeholders on task versus process; and community capacity (Dobbs & Moore, 2002; Israel et al., 1998). In addition, there may be confusion as to the definition of the community, who represents the community and whether partners participate as individuals or as representatives of their respective organisations (Huxham & Vaugen, 2000; Israel et al., 1998). There is a general assumption that individuals participate in partnerships to represent interests that are greater than their own self-interest, yet often it is individuals who are seen as being critical elements of partnership success (Huxham & Vaugen, 2000). Faced with these challenges, many partnerships report limited or superficial community involvement which can compromise the effectiveness of partnership efforts and undermine local ownership that is necessary to sustain activities beyond grant funding (Dobbs & Moore, 2002; Lasker & Weiss, 2003).

2.5 CONCEPTUALISING EFFECTIVE PARTNERSHIPS

This section looks at how effectiveness is conceptualised in partnership literature and at the actions that partners need to take to maximise that effectiveness. The prevailing approach is to assess partnership effectiveness in terms of its ability to achieve intended outcomes (Audit Commission, 1998; Kelly, 2012; Sullivan & Skelcher, 2002), also referred to as “results” or “consequences” (Watson, Broemeling, Reid, & Black, 2004). A recent study of community-academic research

partnerships found that while partnership participants viewed partnership processes as being important, they ultimately determined whether a partnership was effective based upon improvements in measurable research outcomes and the development of tangible products (Lindquist-Grantz & Vaughn, 2016). Outcomes could be either intended or unintended (Jagosh et al., 2012). The intended outcomes could be short-term such as increased knowledge of stakeholders, intermediate such as capacity building, and long-term (or impacts) such as changes in community programmes, policies and practices, and improvements in health indicators (McLaughlin & Jordan, 1999; Watson et al., 2004). Some scholars (e.g., Clarke & MacDonald, 2019) conceptualise specific outcomes to stakeholders (and their respective organisations) as being distinct from the achievement of the intended outcomes of the partnership. An alternative approach to assessing partnership effectiveness is to focus on process elements, i.e., partnership working and the relationships between partners (Dowling et al., 2004).

Despite the centrality of outcome measures in defining partnership effectiveness, most available tools, benchmarks and guidelines focus on processes and structural elements (Dowling et al., 2004; Hunter & Perkins, 2012). This may be due to several reasons. First, it may be assumed that a “healthy” partnership that has a high level of internal functioning will be more likely to achieve the intended long-term outcomes (Zakocs & Edwards, 2006). Secondly, partnerships have intrinsic value. Even if they do not result in better intended outcomes, they are seen as being beneficial from the perspective of democratic participation and creating social capital (Dowling et al., 2004). Thirdly, when evaluating complex undertakings, it is feasible to assess and calibrate processes in the short term, whereas long-term outcomes take time to materialise and may only be measurable in the long term (Dowling et al., 2004). Given that partnerships are frequently nourished by external funding allocated within specific time parameters, evaluating long-term outcomes rarely happens within the initial funding envelope. Finally, as was highlighted in subsection 2.4.5 (*Under-investment in evaluation*) above, evaluating the impacts of partnerships can be challenging due to problems with causality and attribution.

There is no shortage of advice and how-to guides addressing questions of how to form, manage, evaluate and sustain a partnership (Ling, 2000). Despite the depth and breadth of this literature, determining what constitutes effectiveness in any particular case is challenging, given the differences between partnerships in the types of problems being addressed, their target populations, and internal partnership structure and processes (Zakocs & Edwards, 2006). Tables

2-2 and 2-3 below provide a summary of some of the key process and outcome attributes of effective partnerships that are commonly cited in the literature.

Table 2-2. Attributes of effective partnerships for health services – Partnership

	Process attributes	Outcomes attributes
	Partnership process attributes (adapted from Dowling et al., 2004; Horton et al., 2009; Hunter & Perkins, 2012; Stern, 2004; Wildridge et al., 2004)	Partnership outcomes attributes (adapted from Dowling et al., 2004)
P A R T N E R S H I P	Vision and goals • Clear and shared vision of goals, priorities and objectives • Agreement on the ordering of priorities • A realistic plan and timetable for reaching objectives Membership • Appropriate cross-section of members • Clear roles and responsibilities Engagement and commitment of partners • High level of partner engagement • Multiple layers of participation • Flexibility and ability to compromise • Enthusiasm for the partnership Governance and management • Transparent governance and decision-making • Strong management • Clear and consistent communication • Sharing information and results • Effective conflict resolution Monitoring, evaluation and accountability • Systematic and regular monitoring • Realistic ways of measuring partnership's achievements Resources • Sufficient funds, staff, materials and time • Skilled leadership • Appropriate professional support Mutuality • Interdependence and a clear division of labour • Perceptions of mutual benefit Power and equity • Views of service users are included • All partners are viewed as bringing value • Equitable sharing of resources, responsibilities and benefits Trust and respect • Good working relationships • Confidence in each other Capacity building • Mutual adjustment and learning Legitimacy and support • Legitimacy and support for partnership by parent organisations • Commitment from partners to take the partnership's work into account within their mainstream activities • Broader strategic support and commitment	Improvements in accessibility of services to users • Quicker response from service providers • Earlier interventions • Convenience of the service location More equitable distribution of services • Horizontal equity, where people with the same need receive the same attention and services • Vertical equity, where people with different needs receive appropriately different attention and services Improvements in the efficiency, effectiveness and quality of services • Better impact and standards of services • Reduction in duplication and overlap of services Improvements in the experiences of service providers and informal caregivers • Better working conditions and higher job satisfaction of service providers • Improvements in the quality of life of informal caregivers Improvements (or lack of deterioration) in the health status, quality of life or well-being of service users • Health of service users • Capacity to live independently

Table 2-3. Attributes of effective partnerships for health services – Partners

	Process attributes	Outcomes attributes
P A R T N E R	As per Partnership (Table 2-2)	Partner outcomes attributes (adapted from Clarke & MacDonald, 2019)
		Physical capital • Cost savings • Improved efficiency Organisational capital • Innovation • Improved reputation and legitimacy • Access to new resources and opportunities • Improved organisational processes Human capital • Improved knowledge • Employee attraction and retention

Initiating and sustaining partnerships is not easy; it is a complex, dynamic and long process that involves multiple tasks and requires important ingredients (Joss & Keleher, 2011; Zakocs & Edwards, 2006). The diversity of partnerships and methodologies used to study them makes comparisons challenging (Zakocs & Edwards, 2006). However, it has been asserted that there are a number of common features influencing the effectiveness of partnerships, and that the underlying principles behind creating and sustaining effective partnerships are generic (Wildridge et al., 2004). These determinants of effective partnership arrangements tend to be grouped according to the following categories: environment; membership characteristics; process and structure; communication; purpose; and resources (Mattessich & Johnson, 2018). The effectiveness factors are frequently discussed alongside specific steps that the partners should consider at each stage or phase in the life cycle of a partnership (Afsana, Habte, Hatfield, Murphy, & Neufeld, 2009; Centers for Disease Control and Prevention, 2008; VicHealth, 2011; Wildridge et al., 2004). The Centers for Disease Control and Prevention (CDC), for example, identifies the following three stages in the development of a partnership: formation, building and maintenance (Centers for Disease Control and Prevention, 2008). The CDC categorization is helpful for organising the literature on factors that contribute to effectiveness, including an additional stage: closure.

Although studies of partnerships refer to confirmation of funding as the partnership starting point for assessment of partnership effectiveness (Kreuter et al., 2000), this minimises the

investment in ground work. Given that partnerships are time and resource consuming, it is important to first determine the need for the partnership and ascertain that the environment is favourable towards the partnership (Centers for Disease Control and Prevention, 2008; Hardy, Hudson, & Waddington, 2003; VicHealth, 2011). This pre-planning stage can enhance the chances of partnership effectiveness (Kreuter et al., 2000). “Because coalition building involves a long-term investment of time and resources, a coalition should not be established if a simpler, less complex structure will get the job done or if the community does not embrace this approach.” (Butterfoss & Francisco, 2004, p. 108). Effectiveness may be demonstrated in deciding that a partnership is not the optimum way to achieve intended outcomes.

Once partnership has been identified as the preferred mechanism, the planning or formation stage would usually include (Centers for Disease Control and Prevention, 2008; McQuaid, 2010; VicHealth, 2011):

- problem setting;
- identifying the resources needed to implement and sustain the partnership;
- assessing the context within which the partnership will operate;
- identifying and recruiting appropriate partnership members: ensuring that organisations and individual representatives have the authority and institutional flexibility to engage in mutual decision-making and resource-sharing; ensuring the right mix of skills and expertise and a good “match” between the organisations represented in the partnership;
- defining and achieving agreement on the mission, vision and core strategy for the partnership;
- determining the roles and responsibilities of partners, including formal agreements.

Some of the factors contributing to effectiveness at this stage include: a clear mandate for collaboration; a history of collaboration or cooperation in the community; a favourable political/social climate and general public support (or at least a lack of opposition) for the partnership; achieving a sufficient variety in partnership membership to have a comprehensive understanding of the issues being addressed; and organisational structures that enable collaboration (Mattessich & Johnson, 2018; Valaitis et al., 2018; VicHealth, 2011).

The second, building, stage, would usually involve (Centers for Disease Control and Prevention, 2008; McQuaid, 2010):

- developing the infrastructure;

- ensuring clear strategic leadership and support for the partnership;
- developing capacity, including training partners to participate effectively in the partnership;
- ensuring that communication, decision-making, reporting and evaluation processes are in place;
- fostering commitment.

Some effectiveness factors at this stage include: the clarity of the lines of communication, roles and expectations; a participatory decision-making system that is accountable, responsive and inclusive; and a genuine willingness to make the partnership work (Mattessich & Johnson, 2018; McQuaid, 2010; VicHealth, 2011).

As partnerships move into implementation and maintenance of collaborative action, the focus shifts to outcomes and setting the ground for sustainability, but collaborative processes, such as communication, decision-making and accountability, continue to be important (Centers for Disease Control and Prevention, 2008). This stage (or stages) would include (Wildridge et al., 2004):

- ensuring joint ownership of decisions and collective responsibility;
- developing and maintaining trust;
- ensuring that all partners continue to feel involved and that they are bringing value;
- monitoring and evaluating the partnership;
- managing change.

Some effectiveness factors at this stage include: the availability of formal structures for sharing information and resolving demarcation disputes; the value added of the action (rather than duplicating services) for the community, clients or agencies involved in the partnership; and the satisfaction of members with the partnership (Afsana et al., 2009; VicHealth, 2011).

Finally, effective closure in an important stage. Partnerships need to consider a number of important steps as part of the closing of the partnership (Afsana et al., 2009; VicHealth, 2011; Wildridge et al., 2004):

- planning an exit strategy;
- celebrating and publicising collective achievements and/or individual contributions;
- disseminating partnership results;
- determining the need and commitment to continue the partnership;

- identifying the resources from internal and external sources to continue the partnership.

One of the effectiveness factors at this stage is the partnership's ability to demonstrate and document the outcomes of collective work (VicHealth, 2011).

It is important to note that taking into consideration the highly complex, dynamic and context-specific nature of partnerships, each of the factors outlined above may be more or less relevant depending on the specific circumstances and the goals of a partnership (Himmelman, 2002; Horton et al., 2009; Wildridge et al., 2004), and there may be other factors that are relevant to other partnerships. In addition, it should be stated that the process of developing, implementing and sustaining partnerships is not linear. Partners may need to go back and forth between steps, if changes occur in the membership, the environment, funding or partnership goals and direction (Centers for Disease Control and Prevention, 2008).

2.6 KNOWLEDGE GAP

As sections above illustrate, the literature that identifies benefits that can be expected in the case of well-organised and well-resourced partnerships is sound. These benefits are frequently highlighted to justify working in partnership or mandating the partnership approach. Indeed, the appeal of joint working is so strong that it can be seen as a “panacea” (Butterfoss & Francisco, 2004) - as the only logical way to tackle society's ills. In today's fast-paced and complex world, partnerships are in vogue and are frequently embarked upon blindly without properly analysing all of the potential costs and challenges outlined in section 2.4 (*Partnership Challenges*). It is, perhaps, not surprising that many partnerships fail to achieve the intended outcomes in terms of individual or population health or system change. Partnerships have provided a mechanism for working toward common goals for millennia and yet we are still struggling to make them work.

While underestimating the costs of partnerships is one reason that partnerships fail, another contributor to failure is the type and quality of evidence that is available regarding the arrangements and processes that lead to the effectiveness of partnership outcomes. Surprisingly, many guidelines for organising and managing partnerships stem from studies that are based on secondary research of past partnerships, predominantly surveys (Horton et al., 2009). Empirical primary studies of ongoing partnerships and systematic evaluations of the effectiveness of partnership arrangements, especially intended partnership outcomes, are rare (Horton et al., 2009; Keleher, 2015a). In addition, while there is no shortage of theoretical frameworks to understand

partnerships (Dowling et al., 2004), it is rarely clear to what extent partnerships are founded on a solid theoretical base (Horton et al., 2009; Hunter & Perkins, 2014). Indeed, practice frequently precedes, and is seldom linked to, theory (Scott, 2001). In particular, understanding the pathway through which the factors associated with effective partnerships (as described in section 2.5. *Conceptualising Effective Partnerships* above) lead to the achievement of intended outcomes has received relatively little attention in research. There is still insufficient rigorous evidence that would inform decision-making on planning, implementing, evaluating and sustaining partnerships, and improve collaborative practice (Drahota et al., 2016; El Ansari et al., 2001; Joss & Keleher, 2011; Keleher, 2015a). Moreover, taking into consideration that partnerships can exhibit a high degree of volatility due to internal dynamics and external influences, it is important to have studies of partnerships in various geographical and organisational contexts in order to tease out the drivers of partnerships that may be consistently usable across contexts. Finally, most of the solid evidence on collaborative ways of working in health care comes from fields such as public health, including health promotion, and not PHC. In Canada, this may be due to the fact that the ministries of health have only recently started viewing PHC as a priority (Brown, Upshur, & Sullivan, 2013) and that PHC research is still relatively new. While there are similarities between these health care fields, PHC presents unique challenges.

PHC refers to a spectrum of community-based health-related services (Starfield, Shi, & Macinko, 2005). The community-based clinical services within the formal health care system, sometimes referred to as primary care, is where a broad range of needs are addressed for a defined population of patients (comprehensiveness), and patients are connected to other needed services. Definitions of PHC services tend to be more comprehensive in scope than primary care (Canadian Institutes of Health Research, 2010; Keleher, 2001; World Health Organization, 1978), and they are sometimes portrayed as being in tension with one another. However, as the contribution of social determinants of health is increasingly being recognised in clinical practice, so is the imperative to extend health-related community-based services beyond the primary care clinic walls to include other services such as social support, housing, and education. Intentional partnerships of clinical care organisations with organisations in other sectors and representing other professions enable patients, communities and population to benefit from PHC and not only primary care. There is still a shortage of studies on how processes and approaches to promote and solidify these

partnerships are applied and how they interact both with each other and with partnership assets to produce intended outcomes in PHC.

The purpose of this doctoral project was to help bridge the above-mentioned knowledge gaps by adding depth to understanding processes and approaches that contribute to partnership effectiveness and achievement of intended outcomes in the context of care transformation in PHC. More specifically, the doctoral candidate studied the linkages between the structures, processes of partnerships and different manifestations of effectiveness, including the effectiveness of processes and outcomes. Conceptual and theoretical underpinnings of partnerships were used to guide the observation and analysis of local partnerships within the framework of the IMPACT research programme.

CHAPTER 3. Epistemological Influences, Theoretical Frameworks and Research Approach

This research reflects a social constructivist epistemology and was informed by the following theoretical frameworks: partnership synergy (Lasker et al., 2001), contingency theory (Lawrence & Lorsch, 1969) and resource-based theory (RBT) (Barney & Clark, 2007).

3.1 EPISTEMOLOGICAL COMMITMENTS

For the purposes of this discussion, “epistemology” is defined as the researcher’s theory of knowledge (Carter & Little, 2007). Some authors refer to one’s epistemological position as a “worldview”, “paradigm” or a “mental model” (Giddings & Grant, 2007; Greene, 2007; Guba & Lincoln, 1994; Senge, 2006). Epistemology entails beliefs about how the world should be studied and influences the relationship between the researcher and inquirer (Carter & Little, 2007; Denzin & Lincoln, 2018). The doctoral candidate’s stance is social constructivist. Table 3-1 below details the key elements of the social constructivist worldview. The main claim of constructivism is that knowledge is created through social processes and interaction as opposed to something that is to be discovered (Schwandt, 2001). Constructivists stress the understanding or meaning of phenomena through the subjective accounts of participants, accounts that are shaped by shared understanding, language and past histories (Creswell & Plano Clark, 2011; Schwandt, 2001). In other words, “reality is an outcome of human processes, and impossible to separate from the processes from which it is constituted” (Green & Thorogood, 2018, p. 44).

Table 3-1. Elements of the social constructivist worldview and implications for practice

Constructivism	
Understanding	Researchers seek to understand how social actors recognise, produce, and reproduce social actions and how they come to share an intersubjective understanding of specific life circumstances (Schwandt, 2001, pp. 31-32).
Multiple participant meanings	Human beings do not find or discover knowledge so much as construct or make it (Schwandt, 2001, p. 30). There are multiple realities, researchers illustrate different perspectives (Creswell & Plano Clark, 2011, p. 42).
Social and historical construction	Reality is constructed and interpreted within specific linguistic, social, and historical contexts (Schwandt, 2001, p. 32). Researchers actively talk about their biases and interpretations (Creswell & Plano Clark, 2011, p. 42).
Theory generation	Researchers start with participants' views and build "up" patterns, theories, and generalisations (Creswell & Plano Clark, 2011, p. 42).
Role of evidence	Evidence, including statistics, is treated with a critical eye (Green & Thorogood, 2018, p. 44).
Method	Typically associated with qualitative approaches (Creswell & Plano Clark, 2011, p. 40). The tendency is to use open-ended questions so that participants can express their views (Creswell & Creswell, 2018, p. 8).

There are two schools of constructivist thinking: psychological (or radical) constructivism and social constructivism (Schwandt, 2001). The former is focussed on the individual and their acts of cognition, whereas the latter is concerned with social processes and interaction. In addition, Schwandt (Schwandt, 2001) distinguishes between "strong" and "weak" constructivist thinking. Strong social constructivists deny the existence of reality and claim that "the world is nothing but a sociolinguistic product of historically situated interactions" (Schwandt, 2001, p. 33). Conversely, weak constructivists (including this doctoral candidate) contend that "something can [...] be both socially constructed and yet "real"" (Hacking, 2000), and are instead interested in unveiling how one's experience or classification of this reality is socially constructed (Schwandt, 2001).

Alongside other paradigms such as critical theory, participatory paradigms, hermeneutics and interpretivism, social constructivism is commonly associated with qualitative modes of inquiry (Denzin & Lincoln, 2008). On the other hand, quantitative research is typically associated with post-positivism which is located at the opposite end of the paradigmatic continuum (Betzner, 2008; Creswell & Creswell, 2018; Green & Thorogood, 2018). Post-positivism, a more moderate form of positivism, reflects: a) determinism, in which "causes (probably) determine effects or outcomes"; b) reductionism, "in that the intent is to reduce the ideas into a small, discrete set to test"; c) detailed observations and measures of the objective reality; and d) testing, verification and refinement of theories and laws that govern the world (Creswell & Creswell, 2018, pp. 6-7).

Mixed methods research, which entails both qualitative and quantitative data, can enrich understanding on a subject precisely because it can draw on and integrate the underlying

epistemologies of distinct methods. It has been argued that mixed methods research is incompatible with either the constructivist or post-positivist paradigm in isolation (Hall, 2013). In an attempt to resolve the challenges related to the quantitative-qualitative dichotomy, several approaches have been proposed, namely, the a-paradigmatic, the multiple paradigm, and the alternative single paradigm approaches – pragmatism and the transformative approach (Hall, 2013). According to some scholars, most modern mixed methods research has been influenced by pragmatism (Giddings & Grant, 2007). Tashakkori and Teddlie (Tashakkori & Teddlie, 2003) identify pragmatism as the worldview that is subscribed to by a sizable number of researchers in relation to mixed methods research. Giddings and Grant (Giddings & Grant, 2007), on the other hand, argue that, unlike post-positivism, pragmatism is not a paradigm but an ideological position not inconsistent with any paradigm, and that most mixed methods studies to date reflect methods of inquiry and contain the forms of analysis associated with post-positivism. While the discussion of whether pragmatism constitutes a separate paradigm is beyond the scope of this work, what is clear from the literature is that mixed methods research does not need to be confined to one single paradigm or worldview (Creswell & Plano Clark, 2011). Mixed methods research is conducive to drawing on more than one perspective (Creswell & Plano Clark, 2011). This epistemological pluralism is, however, only possible if a mixed methods study is conducted by a team of researchers who contribute their different perspectives to the research. Despite the fact that the research described in this thesis has been conducted by a social constructivist, the doctoral training and the results of this research have been informed by a broader set of epistemologies.

3.1.1 Summary of epistemological influences on research approach

The candidate's social constructivist epistemological position emerged and crystallised in the course of prior training in social sciences and research experiences in the tradition of qualitative research. This position influenced the research objective to understand and describe the phenomenon of multi-stakeholder partnership in PHC through the subjective lens of the partnership participants (Creswell & Plano Clark, 2011). The partnerships under doctoral investigation were viewed as being socially constructed by partnership stakeholders through social processes within specific social and historical contexts. The objective of the research was to understand these multiple socially and experientially based constructions by eliciting the accounts

of partnership participants, and to juxtapose these accounts to distil a consensus construction of each partnership under investigation (Guba & Lincoln, 1994).

The qualitative phase of the doctoral project was designed in line with the case study procedures outlined by Robert K. Yin (Yin, 2014). Yin is frequently cited as one of the foundational methodologists of case study research along with Sharan Merriam and Robert E. Stake (Yazan, 2015). In contrast to the consensus that exists in the research community regarding the epistemological commitments of Merriam and Stake, there is disagreement in relation to which stance is being espoused by Yin. This tension is likely due to the fact that Yin does not explicitly articulate his epistemological allegiances in his work. Some scholars claim that Yin advances assumptions of a social construction of reality and the close relationship between the researcher and the participant (Baxter & Jack, 2008). Other researchers describe Yin as a post-positivist due to the emphasis he puts on using a “formal conceptual framework and propositions that are tested and accepted or refuted as data are collected and analyzed” (Boblin, Ireland, Kirkpatrick, & Robertson, 2013, p. 2), as well as the importance of construct validity, internal validity, external validity, and reliability (Yazan, 2015). In the case of this doctoral project, Yin’s approach to case study research was chosen based upon its suitability for studying events and processes and its applicability to combining qualitative and quantitative evidentiary sources (Yazan 2015). In addition, Yin’s approach lends itself well to pragmatic application by offering a detailed, comprehensive strategy for linking empirical data with the study’s initial questions and, subsequently, conclusions and reporting. (Yazan 2015, Yin, 2014). Yin’s emphasis on the design of the case study, including the development of theoretical propositions based on prior literature review, and his detailed guidelines regarding cross-case synthesis were found to be particularly useful in this research.

Quantitative research methods that were employed in the second phase of the doctoral project are often associated with post-positivism (Creswell & Creswell, 2018). However, epistemological beliefs do not determine the choice of methods. Both qualitative and quantitative methods could be used appropriately irrespective of the epistemological position of a researcher (Guba & Lincoln, 1994). “The use of numerical and verbal data together for gaining profound understandings does not necessitate abandoning [an] epistemological position and forging or adopting a new one.” (Mirhosseini, 2018). The combination of qualitative and quantitative methods in the current project allowed the candidate to study the multi-stakeholder partnership

phenomenon more deeply (through document review, non-participant observations and in-depth qualitative interviews) and more broadly (analysing the phenomenon across multiple sites). It allowed to not only obtain an understanding of the complexity of views of partnership stakeholders and how these views were shaped by their partnerships and broader contexts, but also to derive conclusions regarding the contribution of various components to partnership effectiveness.

The overall knowledge gained through this research has drawn on a larger set of epistemologies, including post-positivism and critical theory, through being part of a team involving research supervisors and committee members, and of a broader community of PHC researchers and practitioners espousing different worldviews.

3.2 RESEARCH APPROACH

The IMPACT research programme's investigations were framed in a participatory action research approach, being based upon shared governance and ownership of all aspects of the research process (Schmittiel, Grumbach, & Selby, 2010). This included the selection, adaptation, implementation, and evaluation of PHC innovations, as well as dissemination of research findings. Unlike the more traditional investigator-driven research, all participants (including researchers, clinicians, organisational representatives and decision makers) were to contribute at each stage of the process (Drahota et al., 2016; Israel et al., 2008). IMPACT research programme's stakeholders were to identify regional access priorities; assess and select relevant organisational innovations; engage a broader set of stakeholders in collective decision-making to examine the feasibility of implementing organisational innovations that have been selected; design the innovations; identify resources; and implement system improvements. The doctoral research project incorporated elements of participatory research including: engaging the stakeholders in determining the research objectives; gathering project participants' feedback on the relevant sources of information; applying strategies to achieve higher levels of participation; and focussing on developing rapport with research participants.

3.3 THEORETICAL FRAMEWORKS

This investigation was primarily informed by the following theoretical frameworks: the partnership synergy framework (Lasker et al., 2001), contingency theory (Lawrence & Lorsch,

1969) and resource-based theory (RBT) (Barney & Clark, 2007). These theories helped to frame data gathering and synthesis, and supported a more meaningful presentation of outcomes. The frameworks were selected after an iterative process that involved initial observations of the IMPACT research programme meetings, refining the research objectives and an accompanying literature review. The literature review focussed on theories that would be most applicable to studying complex evolving partnerships in general, and the IMPACT research programme partnerships in particular, as well as those that would provide the best fit with the doctoral project's research objectives (Grant & Osanloo, 2014). The selection was also guided by the need to understand the interplay of factors influencing the development and maintenance of partnerships, including organisational and system-level factors.

3.3.1 Partnership synergy

The partnership synergy framework was adopted as an umbrella framework for looking at numerous aspects of interest in relation to the formation and functioning of the IMPACT research programme partnerships. The partnership synergy framework posits that synergy is “the degree to which the partnership combines the complementary strengths, perspectives, values and resources of all partners in the search for better solutions” (Jones & Barry, 2011b, p. 37). Synergy is reached when the combined efforts of partners enhance the outcomes beyond what could be achieved independently by each stakeholder/stakeholder group working towards the same goals (Jagosh et al., 2012), namely when the whole becomes greater than the sum of the parts (Lasker et al., 2001).

The framework considers a variety of factors affecting partnerships, including resources, partner characteristics, partner relationships, partnership characteristics and the environment in which partnerships function (Lasker et al., 2001). The partnership synergy lens was therefore useful in analysing the IMPACT research programme local partnerships not only from the perspective of stakeholder dynamics but also the contextual conditions in which they operated. In addition, the framework is accompanied by two validated scales of measuring synergy, which was an appealing feature for a mixed methods study. Another reason for selecting the partnership synergy framework was that it had been found to be useful in framing the outcomes of participatory research (Jagosh et al., 2012).

Lasker, Weiss and co-workers worked on various aspects of partnerships in the area of public health. Lasker et al. identified a number of elements of partnership functioning that are

likely to influence partnership synergy (outlined in Table 3-2 below) and suggested looking at synergy as the “proximal outcome” or a product of an effective partnership (Lasker et al., 2001). On the other hand, Jones and Barry, working in the field of health promotion, conceptualised synergy as being both a process and a product of partnership (Jones & Barry, 2011b).

Table 3-2. Determinants of partnership synergy (adapted from Lasker et al., 2001)

Determinants of partnership synergy	Factors likely to influence partnership synergy
Resources	Money: financial and in-kind resources that are the basic building blocks of partnership synergy
	Space, equipment, goods: e.g., computers, medications, food and books
	Skills and expertise: to engage partners, support the collaboration process, and carry out and coordinate the multiple components of interventions
	Information: scientific data, perspectives, values and ideas of different stakeholders, information on community’s assets, political environment, and history
	Connections to people, organisations, groups: e.g., target populations, political decision makers, government agencies, private sector funders, and other partnerships in the community
	Endorsements: that give partnership legitimacy and credibility with various stakeholders
	Convening power: the influence and ability to bring people together for meetings and other activities
Partner characteristics	Heterogeneity: an optimal mix of partners with a sufficient range of perspectives, resources, and skills
	Level of involvement: an optimal and active way of engaging partners to give the group a full picture of the problem, to stimulate new, locally responsive ways of thinking about solutions, and to implement comprehensive actions
Relationships among partners	Trust: confidence of the people and organisations involved in a partnership that other partners will follow through on their responsibilities and obligations and will not take advantage of them
	Respect: appreciation of the value of the others’ contributions and perspectives
	Conflict: has the potential to foster synergy if differences of opinion sharpen partners’ discussions on issues and stimulate new ideas and approaches; if not managed well, the same differences of opinion can lead to strained relations among partners
	Power differentials: have the potential to undermine synergy through limiting who participates, etc.
Partnership characteristics	Leadership: boundary-spanning leaders who understand and appreciate partners’ different perspectives, can bridge diverse cultures, and are comfortable sharing ideas, resources and power
	Administration and management: approaches that are flexible and supportive
	Governance: key to partnership functioning, influences the extent to which partners’ perspectives, resources and skills can be combined
	Efficiency: the degree to which a partnership optimises the involvement of its partners
External environment	Community characteristics: e.g., history of cooperation and trust, significant competition for resources or clients, etc., beyond the control of a partnership
	Public and organisational policies: e.g., external funding, performance standards and promotion and tenure policies which might create disincentives for key people or organisations to participate in partnerships

Both Weiss et al. and Jones and Barry developed specific synergy measurement scales: the Weiss et al. scale (Weiss et al., 2002) and the Jones synergy scale (Jones & Barry, 2011b). The two scales measure partnership synergy in different ways: the Weiss et al. scale – looking at synergy as a product of a partnership that has achieved its full potential, and the Jones synergy scale – measuring synergy as both a partnership process or experience and a partnership product (Jones & Barry, 2011a). The Weiss et al. synergy scale measures the construct of partnership synergy eliciting adverbial responses to nine items using a five-point frequency Likert response scale from “extremely well” to “not well at all”. The Jones synergy scale measures partnership synergy using eight items and a five-point frequency Likert response scale from “always” to “never”, with “don’t know” offered as a response option. The Weiss et al. synergy scale measures performance and asks the respondents to identify how well a partnership does certain things (Jones & Barry, 2011b). By contrast, the Jones synergy scale measures partnership performance and direct experience and asks the respondents to identify how often a partnership experiences certain things (Jones & Barry, 2011b). Both scales had been used in conjunction with one another in past research (Jones & Barry, 2011a). For a complete questionnaire that incorporates both synergy scales, please refer to Appendix B. Both synergy scales were used in the present doctoral project, taking into consideration that this study focussed on analysing the partnerships from both the outcome and process angles, in order to obtain a richer assessment of the partnership synergy phenomenon. The two scales were applied as the basis for coding qualitative data and designing the questionnaire.

The synergy discourse is not confined to the field of partnerships or organisational behaviour. Synergistic phenomena (or “synergism”) had been described in scientific literature in fields as varied as toxicology and ecology (Piggott, Townsend, & Matthaei, 2015) long before the term entered the organisational realm. This literature from natural sciences describes synergy as one of the possible effects of combination of various substances or “stressors”, with the other two effects being “additive” and “antagonistic” (Folt, Chen, Moore, & Burnaford, 1999; Hay, 1996; Hay, Kappel, & Fenical, 1994). While synergy is claimed to occur when the combined effect of multiple stressors is greater, antagonism denotes instances when the combined effect is less than the additive sum of effects, and the additive effect implies that stressors are operating independently of each other (Folt et al., 1999; Hay, 1996; Hay et al., 1994; Piggott et al., 2015). Counterintuitively, in the field of environmental sciences antagonistic effects may represent “best

case scenarios” for they imply less stress on the eco-system (Piggott et al., 2015, p. 1545). Conversely, in the field of partnerships antagonism refers to partnership processes which waste partners’ time and resources (Corbin & Mittelmark, 2008). While the research described in this thesis adopted partnership synergy as the primary lens to analyse partnership dynamics, it acknowledges tacitly the potential for antagonism.

3.3.2 Contingency theory

Contingency theory, or the situational approach to management, posits that there is no one best way of organising, and that the most appropriate form will depend on internal and external situational variables (Hofler & Barnett, 2006; Morgan, 2006). In other words, to be effective, structuring, organising and managing have to be tailored to the organisation’s particular circumstances (Hofler & Barnett, 2006). The main premise of the theory is that organisations that exhibit the best alignment between their internal features and environmental circumstances will achieve the best adaptation to that environment (Scott, 2003). This emphasis on organisations as open systems interacting with their environment is seen as a departure from classical management theory that devoted relatively little attention to the environment and largely viewed organisations as self-contained entities (Bastedo, 2006; Morgan, 2006).

There are many branches of contingency theory, however, most of them focus on how organisations are structured and led which, in turn, determines their fate (Hofler & Barnett, 2006). The contingency theory of leadership asserts that a leader’s effectiveness is contingent upon whether their leadership style fits a particular situation (Fiedler, 1967). Effective leaders should practice self-awareness and constantly analyse each situation to determine which leadership characteristic would fit best (Fiedler, 1967).

According to the contingency approach to organisation theory, the most appropriate form of organising will depend on external contingencies, such as market, political and technological conditions (Burns & Stalker, 1994). Organisations with a high degree of uncertainty and rapid rates of change will necessitate open and flexible styles of organisation, whereas the mechanistic approach to organising may be more appropriate if the environment is more stable and predictable (Lawrence & Lorsch, 1969). It has been demonstrated that successful organisations operating in highly volatile environments adopted more organic, multidisciplinary team-based forms of working, with flexibility in job parameters and a high reliance on meetings as a way to exchange

information and identify problems (Morgan, 2006). In addition, these organisations tended to have a higher degree of differentiation between departments, with such units as research and development adopting more informal modes of interaction than finance (Lawrence & Lorsch, 1969). Lawrence and Lorsch (Lawrence & Lorsch, 1969), who isolated the key elements of modern contingency theory, also made important contributions to our understanding of optimal integration, demonstrating that conventional (hierarchical) forms of integration worked well in relatively stable environments.

More recent contingency theory research has focussed on identifying the characteristics of different types or “species” of organisations that would be appropriate under different circumstances (Morgan, 2006). Of particular interest to the work described in this thesis was Henry Mintzberg’s (Mintzberg, 2003) classification of organisations into a number of internally consistent groupings or “configurations”, distinct in their structural designs – entrepreneurial, machine, professional, diversified, innovative, missionary and political organisations. Each of these configurations can be differentiated along three basic dimensions: (1) the key part of the organisation – that plays a key role in determining its success and failures; (2) the prime coordinating mechanism – the way in which the organisation divides and coordinates activities; and (3) the type of decentralisation used – the extent to which the decision-making power is diffused (Lunenburg, 2012; Mintzberg, 2003).

The ideas and concepts of contingency theory are highly relevant to the study of partnerships, for 1) despite being composed of members of different organisations, partnerships represent a separate organisational entity, and 2) the way partnerships evolve is highly dependent on external and internal factors. Contingency theory was deemed pertinent to this doctoral project given that the project entailed studying partnerships evolving in different political, social and economic contexts. It provided a systematic, theory-based approach to assessing the broader dimensions of partnerships’ structures and ways of working. More specifically, Mintzberg’s essential parameters of design were referred to in the process of analysing the congruence between the context and function of each partnership on the one hand and, on the other, its various attributes, including, how it was structured and how it engaged its stakeholders. These ideas were used to inform the interpretation of results as described in Chapter 5 (*Manuscript 1*).

3.3.3 Resource-based theory

Resource-based theory (RBT) (Barney & Clark, 2007) is a strategic management theory looking at internal organisational resources from the point of view of their strategic value and their role in achieving enduring competitive advantage. Building on resource-related ideas of such scholars as Edith Penrose (Penrose, 1959) and Philip Selznick (Selznick, 1957) RBT proposes a comprehensive framework to be used by organisations to assess the relative strategic value of the resources under their control and to devise ways of leveraging these resources to enhance performance. Resources are conceptualised as “assets, capabilities, organizational processes, firm attributes, information, knowledge, etc. controlled by a firm that enable the firm to conceive of and implement strategies that improve its efficiency and effectiveness” (Barney, 1991, p. 101). RBT theorists have offered several typologies of these assets. In broad terms, they can be categorised into tangible and intangible assets (Grant, 1991). Tangible resources can be grouped into physical (e.g., technology) and financial (e.g., revenue) assets (Barney, 1991; Hart, 1995). The intangible resources can be classified into human (e.g., skills, training, experience, relationships) and organisational (e.g., culture, reputation, reporting, coordinating systems) assets (Barney, 1991; Hart, 1995).

Not all of these resources are of equal value: some will be more or less important from the point of view of contributing to competitive advantage. In addition, their relative importance may fluctuate based on changes in the organisation’s environment (Barney & Clark, 2007). A resource is considered strategic to the extent that it is (1) valuable (to the end users); (2) rare (not possessed by a large number of competitors); (3) imperfectly imitable (other organisations cannot duplicate or substitute it); and (4) is capable of being exploited by organisational processes (Barney & Clark, 2007). The main assumptions underlying these criteria are: (1) that organisations within the same grouping or industry are heterogeneous in terms of resources that they control; and (2) that these resources are not perfectly mobile (Barney, 1991). Tangible (financial and physical) resources may be easier to acquire by competitors, whereas intangible resources may be more difficult to replicate due to their social complexity, causal ambiguity and their roots in the specific history of the organisation (Barney & Clark, 2007; Dierickx, Cool, & Barney, 1989). These attributes make intangible resources more valuable (Das & Teng, 2000; Prahalad & Hamel, 1990). Indeed, recent research has demonstrated that intangible assets contributed considerably more to corporate growth and shareholder value than physical assets (Lev, 2004).

Given that RBT focusses primarily on the management of for-profit entities, it emphasises competitive advantage and profit maximisation (Barney, 1991; Wernerfelt, 1984). RBT conceptualises competitive advantage as the ability of an organisation to capitalise on resources to create greater value than competitors (Barney & Clark, 2007). It is important to note that the mere possession of resources does not confer value, rather value is created through effective and innovative management of “bundles” of resources, or effective resource integration (Kor & Mahoney, 2004; Penrose, 1959). In the context of rapid technological change, increased competition for resources and given that valuable resources are rare and difficult to move, one way to acquire needed resources is through strategic alliances (Das & Teng, 2000). Indeed it was suggested that a deep commitment to work across organisational boundaries constitutes one of the core organisational competencies (Prahalad & Hamel, 1990). The pooling and utilisation of valuable resources contributed by partners enables value maximisation for the alliances’ key stakeholders (Das & Teng, 2000).

The emphasis on resources and leveraging existing strengths for success is not limited to the field of business. One of the examples in the public sphere is the Asset-based community development (ABCD) approach (Kretzmann & McKnight, 1993). Instead of focussing on community deficiencies, the approach stresses identifying and mapping community assets and mobilising them for development purposes (Kretzmann & McKnight, 1993). In relation to this doctoral thesis, the RBT classification of resources was applied in order to identify the range of resources that the partners brought to the partnership table. RBT’s notion of competitive advantage was less relevant in the context of the partnerships that were the focus of this investigation. Instead, the doctoral study utilised the concept of value creation through resource integration. In addition, RBT was used to frame outcomes to partners that were gained in the process of participating in the partnership (Clarke & MacDonald, 2019).

CHAPTER 4. Methodology

4.1 CONTEXT - IMPACT PROGRAMME OF RESEARCH

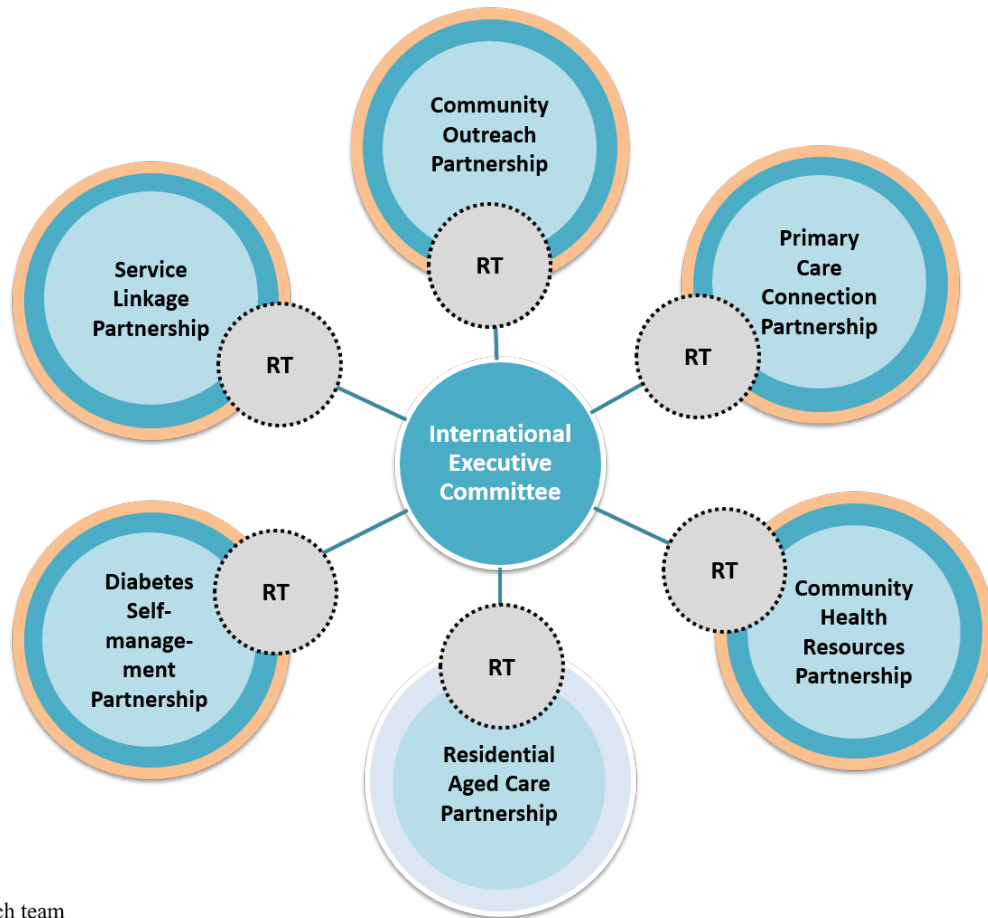
This doctoral project was embedded within a Canada-Australia research programme, entitled “Innovative Models Promoting Access-to-care Transformation (IMPACT)” (Levesque et al., 2013). The programme began in 2013 and finished in 2018. It aimed at implementing organisational innovations to improve access to appropriate PHC for vulnerable populations. In the context of the IMPACT research programme, PHC was conceptualised as “... the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitute[ing] the first element of a continuing health care process” (World Health Organization, 1978, p. 2).

The IMPACT research programme organisational innovations were designed and implemented through collaborative local partnerships between decision makers, researchers, clinicians and organisational representatives (the stakeholders) in three Australian states (Victoria, South Australia and New South Wales), and three Canadian provinces (Quebec, Ontario and Alberta). Each of these six teams was working within their respective region to identify PHC access needs, and to select, adapt and implement coordinated actions to best address these needs (Levesque et al., 2013). “The objective of these interventions was to enhance the approachability, acceptability, availability/accommodation, affordability and appropriateness of generalist/primary medical care services in order to improve the extent to which services are provided on the basis of health needs, without systematic differences on the basis of individual or social characteristics” (IMPACT Programme Team, 2014, p. 2). The implementation of these interventions was subsequently evaluated.

The engagement and creation of meaningful partnerships between stakeholders were central to achieving the objectives of the research programme (Levesque et al., 2013). A critical feature was that the research programme did not bring funding for the interventions; consequently, successful implementation of the innovations was entirely dependent on the capacity of the local partnership stakeholders to work together to identify and mobilise local resources. The sustainability of the intervention relied on the ability of the local players to commit to the intervention, provide adequate resources, and maintain it beyond the life of the IMPACT research funding.

Each IMPACT local partnership was unique, based upon the specific context within which it was unfolding and the local access need that the partnership was trying to address. The tailored processes and requirements were needed to meet this need, and relationships were formed to move the work forward. As a result, the interventions in each partnership were different. For example, one Canadian local partnership aimed to connect unattached vulnerable patients to family physicians (Russell et al., 2019). In the other, the intervention focussed on integrating a primary care patient navigator to improve access to resources in the community for patients experiencing social barriers (Russell et al., 2019). An integral part of implementing the interventions was continuous learning from the experiences of partnerships with regards to what was working (and what was not), in order to make timely adaptations, thus ensuring that the interventions remained responsive to community needs and resources.

Despite the differences between IMPACT local partnerships, the following structures had been proposed across all six local partnerships: a) research team – composed of academic investigators, including Principal Investigators and co-investigators, and research coordinators; b) local partnership core team – comprising the research team, clinicians, policy makers and organisational stakeholders (e.g., representatives of non-profit organisations working with vulnerable populations); and c) local partnership management committee – which included the core team, higher level decision makers and stakeholders beyond the core team. The local partnership core team was the principal object of interest within the framework of the doctoral project. The executive team of Principal Investigators in Canada and in Australia took responsibility for the overall management of the IMPACT research programme. This team made the final decisions in relation to the IMPACT research programme. See Figure 4-1, below, for a schematic representation of the IMPACT programme structure.



RT – research team

Circles in dark blue – local partnership management committee

Circles in orange – larger local partnership network

Figure 4-1. IMPACT research programme structure

4.2 RESEARCH DESIGN/METHODOLOGY

This doctoral project entailed a two-phase mixed methods sequential exploratory design (see Figure 4-2 below). The rationale behind selecting a mixed methods design was to build on the strengths of both qualitative and quantitative research approaches to obtain a deeper understanding of the phenomenon under study – the multi-stakeholder partnership – than would have been possible by applying either approach alone (Creswell & Plano Clark, 2011). The sequential exploratory design was selected on the basis of its usefulness for exploring an organisational phenomenon and its suitability for identifying important variables to be studied quantitatively (Creswell & Plano Clark, 2011).

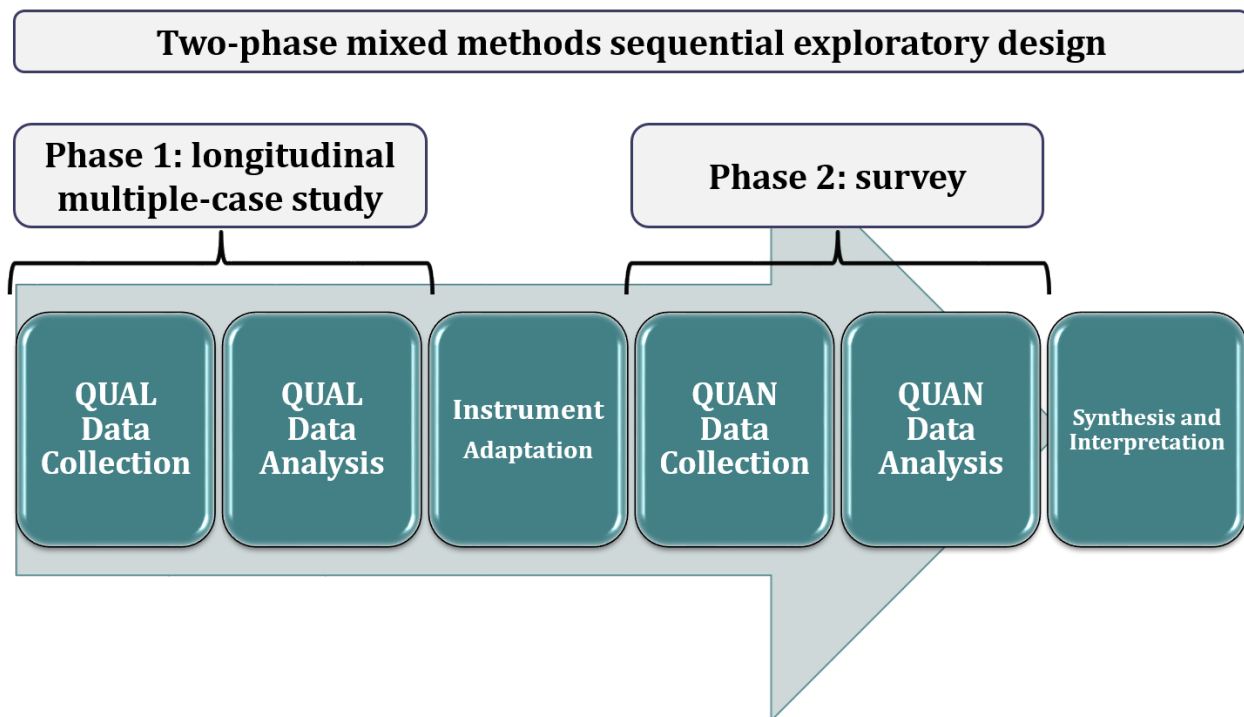


Figure 4-2. Schematic of research methodology

4.3 METHODS

4.3.1 Integration of qualitative and quantitative data

The integration of qualitative and subsequently-collected quantitative data occurred at three levels: a) the study design (its conceptualisation), b) methods and c) interpretation and reporting (Fetters, Curry, & Creswell, 2013). At the study design level, in line with the exploratory sequential design, the qualitative inquiry in Phase I informed the adaptation of a quantitative instrument in the second, quantitative, phase. Thus, instrument adaptation and questionnaire development constituted an intermediate step between the qualitative and the quantitative phases (Creswell & Plano Clark, 2011). At the methods level, the two phases were linked through the “building” approach (Creswell & Creswell, 2018; Fetters et al., 2013, p. 7) – the domains and concepts for inclusion in the quantitative phase were built upon qualitative data that identified the dimensions of partnership synergy, structural elements and broad categories of processes relevant to the two local partnerships. Moreover, the observation data and responses to qualitative interviews guided the choice of language to be used in the quantitative instrument (Fetters et al., 2013). At the interpretation level, qualitative and quantitative data sets were first analysed separately. This was

then followed by interpreting and connecting the results from the two phases. The qualitative findings and quantitative results were juxtaposed in the form of a “visual joint display” and analysed for commonalities and discrepancies, to generate insights beyond what was achieved in each preceding phase (Fetters et al., 2013; Guetterman, Fetters, & Creswell, 2015). At the reporting level, the qualitative findings and quantitative results were described separately in two academic manuscripts (*Manuscripts 1* and *2*, respectively), which were followed by a mixed methods manuscript (*Manuscript 3*). Integrating the qualitative and quantitative data resulted in a more holistic understanding and description of partnership synergy as experienced within the framework of the IMPACT research programme, of the processes to promote partnerships, and how these processes were linked with partnership synergy.

4.3.2 Participants

The **target population** for the doctoral project was all multi-stakeholder partnerships for care transformation in PHC in Canada and Australia. The **study population** was all the stakeholders involved in the IMPACT research programme’s six partnerships. The **study samples** were two of the six partnerships for the qualitative phase and five of the six partnerships for the quantitative phase. One of the partnerships (the Residential Aged Care Partnership) did not meet the criteria for inclusion in Phase II: the project was mostly undertaken by the research team, following the loss of non-academic stakeholders due to major structural changes within the local health service and the closure of a key local partner organisation. The study samples are described in more detail in Chapters 5 (*Manuscript 1*) and 6 (*Manuscript 2*) below.

4.3.3 Phase I – case study

The project began with the collection of predominantly qualitative data through a longitudinal multiple-case study (Yin, 2014). This methodology was selected to gain a thorough understanding of a complex social phenomenon and its underlying dynamics – the partnership evolution and processes within its contemporary contextual conditions (Siggelkow, 2007; Yin, 2014). Phase I generated rich data on how two of the IMPACT local partnerships, namely the Primary Care Connection Partnership and the Community Health Resources Partnership, functioned. Phase I allowed the candidate to isolate the dimensions of partnership synergy that manifested in these particular partnerships, to identify the processes employed by the teams to enhance partnerships,

and to understand how these processes were implemented. The two cases were studied between August 2016 and September 2018. The summer 2016 time point was selected because it reflected the move of both partnerships from a conceptual phase into an implementation phase: each local partnership had identified the nature and scope of the intervention and had developed a recruitment strategy. The fall 2018 time point coincided with the wrap-up of the local interventions to enhance access to PHC in both provinces and had been selected to allow adequate time for Phase II of the doctoral project. The rationale for studying both cases longitudinally was to follow their developmental course over time (Yin, 2014). The summer 2016 to fall 2018 time period allowed the candidate to understand partnership processes over time, to trace any changes that affected the partnerships and to identify how the partnerships responded to these changes, to understand how the different structures and processes contributed to partnership effectiveness and achievement of intended outcomes. In other words, the choice of the longitudinal design was guided by the research objectives.

4.3.3.1 Selection of cases

The two cases were selected based on practical considerations such as geographical proximity (within Canada) and sound use of financial resources for doctoral candidate's travel. In order to ensure that the study remained viable in scope, particular attention was paid to setting clear boundaries around each case (Yin, 2014). In addition to the geographical boundaries, this entailed identifying the organisations and stakeholders who were part of the study scope and determining the time to define the beginning and end of each case. Given the research objectives and the frequency of face-to-face meetings, the focus of this phase of the project was on two local partnerships' core teams (Figure 4-1 above).

4.3.3.2 Instruments and data collection techniques

The case study methodology is amenable to multiple sources of evidence to enhance data quality. The repertoire of methods for the qualitative phase included: a) review and secondary analysis of data from documents produced within the framework of the IMPACT research programme (e.g., minutes of meetings, documents on governance and administrative procedures, the programme's logic model and implementation guide, programme evaluation reports, etc.); b) non-participant observation of the meetings of the two local partnerships and the Canadian research team

composed of research teams from the three Canadian provinces; and c) semi-structured in-depth interviews with a sample of all stakeholders in two provinces. The review of documents was conducted in order to gain familiarity with the context and the terminology used within the IMPACT research programme. In addition, it provided data on the operational elements, participants' roles and responsibilities, on the common agenda of the initiative and how this common agenda and the involvement of different stakeholders had evolved since the start of the IMPACT research programme in 2013. Specific attention was devoted to the environmental (contextual) factors that might have had an influence on the two local partnerships. Non-participant observation of meetings allowed the candidate to gain an understanding of the partnership processes and dynamics over time, including the behaviours of partners and interactions between them. Specific attention was paid to observing how the approaches and processes agreed upon at the start of the research programme were being implemented and to identifying any new processes that influenced partnership synergy. Finally, semi-structured in-depth interviews were conducted with the objective of understanding and describing how partnership synergy and processes and approaches to enhance local partnerships were perceived and experienced among the local partnership stakeholders. These steps are detailed further below in Chapters 5 and 7 (*Manuscripts 1 and 3, respectively*).

4.3.3.3 Data analysis

The observations were recorded systematically in the form of field notes and provided “detailed, highly descriptive accounts of what was observed, a chronology of events, and a description of the people involved, their talk and their behaviour” (Pope & Mays, 2007, p. 37). The interviews were digitally recorded and transcribed verbatim. The analysis of notes and transcripts involved a cross-case synthesis to describe the cases and generate insights (Yin, 2014) and framework analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013). The data from interviews were coded both deductively and inductively. The hybrid deductive-inductive approach involved starting with predefined themes from the partnership synergy framework, assigning data to themes, revising themes with data and identifying new themes (Pluye & Hong, 2014). The data analysis occurred concurrently with data collection. Please see Chapter 5 (*Manuscript 1*) for a detailed description of qualitative data analysis.

4.3.3.4 Rigour/trustworthiness strategies

Several strategies were employed in order to ensure the trustworthiness and the high quality of the research design. Credibility was optimised through (a) the adoption of recognised research methods; (b) team debriefing to discuss emerging findings and interpretation; (c) being exposed to the partnership phenomena over a prolonged period of time; (d) triangulation from multiple sources of evidence; (e) an iterative process of data collection and analysis; and (f) maintenance of field notes (Krefting, 1991; Lincoln & Guba, 1985; Shenton, 2004). Dependability was optimised through the use of in-depth methodological description (Shenton, 2004). In terms of transferability, sufficient contextual information and a thick description of the partnership phenomenon were provided in order for the readers to make determinations regarding transferring the findings to other situations (Shenton, 2004).

4.3.4 Phase II – survey

Phase I resulted in a thick description of the two partnerships, data on the dimensions of partnership synergy relevant to the two local partnerships, as well as on the processes that were employed to enhance the partnerships. These data were then used to adapt a partnership self-assessment instrument - the Partnership Self-assessment Tool (PSAT) (see Appendix C), that contained measures of partnership functioning and partnership synergy.

4.3.4.1 Sampling

The instrument (Appendices D and E) was used for the survey of stakeholders in five of the six IMPACT local partnerships. The census sampling method, where every member of the study population is included, was used, as it is an appropriate sampling method when the entire population is very small. All 61 stakeholders who were active in the partnerships at the time of administration were considered eligible and were invited to participate. The final sample size was 54 participants (aggregated to five local partnerships).

4.3.4.2 Instruments and data collection techniques

Each theme and sub-theme generated throughout the qualitative phase of the study was defined to be mutually exclusive. The themes and sub-themes constituted the constructs to be measured. Operational definitions of the sub-themes or component codes were developed for each theme. In

other words, each code was restated in measurable terms, using the measurement features of the scale.

The themes were then mapped to the existing PSAT scales, in order to identify redundancies and omissions. Scale items for important and discriminating themes not covered under the PSAT were developed according to the recommendations by DeVellis (DeVellis, 2016). The selected items from the Weiss et al. partnership synergy scale (Weiss et al., 2002) were supplemented with items from the Jones synergy scale (Jones & Barry, 2011b) to capture more information on the process dimensions of synergy. Each of the themes was measured by at least two items. Most questions within the questionnaire were closed-ended.

In relation to the general features, participants were asked to provide an assessment of their respective partnership from the perspective of the organisation they represented and not their individual experiences. The respondents were asked to provide an assessment of the partnership at the point in time when the questionnaire was administered. The questionnaire was designed and administered according to existing guidelines in the survey literature (Dillman, Smyth, & Christian, 2014). The questionnaire was mixed-mode (paper and web-based). The mixed-mode administration increases the response rate (Dillman et al., 2014) and reduced the costs associated with mailing the survey out to the partnership stakeholders in Australia.

The resulting version of the questionnaire was tested through cognitive interviewing (Willis, 2005). This process involved verifying that the content of the questions was understood as intended, selecting the most appropriate response scales, and ascertaining whether the language and the length were appropriate. Given that the PSAT originated in the area of public health, this process helped the candidate to ensure that the instrument was relevant to multi-stakeholder partnerships in PHC.

4.3.4.3 Data analysis

The small sample size precluded a full psychometric analysis of the scales. Instead, the analysis focussed on examining some of the underlying metric assumptions. For example, the candidate examined if there were items that had problems with variation (e.g., floor or ceiling effects, no variation) that would indicate that the item should be dropped. When it comes to the construct of partnership synergy, the findings for each of the two scales were presented, followed by the combined synergy score of both scales. Descriptive statistics were used to characterize the sample

and the distribution of scores within each item and scale. Non-parametric tests were used to estimate the correlation between items within and between scales, and to determine if there were statistically significant differences in scale scores between any of the partnerships. Internal consistency of the scales was examined by calculating the Cronbach's Alpha. At the partnership level, the score for each scale was calculated by aggregating the scale scores of the component member respondents within each partnership. Please see Chapter 6 (*Manuscript 2*) for a more detailed description of quantitative data analysis.

4.4 ETHICAL CONSIDERATIONS

4.4.1 Research Ethics Board approval

The formal request for ethics clearance was preceded by a dialogue with key IMPACT stakeholders to define the parameters of the doctoral research, including determining project goals and objectives, methods and the sample. Amendments to the existing ethics clearances for the IMPACT research programme were requested and obtained from the Research Ethics Committee of a community hospital where the Principal Investigator of IMPACT was located and one other project site. Institutional approval for the doctoral project was subsequently obtained on August 10, 2016 (and renewed annually) from the St. Mary's Hospital Centre Research Ethics Committee (No. SMHC-13-30C, Appendix F).

4.4.2 Consent and voluntary participation

All participants provided written consent prior to data collection (see Appendices G and H for the approved consent forms, in English and in French, respectively). The research teams provided input in relation to the contents of the consent form. No data gathering, including document review and non-participant observation, took place until the forms were duly signed. The permission to observe IMPACT meetings, part of the qualitative phase of the study, was given by the Principal Investigators at both sites, but meeting participants reserved the right to ask the doctoral candidate to withdraw from any portion of the meeting considered too sensitive to observe. To avoid the suggestion of coercion or undue influence, IMPACT research programme coordinators were recruited by the doctoral candidate directly, instead of their line managers. Incentives for participation were not offered, not to overbear the will of participants (Jackson, 2010). All

stakeholders were informed that their participation in the study was voluntary and that they were free to withdraw from it at any time. If a participant discontinued their participation in the study, their data provided up to the point of stopping participation were kept and used, unless there was an explicit request from the participant not to do so. Questionnaire data were completely deleted for one participant only, for they admitted to choosing their answers at random.

4.4.3 Privacy and confidentiality

Taking into consideration that the project involved conducting face-to-face individual interviews, anonymity could not be guaranteed; however, steps were taken to protect the confidentiality of information obtained. In light of the purposes of the study being to understand the evolution of partnerships specific in each geographic location and the small sample of stakeholders, replies to the questionnaire also remained confidential as opposed to anonymous. The strategy to ensure confidentiality included keeping observations, interview and survey material (tapes, transcripts, etc.) in a locked cabinet. Numeric IDs were assigned to transcripts and questionnaire files, and all names and other identifying information were removed from interview transcripts. In addition, steps were taken to ensure that individual participants could not be identified in any published material stemming from this study. Project locations were assigned descriptive names.

4.4.4 Participant burden

Instruments used in this study were developed to be easy to complete in order to reduce participant burden. In addition, given that the doctoral project unfolded within the framework of a larger programme of research attempts were made to ensure that data gathering did not coincide with other programme's efforts for which the same participants were solicited.

CHAPTER 5. Manuscript 1 – Improving primary health care through partnerships: Key insights from a cross-case analysis of multi-stakeholder partnerships in two Canadian provinces

5.1 PREAMBLE

This is the first of three manuscripts that form part of this thesis. The manuscript covers the findings from the first, qualitative, phase of this mixed methods study. It describes the commonalities and differences between the two partnerships under investigation (the Primary Care Connection Partnership and the Community Health Resources Partnership), with a particular focus on how partnership synergy manifested itself. Synergy was apparent in how the partnerships integrated their non-financial and financial resources, in partnership atmosphere, reported benefits and contextual adaptation. This is then followed by an overview of synergy enabling processes at interpersonal, organisational and system levels - processes that enabled synergistic action among actors from different organisations. In addition, the manuscript describes how the two partnerships were resourced and structured. This manuscript made an important contribution to our evolving understanding of partnership synergy not only as a proximal outcome of partnership functioning but also a facilitator of partnership strength. It generated critical data for our evolving partnership synergy model. This phase of the study was the foundation for the quantitative phase that followed, in that it provided important information on the qualitative categories to be built upon in a survey.

This manuscript was published in *Health Science Reports* in October 2021.

Loban, E., Scott, C., Lewis, V., Law, S., & Haggerty, J. (2021). Improving primary health care through partnerships: key insights from a cross-case analysis of multi-stakeholder partnerships in two Canadian provinces. *Health Science Reports*, 4(4), 397. <https://doi.org/10.1002/hsr2.397>

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Improving primary health care through partnerships: Key insights from a cross-case analysis of multi-stakeholder partnerships in two Canadian provinces

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5.2 ABSTRACT

Background and Aims

Multi-stakeholder partnerships offer strategic advantages in addressing multi-faceted issues in complex, fast-paced, and rapidly-evolving community health contexts. Synergistic partnerships mobilize partners' complementary financial and nonfinancial resources, resulting in improved outcomes beyond that achievable through individual efforts. Our objectives were to explore the manifestations of synergy in partnerships involving stakeholders from different organizations with an interest in implementing organizational solutions that enhance access to primary health care (PHC) for vulnerable populations, and to describe structures and processes that facilitated the work of these partnerships.

Methods

This was a longitudinal case study in two Canadian provinces of two collaborative partnerships involving decision makers, academic representatives, clinicians, health system administrators, patient partners, and representatives of health and social service organizations providing services to vulnerable populations. Document review, nonparticipant observation of partnerships' meetings (n = 14) and semi-structured in-depth interviews (n = 16) were conducted between 2016 and 2018. Data analysis involved a cross-case synthesis to compare the cases and framework analysis to identify prominent themes.

Results

Four major themes emerged from the data. Partnership synergy manifested itself in the following: (a) the integration of resources, (b) partnership atmosphere, (c) perceived stakeholder benefits, and (d) capacity for adaptation to context. Synergy developed before the intended PHC access outcomes could be assessed and acted both as a dynamic indicator of the health of the partnership and a source of energy fuelling partnership improvement and vitality. Synergistic action among multiple stakeholders was achieved through enabling processes at interpersonal, operational, and system levels.

Conclusions

The partnership synergy framework is useful in assessing the intermediate outcomes of ongoing partnerships when it is too early to evaluate the achievement of long-term intended outcomes. Enabling processes require attention as part of routine partnership assessment.

5.3 INTRODUCTION

In the environment of increasing demands and limited resources, rapid technological change, and an aging and progressively complex patient population, partnerships involving multiple stakeholders from different sectors offer a meaningful way of tackling complex health care system problems.¹⁻⁴ Multi-stakeholder partnerships including community members and representatives of academic institutions are prevalent across multiple disciplines and spheres.⁵ To a certain extent, this can be attributed to the role of governments and funding agencies that mandate partnerships as an essential element of the programs and initiatives that they support.^{4,5} For example, the Canadian Government has promoted collaboration as a means of improving the quality of health care provided to the Canadian population.⁶ The partnership approach to health care system change and service redesign has also enjoyed widespread endorsement in other countries, particularly within the context of health and welfare services.^{4,7}

Partnership benefits have been studied from a diverse range of perspectives, disciplines, and communities of practice.^{8,9} Academic literature outlines what constitutes an effective partnership and describes approaches and strategies to enhance partnership processes and to increase partnership effectiveness.^{5,10-15} In theory, effective partnerships can be useful for overcoming organizational fragmentation and traditional divisions of power, improving communication and access to information, optimizing resource utilization, and helping to avoid a wasteful duplication of effort.¹⁶ In addition, there is evidence to suggest that effective partnerships contribute to more comprehensive interventions, help to contextualize policy, and support the feasibility and relevance of research through direct involvement of knowledge users.^{1,16,17} In primary health care (PHC), cross-sector partnerships have been used to ensure integrated service delivery.¹⁸ Reported facilitating processes include capitalizing on the diverse perspectives of partners, pooling of resources, promoting a common understanding of issues, forging common action plans, ensuring joint accountability and evaluation of progress, and employing appropriate forms of leadership and coordinating activities to ensure the alignment of efforts.^{3,19}

In practice, however, partnerships are frequently unable to generate effective collaborative advantage and achieve the intended change in systems and/or health outcomes.^{19,20} Many crumble under challenges such as insufficient resources, significant time commitments, conflicting interests, problems with governance and leadership, lack of necessary skills, insufficient recognition, and lack of buy-in from key stakeholders.^{2,5,19,21} Considering these challenges, there

is a growing need for evidence demonstrating the link between the implementation of processes and approaches that are claimed to enhance partnership effectiveness and the achievement of intended outcomes.

The notion of “partnership synergy” has been proposed as a marker or a “proximal outcome” of partnership functioning.^{4(p182)} Partnerships are said to be synergistic when they combine resources successfully and mobilize the complementary knowledge and expertise of all the partners.²² Synergy is reached when the combined efforts of partners enhance the outcomes beyond what could be achieved independently by each stakeholder/stakeholder group working toward the same goals,²³ namely that the whole becomes greater than the sum of the parts.⁴ Synergy could manifest itself through creative and holistic ways of thinking, the ability to carry out more comprehensive interventions aimed at target populations, the relationships between partners and relationships of partnerships with the broader community.⁴ Lasker et al identified a number of elements of partnership functioning that are likely to influence partnership synergy (Table 5-1) and suggested looking at synergy as a predictor of an effective partnership.⁴ Subsequent research conceptualized synergy as being both a process and a product of partnership, and highlighted the dynamic and cumulative nature of partnership synergy demonstrating its capacity to build over time and its role as an evolving indicator of effectiveness and sustainability.²³⁻²⁵

Table 5-1. Determinants of partnership synergy (adapted from Reference 4)

Determinants of partnership synergy	Factors likely to influence partnership synergy
Resources	Money
	Space, equipment, goods
	Skills and expertise
	Information
	Connections to people, organizations, groups
	Endorsements
	Convening power
Partner characteristics	Heterogeneity
	Level of involvement
Relationships among partners	Trust
	Respect
	Conflict
	Power differentials
Partnership characteristics	Leadership
	Administration and management
	Governance
	Efficiency
External environment	Community characteristics
	Public and organizational policies

This study adopted partnership synergy as an umbrella framework for looking at the functioning of two multi-stakeholder partnerships in two Canadian provinces involving stakeholders from different organizations and constituent groups with an interest in implementing organizational solutions to enhance access to appropriate PHC for vulnerable populations. The overall aim of our study was to gain an in-depth understanding of the effectiveness of multi-stakeholder partnerships in addressing complex issues in PHC. PHC is conceptualized here as an approach to health that encompasses continuous and comprehensive care across diverse curative, preventative, education, and rehabilitation services, with a person (micro), community (meso), and population (macro) orientation.²⁶⁻²⁸ For the purposes of this paper, we conceptualize “partnership effectiveness” in relation to both the processes and outcomes of partnerships: the quality of the processes and relationships between partners and the health of the partnership on the one hand, and the realization of intended outcomes on the other. We define a multi-stakeholder partnership as a complex human system based on voluntary collaborative relationships among stakeholders who agree to work together to achieve a common purpose and to share competencies, resources, responsibilities, risks, and benefits (adapted from Reference 29). We focused on partnerships involving representatives of different organizations—each bringing their unique perspectives, competencies, organizational mandates, interests and weaknesses, working toward a common goal of transforming PHC service delivery. The main research questions that this study attempted to address were as follows: (a) How does partnership synergy manifest itself in multi-stakeholder partnerships? and (b) What structures and processes are required to build synergistic action among actors from different sectors?

5.4 METHODS

5.4.1 Study context

This study was undertaken within a Canada-Australia research program entitled “Innovative Models Promoting Access-to-Care Transformation” (IMPACT) conducted between 2013 and 2018.³⁰ The aim of this program was to design, implement, and evaluate, through a network of local partnerships, organizational interventions to improve access to appropriate PHC for vulnerable populations in three Australian states (Victoria, South Australia, and New South Wales) and three Canadian provinces (Quebec, Ontario, and Alberta).³⁰ Each of the six projects entailed identifying, in consultation with a broader set of local stakeholders, PHC access needs, and

selecting, adapting, and implementing coordinated actions to best address these needs, within available resources. This study focused on two of the Canadian IMPACT local partnerships, namely the Primary Care Connection Partnership (PCCP) and the Community Health Resources Partnership (CHRP) (Table 5-2).

Table 5-2. Overview of interventions in two Canadian IMPACT local partnerships (adapted from References 30-32)

Partnership title	Primary Care Connection	Community Health Resources
Target population and access problem	Unattached patients in high deprivation neighborhoods have trouble connecting effectively to newly assigned family physicians from centralized wait list.	Primary care patients with complex health and social needs not receiving available community services (e.g., smoking cessation, falls prevention, etc.) that would optimize their illness management.
Type of vulnerability	Low income, unemployment, low social support.	Socially complex patients, including one of Canada's linguistic minorities.
Intervention	Volunteer guides discuss the health and social needs of patients before their first appointment with a family physician.	Lay, bilingual navigators integrated into primary care practices support patients to reach community resources.
Tasks	Develop the intervention, in collaboration with regional health organizations that manage a centralized waiting list for family physicians; obtain consent from primary care practices to contact assigned patients; recruit patients; develop relevant materials; recruit and train lay volunteer navigators; lay volunteer navigators reach out by telephone to patients in materially or socially deprived neighborhoods prior to the first visit to a newly-assigned family physician; evaluate the intervention.	Develop the intervention; recruit primary care practices and patients; prepare relevant materials; assist practices in making adaptations in the electronic medical record system to allow referral to navigation services; orient providers regarding the availability and potential benefits of community resources; recruit and train a lay navigator in patient-centered communication and system navigation; lay navigator works with patients to prioritize needs, identify potential barriers to access, and facilitate access to services; evaluate the intervention.
Intended consequence	Successful affiliation to a family physician.	Increased referrals to community health resources and improved access to these services.

Abbreviation: PHC - primary health care.

The stakeholders within each partnership included a mix of decision makers, clinicians, health system administrators, service providers, academic members—composed of academic investigators, including principal investigators and co-investigators, and research coordinators, and, in some cases, members of vulnerable populations.³⁰ Vulnerable populations were “community members whose demographic, geographic, economic and/or cultural characteristics impeded or compromised their access to PHC.”^{30(p4)}

5.4.2 Study design

This longitudinal case study^{33, 34} involved document review, nonparticipant observation³⁵ of partnerships' meetings, and semi-structured in-depth interviews³⁶ with a sample of study stakeholders in two partnerships. The study was conducted between August 2016 and September 2018. The rationale for studying both cases longitudinally was to follow their development over time, to understand the evolution of processes, to trace any changes that affected the partnerships, and identify how the partnerships responded to these changes. Consolidated criteria for reporting qualitative research (*COREQ*) were used in the reporting of this study.³⁷

5.4.3 Sampling and recruitment

The PCCP stakeholders represented two administrative jurisdictions covered by two regional health networks, two local general practice divisions, community development organizations serving the two neighborhoods, and two universities. The CHRP included stakeholders from one health authority, a university, community and home care services, social and public health services, community health centers, information resources, primary care, and the community.

Interview candidates were selected using purposive sampling with the aim to achieve maximum variation within the sample.³⁸ The goal of the sampling strategy was to include representatives of each stakeholder group, who varied in seniority in the partnership and nature of engagement. The PCCP interview candidates were identified by the first author based on meeting observations; the CHRP candidates were identified by the CHRP principal investigator.

5.4.4 Data collection

Preliminary documents reviewed (between August 2016 and May 2017) were minutes of meetings, protocols, and reports produced by the IMPACT program and the two partnerships. The first author subsequently observed (between January 2017 and September 2018) 11 PCCP and three CHRP meetings—all available meetings that took place during this time frame. The document review and observations provided data on the operational elements, contextual factors, participants' roles and responsibilities, the common agenda of each initiative, and how this common agenda and the involvement of different stakeholders evolved since the start of the IMPACT research program in 2013. The first author then conducted (between July 2017 and March 2018) nine interviews with PCCP stakeholders and seven with CHRP stakeholders. Interview candidates were initially invited

to participate via e-mails that were sent by PCCP and CHRP research coordinators. Follow-up contact by the first author was in person, at the end of partnership meetings, and via e-mails sent directly to each candidate. The interviews lasted approximately 1 hour, were conducted either in-person or over the telephone, and were audio-recorded.

The interview guide (Appendix I) was developed with reference to the literature on partnership synergy.^{4, 25} Synergy dimensions explored included the organization of partnerships, work sharing, decision-making/problem-solving, complementarity of skills, outcomes, and experience. The guide was pilot tested, in both English and French, prior to administration.

5.4.5 Ethics

Ethics approval for the study was obtained from the St. Mary's Hospital Centre Research Ethics Committee (No. **SMHC-13-30C**). Authorisation to conduct research was obtained from the second participating institution. All participants were provided with written information about the study and consent was obtained prior to data collection.

5.4.6 Data analysis

Nonparticipant observations (which entailed observing participants without actively participating in their meetings) were recorded as field notes. All interviews were transcribed verbatim, in the original language, with subsequent translation from French into English for quotation purposes. Our analysis of notes and transcripts reflected the dual-level inquiry of the study: it involved a cross-case synthesis to describe the cases and generate insights³⁴ and framework analysis.³⁹ The strategy used for data analysis involved a hybrid deductive-inductive approach,^{39, 40} involving assigning data into predefined themes based on the partnership synergy framework, revising themes based on nuances within the data, and identifying new themes arising from the data. The data were coded iteratively, going back and forth from text to themes. NVivo 12 software was used to support data management and analysis. The material was analyzed by the first author. Coding was verified with another co-author. Emerging findings were discussed at regular team meetings. The final codes were grouped along the dimensions of partnership synergy and six categories of factors likely to foster synergy: structure; partner characteristics; partnership characteristics; relationships among partners; resources; and external environment.

5.5 FINDINGS

The following paragraphs detail the key findings from this study. Section 5.5.1 presents the characteristics of the sample. Section 5.5.2 summarizes the key findings and refers to descriptive cross-case synthesis (presented in Appendix J) that is based on observations and accounts of interview respondents. In Section 5.5.3 we elaborate on four themes that emerged from our data where partnership synergy was apparent, namely resource integration, partnership atmosphere, reported benefits, and partnership's capacity for adaptation to context. Finally, Section 5.5.4 describes partnership collaborative processes that enabled stakeholders from different organizations to achieve synergistic action.

5.5.1 Study participants

Interview participants represented a range of organisational expertise (Table 5-3). Academic representatives and decision makers constituted the largest two groups (n = 10, 63%). Participants (n = 16) were predominantly female (n = 13, 81%).

Table 5-3. Study sample characteristics (n = 16)

Characteristic	Primary Care Connection Partnership (PCCP) (n=9)	Community Health Resources Partnership (CHRP) (n=7)
	N (%)	N (%)
Gender		
Female	8 (89%)	5 (71%)
Male	1 (11%)	2 (29%)
Main role in the partnership		
Academic representative:		
- Researcher	1 (11%)	1 (14%)
- Research coordinator	2 (22%)	1 (14%)
Decision maker	3 (33%)	2 (29%)
Clinician/practitioner	2 (22%)	1 (14%)
Organizational representative/patient	1 (11%)	2 (29%)
Interview language		
English	0 (0%)	7 (100%)
French	9 (100%)	0 (0%)

5.5.2 Cross-case synthesis

Our key findings are summarized in Figure 5-1. It portrays human and material resources as the building blocks of partnerships. These resources are then activated via interpersonal, operational, and system-level processes to produce partnership synergy. Partnership synergy manifests itself in

different ways: in the integration of resources, partnership atmosphere, perceived stakeholder benefits, and the capacity for adaptation to context. It acts as both a dynamic indicator of the health of the partnership, highlighting the likelihood of achieving partnership effectiveness, and as the source of energy fuelling partnership improvement and vitality. The boundaries of the partnership are permeable, reflecting the exchange of influence between the partnership and its context. Appendix J displays how the cases align against the partnership synergy framework and describes how the two partnerships were resourced and structured.

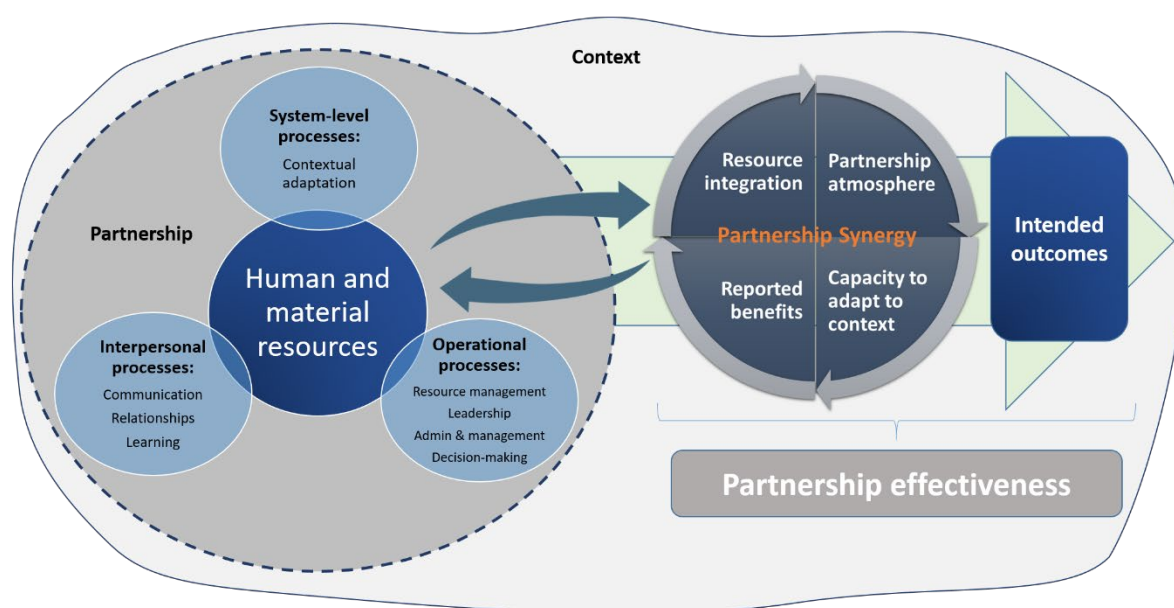


Figure 5-1. Summary of key findings - relationships among partnership synergy, partnership resources, enabling partnership processes and outcomes

5.5.3 Partnership synergy

5.5.3.1 Theme 1: Resource integration

There was evidence of partnership synergy in the integration of nonfinancial and financial resources. Nonfinancial resources included the time, knowledge, expertise, and connections that the stakeholders contributed, as well as the relationships and learning that transpired in the course of partnership work. The partnerships demonstrated capacity to recruit stakeholders with a range of perspectives, skills, information, and connections to a broader set of stakeholders and health systems exerting influence over the partnerships. These unique perspectives and insights (Table 5-4) were deemed to be complementary in that they allowed the group to explore the issues of access from various angles, to obtain timely information from different sectors in order to adapt

interventions, and to enhance the relevance of interventions: “*I think it's a really good mix of people, and you can hear it in the discussion. The very different points of view and they all complement each other very well.*” (016, CHRP).

Table 5-4. Stakeholder perspectives within two Canadian IMPACT local partnerships

Stakeholder group	Primary Care Connection Partnership (PCCP)	Community Health Resources Partnership (CHRP)	Perspective
Medical practitioners	X	X	Clinical perspective, with one CHRP physician’s practice being an incubator for the navigator model.
Decision makers and health planners	X	X	Bridge between researchers and policy-making, ensuring that research activities aligned with and responded to health policy priorities and capabilities and, conversely, that health authorities were aware of research insights relevant to the project.
Academic investigators	X	X	Research knowledge and skills, including: organization of the research process; data gathering, analysis, and synthesis of information of relevance to the partnership; interface with funding bodies and larger IMPACT program.
Research coordinators	X	X	Coordination of partnership activities, group process facilitation.
Anglophone and francophone patient partners		X	The lived experience point of view, including insights regarding specific barriers experienced on the basis of languages spoken.
Community organization representative	X		Insights into the challenges experienced by the target populations.
Community service organizations		X	Information on available community services, ensuring that the research was grounded in reality: that project activities were aligned with the priorities and capabilities of these organizations.

Abbreviation: IMPACT—Innovative Models Promoting Access-to-Care Transformation.

I honestly don't think that there's any other way to do it, because it's in primary care and primary care is incredibly complex, there are so many players involved [...]. If we didn't have those other people at the table how would we know what's going on. (013, CHRP).

In both cases, the nucleus of the partnership, including the research team and a number of key nonacademic stakeholders, remained consistent over time, while new members were invited to join based on project evolution and the need to attract additional expertise and resources. This heterogeneity and fluidity in the composition of the partnerships reflected the complexity and scope of the tasks at hand, the dynamic nature of the projects and organizational and policy changes in the external context that took place over the years. These composition dynamics, however,

necessitated a significant investment of coordination resources and time on the part of the research teams and ongoing attention to and management of stakeholder engagement dynamics.

The CHRP was larger, reflecting a broader array of stakeholders and language groups. Some CHRP interview participants felt that the size of the partnership (23 stakeholders) was too large, potentially inhibiting contribution from some members. The PCCP was smaller (13 members) but had the complexity of involving two independent health authorities, with different organizational cultures and authority structures, with one interview participant describing the partnership's initiative as “*one research project [...] with two different speeds*” (011, PCCP). Despite the differences between cases in size and diversity, the mix of stakeholders in both was perceived by interviewees to be optimal for achieving project goals. The composition was described by stakeholders as an “*excellent mixture of people [...] from diverse sectors*” (016, CHRP) and as “*driven by the research team, but nourished by the practitioners in the field*” (014, PCCP).

The partnerships demonstrated the ability to effectively combine their nonfinancial resources. In both cases, the level of engagement was deemed by most interview respondents to be appropriate for the stated project objectives and the function of the partnership. All stakeholders had clarity regarding their own roles and what was expected of them. Several participants referred to the alignment of efforts of partners and the richness and integrative nature of collaboration: “*These [partnership] tables are an example of integration. [...] We become more integrated and stronger, and there is a certain level of coherence between us.*” (020, PCCP); “*It is very rich. [...] Not everyone has the same reality, and we inspire each other. In understanding the point of view of the other, we advance the discussion.*” (014, PCCP).

Partnership synergy was also apparent in the ways partners leveraged financial resources and sustained partnership activities and interventions despite contextual challenges and funding gaps. The IMPACT research grant included funding for the coordinating infrastructure/research support, including the partnership coordinator position in each site, as well as the evaluation of interventions. There was no funding for intervention implementation, and stakeholders other than research coordinators were not remunerated for participation in partnership activities. Consequently, the successful implementation and sustainability of interventions relied entirely on the local players' capacity to commit to them, provide adequate resources, and maintain them beyond the life of the IMPACT research funding. Both partnerships devised low-cost lay navigator

models to address the needs of the target populations. Both worked toward integrating the interventions into existing health system organizational structures, aligning the proposed models with health system priorities. In the process, the CHRP relied on additional research funding that was secured early on in the project to support a randomized controlled trial to test the effectiveness of the developed navigator model.

5.5.3.2 Theme 2: Partnership atmosphere

Partnership synergy was apparent in the quality of stakeholder relationships, in the perceived value of the initiative, and the general partnership atmosphere, which was described as “*positive*” (011, 018, CHRP), “*dynamic*” (017, CHRP), “*respectful*” (019, CHRP), “*open*” (013, PCCP), “*friendly*” (015, CHRP), “*collaborative*,” “*energising*” and “*engaging*” (013, CHRP): “*Everybody seems to be happy to be involved.*” (018, CHRP); “*I usually see it as we all come together, sort of. I don't feel a sense of that there's some difference between anyone [...]. I feel like they do treat me as an equal.*” (019, CHRP).

The exchanges are very open. That is to say, when we [...] put forth a proposal or a possible solution, it is always well received ... not necessarily always accepted, but well received. Lots of openness. That, I find that interesting. (013, PCCP).

These positive collaborative relationships benefitted the partnerships by enabling more open conversations, faster and effective decision-making, and enhanced project ownership: “*The commitment to the project is higher when you have built it together. [...] When you have done it in collaboration, it is closer to your heart and I think that this is one of the advantages.*” (012, PCCP).

The synergy in relationships blossomed with time; as the work progressed, participants felt that they could speak more openly, including voicing concerns and disagreement:

I have the impression that we are less afraid of losing our partners, we walk less on eggshells, we are more open [...] the partnership is a little more solid and we are more capable of [...] exposing a little, being less artificial in our meetings. (011, PCCP).

Participants highlighted the importance of face-to-face meetings and having signed letters of understanding with institutions at the start of the project. Despite the fact that membership fluctuated, these letters underscored the credibility of the project and facilitated trust-building with new members.

5.5.3.3 Theme 3: Reported benefits

Members in both cases reported a variety of anticipated and actual benefits stemming from their participation in the project, reflecting a core component of partnership synergy. Participants described more professional than personal benefits. Benefits included, but were not limited to the following: learning about the work of other organizations and sectors; understanding how the services in one's organization complement services and approaches in others; learning about how a well-organized meeting unfolds; devising more effective ways of addressing an issue that the organization had been grappling with; and ensuring system-wide benefits if the project can demonstrate that the approach that is pursued works. In addition, respondents highlighted the benefits of the partnership approach to delivery of project goals, stating that “*there is no other way to approach it*” (013, PCCP). A number of indirect benefits were also reported, including enhanced visibility of one's own organization and opportunities for face-to-face exchange with other key stakeholders under the same organizational umbrella. Partnership members who were early career researchers were less positive about the benefits, citing high demands of participation for limited academic outputs. However, some of them remained committed to the partnership due to the strength of relationships with other stakeholders. While for most members participation in the project had been mandated by their respective organizations, the majority participated willingly, looked forward to meetings and saw a direct fit between the project's objectives and the priorities of the entities they represented. According to most interview respondents, the benefits of participation outweighed the drawbacks, effectively demonstrating positive partnership synergy.

The mutually beneficial nature of the partnerships was apparent as participants described mutual and personal learning and satisfaction with their involvement in the projects:

So to be able to be part of the project [...] I think that they had a great idea, it's really smart, and I felt really glad to be part of that. You know because I feel like that's a good project [...] very helpful, this is a very [...] significant issue for people. And to be able to be part of maybe, you

know, exploring why it's a problem and offering my insights, I'm very excited to be able to do that. (019, CHRP).

5.5.3.4 Theme 4: Capacity for adaptation to context

Partnership activities were unfolding within the context of health care system reforms in both provinces. Both partnerships had to make adaptations to the interventions to respond to evolving contextual opportunities and threats, but the extent of contextual impact and adaptation was far greater in the case of the PCCP, which demonstrated synergy in its ability to adapt to its changing context. During the implementation period, the province's health care system underwent a major reform,^{41, 42} leading to a number of policy changes. In the process, the partnership lost most of its nonacademic members, had to re-develop relationships with new stakeholders, and had to modify the intervention several times to accommodate new system priorities. Academic partnership participants revealed that the impact of changes was so profound that they feared a complete dissolution of the partnership and termination of the project. These developments reflected weakened partnership synergy. However, the momentum generated through synergy in other areas, namely trust, partnership credibility, and organizational buy-in, contributed to keeping the project alive:

[...] even though everyone around the table had changed, we have managed to keep representatives roughly the same from each of the organizations that were with us since the beginning. What made it easier was that we had the commitment of people pretty high up in those organizations [...] In addition, we managed to establish a climate of trust. So even though the people around the table changed, they knew that the organizations had been there for a while and it was going well. (011, PCCP).

Given that contextual changes were frequent topics of conversation during face-to-face PCCP meetings, there were no reported differences in stakeholders' appreciation of the impact of context depending on their roles in the partnership.

The CHRP stakeholders described the context as “*chaotic*” (018, CHRP), with a well-integrated hospital and specialist sector, poorly organized community health services, and fragmented primary care. At the time of project activities, the province underwent significant

changes in its health care system, with services being integrated sub-regionally based on geographical utilization patterns, within the framework of tight budgets, contract negotiations, and increasing demands on the system. It was felt that the project was timely in terms of addressing some of these challenges posed by changes in the context. The main concern voiced related to the possibility of the intervention duplicating existing services. The research team proactively addressed this concern by incorporating at the start of some partnership meetings a description of how the navigator model was different from and complementary to other services, and by allocating time for dialogue around it. At a closer, organizational, level the CHRP experienced a gap of 1.5 years between partner meetings due to delays in ethics protocols approvals. However, similar to the PCCP, the partnership synergy generated earlier, evidenced in the quality of stakeholder relationships and the importance attributed to the initiative, contributed to sustained stakeholder participation. Overall, the stakeholders' appreciation of the impact of external context on the project and partnership varied depending on their role in the partnership. Decision makers provided a more in-depth assessment of the context and how it affected the intervention. Most stakeholders felt that contextual changes were inevitable, and the partnership just had to adapt to them: “[...] *coping with the environment, the environment is what it is, it's a changing environment and you have to adapt*” (018, CHRP).

Interviewees also noted the influence of the partnerships and the interventions on their organizations and the broader context. Decision makers in particular referred to acquiring and sharing within their respective organizations a deeper understanding of the plight of vulnerable populations in relation to access issues. Members of community-based service organizations referred to generating insights into how to improve their organizations' services, whereas family physicians became more aware of existing services that patients could be referred to.

5.5.4 Synergy enabling processes

Both partnerships employed specific processes to facilitate the work of the partnerships. The following main categories of processes emerged from our data: 1) interpersonal processes, 2) operational processes, and 3) system-level processes (Figure 5-1).

5.5.4.1 Interpersonal processes

At the interpersonal level, participants highlighted the importance of communication processes, relationship building and maintenance, and learning loops. Both partnerships had open and multidirectional channels of communication, mostly confined to regular partnership face-to-face meetings and electronic means, to communicate internally with stakeholders within the partnership. Learning loops involved soliciting feedback during meetings around issues related to the project and being transparent about how this input was subsequently incorporated. External communication aimed at increasing the support for interventions, recruiting medical practices, and disseminating information about partnership activities and achievements to wider audiences. While some stakeholders had a history of working together, relationships with other stakeholders had to be built and nurtured. Face-to-face meetings were identified as being key to developing relationships.

5.5.4.2 Operational processes

At the operational level, the processes involved resource management, leadership, administration and management, and decision-making. Both partnerships utilized a variety of ways to engage respective stakeholders. The partnerships organized deliberative fora involving a broad range of stakeholders, to learn about unmet health care needs of vulnerable populations, relevant community organizations, and available resources to support interventions. The PCCP subsequently involved stakeholders in various aspects of the research process, with a number of nonacademic stakeholders fulfilling tasks outside the partnership meetings. Conversely, the CHRP adopted a research advisory approach to working with stakeholders, with limited contribution of nonacademic stakeholders outside face-to-face meetings. Both partnerships used regular meetings to discuss project progress and to engage in collaborative learning. Participants emphasized the added value of acquiring relevant knowledge, having space to exchange with other partners, reflect and innovate (which was not always possible within the stakeholders' respective organizational contexts), as well as educational and capacity-building opportunities.

The partnerships were largely driven by the research teams responsible for the overall management of the projects, providing strategic direction and facilitating the development of interventions at the local level, through continuous dialogue and learning, as well as sharing of information. The research teams capitalized upon the various strengths and perspectives of

stakeholders, by providing sufficient time to discuss pressing issues, soliciting input from all stakeholders, offering stakeholders different mechanisms to contribute, and tailoring tasks to stakeholders' availabilities and interest. The PCCP leveraged the power of leadership distributed among academic and nonacademic stakeholders, while in the CHRP, the leadership was centralized within the research team. However, the CHRP interview participants reported that the research team seemed genuinely interested in hearing from all stakeholders and made efforts to check in with various groups around the partnership table.

A number of leadership processes were common to both cases. Both partnerships had formal and informal academic leaders knowledgeable about the context and skilled at mobilizing the various perspectives of partners. The leaders did not possess all of the required partnership-related knowledge and skills at the outset, but made intentional efforts to learn from experience and best practices in partnership literature and to acquire additional skills through training. Moreover, as the partnerships evolved and the level of trust within teams increased, the leaders were more transparent about their own gaps in knowledge surrounding the interventions and eagerly welcomed input from different stakeholders. This demonstration of vulnerability contributed to creating further trust.

The PCCP stakeholders reported that the decision-making process was inclusive and transparent, which was particularly useful in relation to adapting the intervention to its evolving context. Conversely, consistent with the advisory nature of the partnership, the CHRP decision-making power was centralized within the research team.

5.5.4.3 System-level processes

At the system level, participants described processes geared toward making ongoing adaptations to the evolving context. In both cases, responsiveness to external stimuli involved adaptations to the interventions' structure, implementation strategy, and personnel resources. Participants reported that processes such as conducting extensive fieldwork to gather information, having around the table a variety of key stakeholders with medium to high level of decision-making power in their respective organizations, open dialogue about the evolving context, and, in the case of the PCCP, transparent processes of decision-making, contributed to the ability of the partnerships to adapt interventions to rapidly changing policy contexts. The situational analysis involved leveraging the knowledge of multiple partners. The active engagement in the partnerships of

decision makers and health system planners was critical in this respect, as it contributed to an in-depth understanding of health system priorities.

5.6 DISCUSSION

This study illustrated the multidimensional, dynamic nature of partnership synergy and its role not only as a proximal outcome of partnership functioning but also as a facilitator of multi-stakeholder partnerships in two geographical settings, in the context of tackling challenges in the delivery of high-quality PHC to vulnerable populations. The study also provided insights into the structures and processes to sustain these partnerships. These two key findings are discussed in more detail below. Although there is a substantial number of quantitative and review studies that have incorporated concepts from the partnership synergy framework,^{10, 22, 23, 43-47} to our knowledge, empirical studies applying these concepts to frame qualitative research findings are rare, with Brush et al²⁴ and Corbin and Mittelmark⁴⁸ being two examples of such studies, which also proposed synergy models. Employing the partnership synergy lens allowed us to systematically assess its manifestations and to acquire a deeper understanding of this phenomenon. Taking into consideration that the partnerships were in the implementation stage of their interventions, we could not comprehensively assess the intended partnership outcomes. Our data contained preliminary evidence of the positive impacts of the interventions in both cases. However, the sustainability of interventions and partnerships beyond the life of the IMPACT grant was, according to our interview respondents, questionable.

This study will be followed by a quantitative study involving all six IMPACT partnerships that will attempt to measure whether (and how) the partnerships have achieved partnership synergy and whether certain partnership processes contributed to more strategic advantages. The results pertaining to the outcomes of the developed IMPACT interventions will be reported elsewhere.⁴⁹

5.6.1 Partnership synergy

Our first key finding relates to the multidimensional nature of partnership synergy. Our data indicate that partnership synergy manifests itself in different ways. We identified the following four areas where partnership synergy was apparent: (a) the integration of nonfinancial and financial resources, (b) partnership atmosphere, (c) reported benefits, and (d) capacity for adaptation to context. Our analysis revealed the complex interactions among the four areas. The composition

that reflected the diversity and complexity of the presenting problem allowed for faster adaptations to contextual stimuli. The generated benefits were critical to the sustained level of stakeholder commitment. The quality of collaborative relationships and positive partnership atmosphere facilitated additional stakeholder recruitment and allowed to maintain momentum. These interconnections suggest that synergy components are neither static nor independent; similar to a hologram,⁵⁰ they allow us to obtain a more intense picture of partnership synergy. Given the highly contingent nature of partnerships, there will arguably be other areas where synergy might manifest itself, depending on a partnership's objectives and internal and external influences. The original Lasker and Weiss's model (2001), viewing partnership synergy as an outcome, for example, placed more emphasis on outcome elements, such as the ability of developed strategies to address the needs of target populations.

Second, our findings highlight the dynamic nature of partnership synergy. As partnerships progressed, partnership synergy in both partnerships fluctuated. Both partnerships evolved from a group of individuals with common interests (low synergy) into entities with a requisite degree of openness, inter-dependence, and enhanced understanding of presenting issues (higher synergy)—all of which contributed to deeper decision-making and effective adaptations to intervention models. Conversely, partnership synergy could weaken, as was illustrated with an example of the profound impact on the PCCP of its volatile context. This finding is broadly consistent with prior research that suggested that synergy was a dynamic health indicator of a collaborative process²⁴ and that it was more likely to accrue during the formation stage of the partnership but subsequently decrease during the implementation stage.⁵¹

The third characteristic of partnership synergy revealed in our analysis is the contribution of partnership synergy to sustaining partnerships. The composite strength of partnership synergy in the PCCP was sufficient to offset the impact of the destructive contextual circumstances and allowed the partnership to regenerate itself. Analogous to the body's immune system, partnership synergy appeared to provoke a protective response allowing the partnership to persevere in the face of adversity. In addition, partnership synergy contributed to partnership improvement. Given that working in partnership required skills that were different from those employed in the typical running of research studies, the partnerships made strategic financial investments into acquiring these new skills. Instead of outsourcing certain partnership-related tasks, the partnerships built capacity in-house through training partnership coordinators in group process facilitation

techniques and then providing them with opportunities to facilitate partnership meetings. This investment was not only part of building capacity within the partnership; the coordinators used the training as a springboard for subsequent process improvements and self-organization that benefitted the partnerships directly, strengthening them and contributing to synergy. The return on this investment was high and contributed to lower effort on the part of academic investigators to facilitate partnership activities.

5.6.2 Structures and processes

This study adds depth to understanding of partnership resource requirements and demonstrates the centrality of enabling processes at the interpersonal, organizational and system levels to achieve synergistic action among multiple stakeholders. Due to the organizational structure and type of the IMPACT program funding, the two partnerships under investigation were largely driven by the research teams that initiated the partnerships—a finding that is consistent with the literature on collaborative health research partnerships.¹⁷ These research teams and a number of key nonacademic stakeholders constituted a relatively consistent continuous core in each partnership, effectively acting as “champions” keeping the collaboration going.⁵² Other members were selected strategically, to attract specific expertise, perspectives, and additional resources. This was supplemented by more organic selection based on emerging needs as the projects unfolded. The dynamic composition allowed for fluidity, complementarity, and heterogeneity that reflected the critical dimensions of the problem to be addressed and of the changing context. Having stakeholders around the table with medium to high level of authority in their respective organizations allowed for timely adaptations to interventions.

The CHRP was larger than the PCCP, reflected more linguistic diversity, and had more permeable organizational boundaries due to receiving additional funding for the second phase of the research project. This independent funding added complexity by broadening the scope of the project and requiring the involvement of additional expertise. The partnership's size necessitated a higher degree of formalization, which was evidenced in the structured ways of organizing meetings and soliciting input from stakeholders. This finding is consistent with the argument from organizational theory that larger organizations tend to require more formalized behavior and more developed administrative components.⁵³ Different stakeholders were brought in as the needs of the partnership evolved, with relatively consistent representation from the target population. The

partnership adopted a research advisory approach, with the decision-making power centralized with the research team, and a limited contribution of nonacademic stakeholders outside the face-to-face meetings. Overall, the project undertaken by the CHRP was deemed by interview respondents to be meaningful and timely.

The PCCP was smaller, with more defined boundaries, but had a higher degree of internal complexity due to working with two local health authorities, each with different organizational cultures and processes. The PCCP exhibited elements of horizontal decentralization⁵³ and holographic organization,⁵⁰ with the diffusion of leadership and decision-making power among academic and nonacademic stakeholders. All stakeholders participated actively in the co-construction of the various aspects of the project, and some nonacademic stakeholders fulfilled tasks outside the partnership meetings. The small size and decentralization of power allowed the PCCP to remain nimble and responsive to change. These findings are aligned with organizational theory that states that more complex and dynamic environments necessitate more organic and decentralized structures and decision-making power.⁵³

We identified a number of collaborative processes driving the synergy of the two partnerships, at interpersonal, operational, and system levels, each a critical piece of the synergy puzzle, but also a source of potential problems if misaligned with the needs or context. For example, the decentralized form of leadership that contributed to partnership synergy in one partnership may have been counterproductive in the other. In practice, however, the key contributor or threat to partnership synergy cannot be isolated due to the inherent complexity of partnerships within their local contexts. “Because an element in a group can affect other elements, any element or combination of elements could be contributing to the group's ineffectiveness.”⁵⁴ Our study demonstrated how contextual adaptation in the case of the PCCP necessitated certain decision-making processes, appropriate forms of communication, and specific actions from the team that fulfilled the “backbone”³ coordinating support to the partnership. This interaction of process variables is not confined to the partnership itself, for partnerships are subject to the influences of their constituent organizations and larger contexts. When partnerships experience decreased synergy, our evolving model of synergy (as depicted in Figure 5-1) can support the diagnostic task of identifying the sources of the problem and the task of devising solutions to address it, paying particular attention to the interplay of variables.

The optimal configurations of these processes and their interaction with partnership resources and context can be highly variable, depending on the specifics of each partnership.⁴³ Indeed, as the IMPACT program progressed, each of the partnerships under our investigation evolved in different ways, based upon the specific context within which it was developing, the local access need that the partnership tried to address, tailored processes and requirements to meet this need, and the relationships that formed to move the work forward. In participatory research terms, the PCCP stakeholder participation exhibited elements of “co-construction” or “co-governance,” whereas in the CHRP it was more aligned with “consultation.”⁵⁵ Each of these configurations fit the objectives and the needs of the respective partnerships. Our findings support prior research that highlights that partnership as a form of multi-organizational working relationship is a variable concept and works differently under different circumstances.^{56, 57}

It is important to note that an in-depth exploration of the challenges of partnering was beyond the scope of this study. The main challenges reported by our study participants included the following: considerable time commitments, insufficient credit for investing energy into the partnership, challenges with bridging organizational divides, and difficulties optimizing the involvement of knowledge users (the people affected by the partnership's work). These obstacles affected some stakeholders' motivation, their level of participation, and, subsequently, partnership synergy. These findings indicate the importance of devoting attention to the balance of costs and benefits and recognizing and responding to perceived and actual disengagement throughout the life of the partnership.

5.6.3 Implications for practice and future research

The partnership synergy framework⁴ is useful in assessing the intermediate outcomes of ongoing partnerships when it is too early to evaluate the achievement of long-term intended outcomes. It should be incorporated into routine partnership evaluation, starting with a baseline assessment. The list of variables offered by the framework allows partnership practitioners and evaluators to select those relevant to a particular partnership, identify the levers of change, and calibrate inputs accordingly in an attempt to increase partnership synergy. Future research should focus on identifying other manifestations of partnership synergy and documenting conditions under which these manifestations emerge. The ultimate objective would be to determine if partnership synergy

could indeed become a source of “renewable energy” for a partnership. It would equally be important to document instances of negative partnership synergy or antagonism⁴⁸ and identify “tipping point” scenarios where the composite partnership synergy no longer offers its protective effect.

5.6.4 Limitations

This section outlines the limitations of this study and how these limitations were mitigated. First, the study of the partnership aspects was largely conducted by one member of the research team (the first author). Individual biases may have affected the coding and interpretation of data. However, the first author is experienced in qualitative data gathering, coding, and analysis. In addition to being exposed to the partnership phenomena over a prolonged period of time, the following strategies were employed to reduce the effect of investigator bias: (a) triangulation from multiple sources of evidence, and (b) keeping an “audit trail” to document decisions made throughout the research process.⁵⁸ Moreover, the coding frames and analytic plan were developed and validated with other members of the research team. Second, participants may have provided a more favorable assessment of the partnerships, given the voluntary nature of engagement and the stage of the partnerships by which those who did not see value in participating would have resigned. We attempted to minimize this limitation through the use of purposive sampling, which enabled the selection for interviews of a mix of seasoned and new partnership participants and those demonstrating high and low levels of participation. In addition, the semi-structured interview format allowed the interviewer to explore negative cases. Third, this study analyzed only two of the six IMPACT local partnerships and just some of the partnership manifestations. Some important aspects of partnership functioning may not have been captured. The two partnerships were chosen in light of feasibility considerations, and the partnership dimensions were selected in alignment with the chosen theoretical framework. This study will be followed by a quantitative study involving all six IMPACT partnerships. Finally, the study unfolded within the context of a funded program of research with a targeted scope to improve accessibility to PHC for vulnerable populations. Caution is warranted when transferring these results to different, less resourced contexts. Rich contextual descriptions were provided for each of the two IMPACT local partnerships allowing other scholars and practitioners to determine whether and how the results may be applicable in different contexts.

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CHAPTER 6. Manuscript 2 – Measuring partnership synergy and functioning: Multi-stakeholder collaboration in primary health care

6.1 PREAMBLE

This is the second of three manuscripts that are part of this thesis. The candidate adapted the Partnership Self-Assessment Tool (PSAT) based on qualitative findings (Chapter 5. *Manuscript 1*), and administered it to five partnerships within the framework of the IMPACT programme of research. This manuscript presents the results of analysis of the tool's performance. The results support the feasibility of using the tool in assessing certain dimensions of partnership functioning and partnership intermediate outcomes in primary health care. In addition, the results highlight gaps in the tool and produce preliminary evidence supporting the utility of an expanded partnership synergy scale.

This manuscript was published in *PLOS ONE* in May 2021.

Loban, E., Scott, C., Lewis, V., & Haggerty, J. (2021). Measuring partnership synergy and functioning: Multi-stakeholder collaboration in primary health care. *PLOS One*, 16(5), e0252299. doi:10.1371/journal.pone.0252299

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Measuring partnership synergy and functioning: Multi-stakeholder collaboration in primary health care

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6.2 ABSTRACT

In primary health care, multi-stakeholder partnerships between clinicians, policy makers, academic representatives and other stakeholders to improve service delivery are becoming more common. Literature on processes and approaches that enhance partnership effectiveness is growing. However, evidence on the performance of the measures of partnership functioning and the achievement of desired outcomes is still limited, due to the field's definitional ambiguity and the challenges inherent in measuring complex and evolving collaborative processes. Reliable measures are needed for external or self-assessment of partnership functioning, as intermediate steps in the achievement of desired outcomes. We adapted the Partnership Self-Assessment Tool (PSAT) and distributed it to multiple stakeholders within five partnerships in Canada and Australia. The instrument contained a number of partnership functioning sub-scales. New sub-scales were developed for the domains of communication and external environment. Partnership synergy was assessed using modified Partnership Synergy Processes and Partnership Synergy Outcomes sub-scales, and a combined Partnership Synergy scale. Ranking by partnership scores was compared with independent ranks based on a qualitative evaluation of the partnerships' development. 55 (90%) questionnaires were returned. Our results indicate that the instrument was capable of discriminating between different levels of dimensions of partnership functioning and partnership synergy even in a limited sample. The sub-scales were sufficiently reliable to have the capacity to discriminate between individuals, and between partnerships. There was negligible difference in the correlations between different partnership functioning dimensions and Partnership Synergy sub-scales. The Communication and External Environment sub-scales did not perform well metrically. The adapted partnership assessment tool is suitable for assessing the achievement of partnership synergy and specific indicators of partnership functioning. Further development of Communication and External Environment sub-scales is warranted. The instrument could be applied to assess internal partnership performance on key indicators across settings, in order to determine if the collaborative process is working well.

6.3 INTRODUCTION

Multi-stakeholder partnerships have been defined as a “voluntary and collaborative relationship ... between various [stakeholders from different organizations] ... in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits” [1]. Partnerships can help people and organizations generate outcomes that are greater than those that can be achieved working independently [2-4]. Partnerships continue to be widely embraced with governments and funding bodies mandating partnerships as an essential element of the programs and initiatives that they support [3, 5, 6].

In practice, however, partnerships can generate a great deal of frustration, as different organizations and individuals frequently struggle to achieve measurable and mutually beneficial outcomes [3, 5, 7-9]. These problems are not surprising given that partnerships are resource-intensive, take time and require governance, procedures and processes that are very different from how independent organizations are run [3]. Measures of partnership functioning and partnership self-assessment tools can help organizations assess how the partnership is evolving, benchmark against external criteria, stay accountable to the partnership’s stakeholders and funders, and monitor and maximize the effectiveness of the collaborative effort [6, 10-12].”

This article presents findings from a survey of five multi-stakeholder partnerships involving decision makers, academic representatives, clinicians and organizational representatives with an interest in improving primary health care (PHC) accessibility. This quantitative study was part of a larger mixed methods sequential exploratory study to understand the processes that enhance multi-stakeholder partnerships in PHC service delivery. The qualitative phase entailed a comparative qualitative case study exploring, in a smaller sample of partnerships, the different manifestations of partnership synergy, different types of partnership resources and broad categories of partnership processes relevant to multi-stakeholder partnerships in PHC. Based on qualitative findings, approximately three-to-four years into the partnerships, we adapted an existing quantitative tool to measure different functions of partnerships and specifically to measure the concept of partnership synergy as an intermediate measure of partnership effectiveness. This article reports on the metric performance of the adapted measures of partnership functioning and partnership synergy.

6.3.1 Partnership evaluation and synergy

Some scholars and practitioners have argued that various dimensions of partnership functioning - including partner relationships, governance, leadership, management, use of resources, and the external environment – influence the achievement of the planned partnership outcomes [3, 13, 14]. The literature offers different definitions and conceptualizations of partnership effectiveness, and complex processes and dynamics are inherently difficult to evaluate [9, 15-18].

The notion of “partnership synergy” has recently been proposed as an intermediate outcome between partnership functioning and the achievement of the planned ultimate outcomes [3]. Synergy is viewed as the key mechanism on the pathway by which partnerships gain advantage over the independent work of individual stakeholders working towards the same goals [3]. Partnerships are said to be synergistic when they leverage resources successfully and mobilize the complementary knowledge and expertise of all partners, with the effect that the whole becomes greater than the sum of the parts [2, 3]. The assumption is that if a partnership achieves a high level of synergy, it is better placed to achieve desired partnership goals. The advantage of measuring synergy is that it is manifested (or not) earlier and is more directly attributed to partnership functioning than the ultimate outcomes [3].

Two validated scales of partnership synergy have been developed. Both scales purport to assess the degree to which the partnership has maximized its synergy but each measures partnership synergy differently. The Weiss *et al.* scale [19] conceptualizes synergy as a product of good quality partnership processes [3], whereas the Jones synergy scale measures synergy as both a partnership process and a partnership product [20]. Both synergy scales are embedded in instruments that include other measures of different partnership functioning dimensions [7, 19, 21].

6.3.2 Partnership Self-Assessment Tool (PSAT)

We selected as the study instrument the Partnership Self-Assessment Tool (PSAT) [22] which contains the Weiss *et al.* partnership synergy scale. The PSAT also measures the various dimensions of partnership functioning including leadership, efficiency, administration and

management, non-financial resources, financial and other capital resources, decision-making, benefits and drawbacks of participation and overall satisfaction with participation [22]. The PSAT was developed by public health scholars for use by groups working to promote health and well-being in their communities [19, 23, 24]. Although very similar to another partnership instrument that integrated the Weiss *et al.* and the Jones partnership synergy scales (Partner Questionnaire) [20], we primarily used the PSAT, but integrated some of the nuances from the Partner Questionnaire. The PSAT is in the public domain and no conditions are specified for its use [25]. The PSAT was “provided to partnerships at no charge by the Center for the Advancement of Collaborative Strategies in Health at The New York Academy of Medicine with funding from the W.K. Kellogg Foundation” [23].

We made some adaptations to the PSAT. First, we modified the Partnership Synergy scale, incorporating items from the Weiss *et al.* and the Jones partnership synergy scales [20, 22]. Second, we developed new measures of communication and external environment and we adapted the content of other sub-scales based on the findings of the comparative case study of two of the partnerships. The objective of this study was to assess the reliability of the adapted PSAT instrument and sub-scales, specifically the measures of partnership synergy, to assess its capacity to discriminate between partnerships, and to provide conclusions that were coherent with the independent qualitative developmental evaluation that ran in parallel to the mixed methods study.

6.4 METHODS

We used a cross-sectional survey design, distributing a self-administered questionnaire to multiple stakeholders within five collaborative local partnerships in three Canadian provinces (Quebec, Ontario and Alberta) and two Australian states (Victoria and New South Wales). The survey took place between September 2018 and March 2019. Ethics approval for the study was obtained from the St. Mary’s Hospital Center Research Ethics Committee (No. **SMHC-13-30C**). All participants provided consent prior to data collection.

6.4.1 Study population and sampling

The five partnerships were established in 2014 within a Canada-Australia research program entitled “Innovative Models Promoting Access-to-Care Transformation” (IMPACT). The program

aimed at implementing organizational interventions to improve access to appropriate PHC for vulnerable populations [26]. Using a participatory action research approach, each partnership identified local PHC access need, and selected, adapted, implemented and evaluated an organizational intervention to address the need. The ultimate outcome was to meet the health care needs of the specific population through PHC and avoid unnecessary emergency room use and hospitalizations.

Each partnership involved a combination of the following stakeholders: policy makers, clinicians and other health and community service providers, health system administrators, university researchers and research coordinators, and, in some cases, members and representatives of vulnerable populations [26]. The premise of the program was that a strong partnership was key to mobilizing the resources for the pilot intervention and ultimately sustaining it, if proved potentially effective. Each IMPACT local partnership was unique, based upon the specific context within which it unfolded, the local access need that the partnership tried to address, tailored processes and requirements that were required to meet this need, and the relationships that formed to move the work forward. As a result, the interventions in each partnership were different both in focus and in the ways in which the partnerships evolved. See Table 6-1 for an overview of interventions in five partnerships.

Table 6-1. Overview of interventions in five partnerships [adapted from 26, 27]

Partnership Title	Intervention objective	Target population	Intervention type
Service Linkage	To identify vulnerable individuals who are likely to benefit from better access to PHC* and to successfully link them with PHC practices.	Vulnerable individuals who are clients of community-based chronic disease services. Clients had at least one the of the following characteristics: low socioeconomic status, social isolation due to geographic distance/public transport, chronic illness of developmental disability.	Community-based chronic disease services identify patients without a primary care provider. A broker then links identified patients to one of a panel of volunteer family practitioners.
Community Health Resources	To increase primary care providers' awareness of and referral to community resources for socially vulnerable patients, and to assist these patients in overcoming barriers to reach the services.	Chronically ill primary care patients not receiving available community services that would optimize disease management.	A lay patient navigator within primary care practices to facilitate access to community-based health and social resources for vulnerable patients – those experiencing social barriers.
Diabetes Self-management	To identify the enabling factors and assess the impact of web-based information and education tools that support chronic disease self-management in a vulnerable PHC population attending practices in low socioeconomic areas.	Patients with poorly controlled diabetes attending practices in low socioeconomic neighborhoods. Targeted subgroups: low socioeconomic status, culturally and linguistically diverse communities, refugee and humanitarian entrants.	A website that provides information and referral options to support diabetes self-management, facilitated by practice nurses at a health check visit in the PHC practice.
Primary Care Connection	To enhance the retention of vulnerable patients who were recently assigned to a family physician from a centralized wait list.	Unattached patients in two high deprivation neighborhoods (e.g., low income, high unemployment, low social support), especially those with mental health diagnoses or poor health.	A telephone outreach service by lay volunteers to help prepare for their first visit and explain important access-related issues, in order to facilitate forging an on-going relationship with their care provider.
Community Outreach	To identify the components of outreach and colocation of PHC services, as identified by vulnerable populations, that contribute to making these services more approachable and engaging.	Individuals and groups of vulnerable populations living in a geographic area with few PHC services but high concentration of marginalized populations, including: recent immigrants, Aboriginal people, seniors, the homeless.	Mobile (pop-up) PHC services, held in different locations, for vulnerable patients in an underserved urban area.
* PHC - Primary Health Care			

The partnerships met the following criteria for the PSAT use: the partnerships had been in existence for at least six months, had at least five active partners, had continually worked together to develop and modify strategies in order to achieve their goals, and had begun to implement their plans [23]. We used a census sample of all members of the five local partnerships at the time of

data collection. All 61 stakeholders who were active in the partnerships at the time of administration were considered eligible and were invited to participate.

6.4.2 Instrument adaptation and administration

We adapted the validated Partnership Self-Assessment Tool (PSAT) [22, 24] as outlined in Appendix K. First, we made small linguistic adaptations to fit the PHC study context, by reflecting the roles and organizational expertise of the stakeholders in PHC partnerships. Second, we adapted the PSAT based on analysis of the case studies in two partnerships with the objective of understanding and describing how partnership processes and approaches to enhance partnerships were perceived and experienced by local partnership stakeholders. We selected PSAT sub-scales and items that corresponded to qualitative codes from the case study and excluded items that were deemed not relevant. In addition, we supplemented synergy items from the PSAT with synergy items from the Partnership Questionnaire [20] to capture more information on partnership processes. The adapted instrument retained the following dimensions of partnership functioning from the PSAT: Decision-making (four items), Leadership (11 items), Administration & Management (11 items), Non-financial Resources (six items); Financial & Other Resources (three items); and Resource Utilization (three items, referred to as “Efficiency” in the PSAT).

We added elements that emerged in qualitative data but were not part of the PSAT: new proposed sub-scales for Communication (three items) and External Environment (two items). The case studies spoke to the importance of communication as an integral dimension of partnership functioning and the critical role of external influences.

Partnership Synergy was assessed using two sub-scales: 1) the adapted Partnership Synergy Processes sub-scale incorporating five items from the eight-item synergy scale developed by Jones and Barry [20]; and 2) the adapted Partnership Synergy Outcomes sub-scale retaining two items from the nine-item synergy scale by Weiss *et al* [19]. The items from these original scales were selected based upon the relevance to the types of partnerships highlighted throughout the qualitative inquiry, and with a view to reduce participant burden. More items were retained from the Jones than the Weiss *et al*. synergy scale as they were deemed more relevant in light of our overall aim to understand the processes and approaches of successful partnerships. In addition, they were more appropriate in our sample of partnerships that were underway and that exhibited

varied levels of engagement of community-based stakeholders representing the target population. The partnerships were at a stage in their development when it was premature or impossible to evaluate elements of the Weiss *et al.* scale, such as the ability “to respond to the needs and problems of the community” or “to implement strategies that are most likely to work in the community” [22]. Respondents were also asked to assess the extent to which the goal of developing a meaningful partnership had been achieved (1 item).

The majority of questions offered five-point Likert response options. We changed the order of response options to present the most negative response first, in order to reduce the commonly observed positive bias in responding [28]. The use of the “don’t know” response option was minimized, to reduce the occurrence of missing data and on the grounds that there was little reason to suppose that respondents would not know. The instrument captured the stakeholders’ assessments of the partnerships: some questions elicited the individual stakeholders’ own perceptions; others, the perspectives of the stakeholders’ respective organizations. The respondents were asked to provide an assessment of the partnership at the point in time when the tool was administered.

Finally, the questionnaire included questions about perceived Benefits (11 items) and Drawbacks (5 items) of participation to their respective organizations, and an overall assessment of benefits compared to drawbacks (1 item). It also elicited descriptive information about the stakeholder (type, of role in the organization, length of time in the partnerships, frequency of engagement).

The questionnaire was tested through cognitive interviewing [29] with three professionals familiar with PHC terminology, to verify that the content of the questions was understood as intended, to select the most appropriate response scales, and to ascertain whether the language, the length and format were appropriate. Modifications were mostly confined to amending response scales and choosing the appropriate terminology in French. The translation into French was performed by the first author (EL) and verified by a member of the research team familiar with the terminology and the IMPACT program context.

The questionnaire was self-administered according to existing guidelines in the survey literature [28]. Both paper and web-based questionnaires were offered, and in either English or French. The electronic questionnaire was hosted on the *Qualtrics* [30] online survey platform.

6.4.3 Data analysis

The unit of analysis for analysing the metric properties of the instrument was the individual respondent (n=54), whereas the unit of analysis for partnership functioning and synergy was the aggregate of individual responses within a given partnership (n=5). We preferred the median and IQR as the most appropriate way of representing central tendency and spread given the categorical nature of the data.

We used descriptive statistics to characterize the sample and the distribution of the items and sub-scale scores. The scores for each sub-scale were derived through unweighted mean and medians of all the component items; scores for a respondent were calculated only if at least 50% of the items in the scale had been completed. Another method for handling the missing data was pairwise deletion. The small sample size precluded classical factor analysis. Instead, the analysis focused on examining some of the metric properties that may compromise precision and reliability. We looked for floor and ceiling effects, using a threshold $\geq 45\%$ respondents in the lowest or highest response option. These items were tagged for exclusion as they indicated reduced capacity to discriminate between respondents. We used Spearman correlation coefficients to estimate the correlation between items within purported sub-scales, and between sub-scales, specifically dimensions of partnership functioning and partnership synergy. We examined internal consistency of the purported sub-scales by calculating the Cronbach's Alpha.

At the partnership level, the score for each scale was calculated by aggregating the scale scores of the component member respondents within each partnership. For partnership synergy, the two sub-scales of Partnership Synergy Processes and Partnership Synergy Outcomes were analysed separately, at the level of individual respondents. However, given that they were highly correlated with each other and demonstrated similar correlations with dimensions of partnership functioning, both sub-scales were combined at the level of the partnerships to provide a single score of Partnership Synergy. We used the non-parametric Kruskal–Wallis test to determine if we were able to detect statistically significant differences in sub-scale scores between any of the partnerships. The ranks of the scores were also derived. SPSS 23 for Windows [31] was used for data analyses.

In lieu of statistical testing of predictive and convergent validity, we used consensus ranking from two external content reviewers who had conducted the independent longitudinal developmental evaluation of the five IMPACT partnerships as part of the IMPACT program's effort to support the partnerships. They ranked the five partnerships based on the operational definitions and item content of the Partnership Synergy sub-scales and of the following partnership functioning sub-scales: Communication, Decision-making, Problem-solving, Resource Utilization and External Environment. The qualitative and quantitative ranks were compared. Finally, we correlated the score of Partnership Synergy with the partnership aggregate assessment of the extent to which developing a meaningful partnership had been achieved.

6.5 RESULTS

6.5.1 Sample characteristics

The response rate was 90% (55/61), of which 62% (34) were online and 38% (21) were in paper format; 82% (45) in English and 18% (10) in French. One respondent was subsequently excluded from analysis due to comments on the questionnaire admitting that they picked answers at random. Our final sample was therefore 54 participants (dataset available electronically at <https://doi.org/10.1371/journal.pone.0252299.s004>). Of note, two partnerships, namely Primary Care Connection and Community Health Resources, participated in both phases of this mixed methods study, with 15 partnership stakeholders participating in both the qualitative phase (involving interviews) and this quantitative phase (entailing a survey).

The partnerships varied in their size and composition. Table 6-2 outlines the descriptive characteristics of each of the partnerships. Academic representatives constituted the largest single group of stakeholders in each partnership. Of the five partnerships, the Community Health Resources partnership had the largest representation of community stakeholders (representing community organizations and patients).

Table 6-2. Study sample characteristics per partnership (N=5)

Partnerships	Total number of participants (N=54)	Gender	Mean length of time in partnership	Min/max length of time in partnership	Main role
		Percent female			
Service Linkage	9	78% (7)	3,8 years	2-6 years	Academic representative – 4 Decision-maker – 1 Health care manager – 4
Community Health Resources	19	68% (13)	2,6 years	1-4 years	Academic representative – 5 Community organization representative – 3 Decision-maker – 2 Health care manager – 4 Patient representative – 3 Primary care physician – 2
Diabetes Self-management	7	71% (5)	3,1 years	0.7-5 years	Academic representative – 3 Community representative – 1 Decision-maker – 1 Health care manager – 1 Primary care physician – 1
Primary Care Connection	11	91% (10)	3 years	1-5 years	Academic representative – 5 Decision-maker – 1 Health care manager – 3 Patient representative – 1 Primary care physician – 1
Community Outreach	8	86% (7)	2,8 years	2,5-5 years	Academic representative – 6 Decision-maker – 1 Health care manager – 1

Five participants did not finish completing the questionnaire for a variety of reasons (stopping at questions 14 (health care manager), 14 (academic representative), 15 (academic representative), 21 (health care manager) and 23 (patient representative) of a total of 76 questions). The missing data rates per question were calculated only on the sample of respondents who completed the questionnaire to that point. Missing data varied from 0% to 18% and the median was 2%, which was under the conventional missing rate of 10% [32]. The missing data rates higher than 10% occurred in the sub-scales of Financial Resources, Resource Utilization and External Environment, suggesting these may be problematic metrically. Ceiling effects were observed in two of the 65 Likert-scale questions in the sub-scales of Decision-making and Leadership. No floor effects were present.

6.5.2 Partnership functioning and synergy

Table 6-3 provides descriptive statistics for the dimensions of partnership functioning. We observed that the responses on all dimensions were skewed towards positive evaluations.

Table 6-3. Score distribution for the partnership functioning and partnership synergy sub-scales (N=54). Responses to various five-point Likert scales response options have a negative (1) to positive (5) valence.

#	Sub-scale	Means (SD)	Medians (IQD)	Range of scores
Partnership Functioning				
1.	Communication (2 items)	3.60 (0.60)	3.50 (1)	2.50-4.50
2.	Decision-making (4 items)	3.75 (0.71)	4.00 (0.94)	2.00-4.75
3.	Leadership (11 items)	3.83 (0.84)	3.86 (1.39)	1.91-5.00
4.	Administration & Management (11 items)	3.77 (0.71)	3.82 (1.09)	1.83-5.00
5.	Non-financial Resources (6 items)	3.73 (0.51)	3.67 (0.50)	2.17-4.83
6.	Financial Resources (3 items)	4.07 (0.66)	4.00 (0.50)	2.50-5.00
7.	Resource Utilization (3 items)	4.07 (0.90)	4.33 (1.00)	1.67-5.67
8.	External Environment (2 items)	3.56 (0.67)	3.50 (1.00)	1.00-5.00
Partnership Synergy				
1.	Partnership Synergy Outcomes (2 items)	3.52 (0.74)	3.50 (1)	2.00-5.00
2.	Partnership Synergy Processes (5 items)	3.71 (0.65)	3.60 (0.80)	2.00-4.80

Table 6-4 presents summary information on the Spearman rank correlations between the items within various dimensions of partnership functioning and Partnership Synergy (table of individual correlations available electronically at <https://doi.org/10.1371/journal.pone.0252299.s002>). We used the following cut-offs for interpreting the scores: .10 – weak correlation; .30 – moderate; .50 – strong [33]. Despite our limited sample size, we examined the correlations to shed light on a number of assumptions that relate to the validity and reliability of measures. We observed that items within the following sub-scales met the assumption of item-convergent validity by being strongly correlated (>0.50) within the sub-scale: Leadership, Administration & Management, Financial Resources and both Partnership Synergy sub-scales. The assumption of item-discriminant validity states that the correlation of items within a hypothesized sub-scale will be higher than with items in other sub-scales. We observed that correlations between items within the following sub-scales were higher

than with other sub-scales: Leadership, Administration & Management, Financial Resources and both Partnership Synergy sub-scales.

Finally, reliability of a scale is assumed if each item has an approximately equivalent correlation within the hypothesized sub-scale and contributes approximately the same proportion of information to the total score. The low and variable correlations in Communication and External Environment translated into a low internal consistency that failed to meet the criterion of ≥ 0.70 [34]. Cronbach's α values demonstrated good internal consistency and reliability for most other sub-scales, although the very high within-scale correlation and high internal consistencies in the Leadership, Administration & Management suggest redundancy in the items.

Table 6-4. Spearman rank correlations between items within each of the sub-scales and between sub-scales of dimensions of partnership functioning and partnership synergy, showing the average, minimum and maximum correlation coefficients, and a measure of internal consistency (N=54)

#	Sub-scale	Average within sub-scale correlation (means)	Average within sub-scale correlation (medians)	Range (min-max)	Cronbach's α	Average correlation with items in other sub-scales (medians)
Partnership Functioning						
1.	Communication (2 items)	0.36		-	0.49	0.39
2.	Decision-making (4 items)	0.45	0.44	0.24-0.63	0.77	0.47
3.	Leadership (11 items)	0.68	0.71	0.34-0.89	0.95	0.53
4.	Administration & Management (11 items)	0.59	0.59	0.35-0.79	0.93	0.48
5.	Non-financial Resources (6 items)	0.36	0.40	-0.14-0.64	0.79	0.40
6.	Financial Resources (3 items)	0.62	0.50	0.50-0.86	0.83	0.18
7.	Resource Utilization (3 items)	0.39	0.28	0.15-0.74	0.73	0.39
8.	External Environment (2 items)	-0.28		-	-0.74	-0.06
Partnership Synergy						
1.	Partnership Synergy Outcomes (2 items)	0.54		-	0.69	0.46
2.	Partnership Synergy Processes (5 items)	0.59	0.65	0.43-0.69	0.89	0.48

Table 6-5 displays correlations between the various dimensions of partnership functioning and Partnership Synergy, as assessed using Spearman's rank correlation coefficient. Together, Tables 6-4 and 6-5 demonstrate that the new sub-scales of Communication and External Environment did not perform well metrically, on assumptions of item-convergent validity, item-discriminant validity, and internal consistency. We subsequently excluded these sub-scales from our partnership-level analysis.

Table 6-5. Spearman rank correlations between partnership synergy outcomes, partnership synergy processes, and the different dimensions of partnership functioning (N=54). Values shaded in light grey denote weak correlations, in dark grey – strong correlations.

	Partnership Synergy Outcomes	Partnership Synergy Processes	Communication	Decision-making	Leadership	Admin & Mgmt	Non-financial Resources	Financial Resources	Resource Utilization	External Environment
Partnership Synergy Outcomes		0.61	0.34	0.60	0.69	0.60	0.39	0.18	0.46	0.15
Partnership Synergy Processes	0.61		0.44	0.59	0.60	0.48	0.51	0.35	0.45	0.26
Communication	0.34	0.44		0.47	0.50	0.45	0.38	0.32	0.39	0.10
Decision-making	0.60	0.59	0.47		0.65	0.52	0.40	0.07	0.29	0.25
Leadership	0.69	0.60	0.50	0.65		0.74	0.42	0.13	0.53	-0.08
Administration & Management	0.60	0.48	0.45	0.52	0.74		0.42	0.05	0.50	-0.06
Non-financial Resources	0.39	0.51	0.38	0.40	0.42	0.42		0.56	0.32	-0.21
Financial Resources	0.18	0.35	0.32	0.07	0.13	0.05	0.56		0.28	-0.18
Resource Utilization	0.46	0.45	0.39	0.29	0.53	0.50	0.32	0.28		-0.17
External Environment	0.15	0.26	0.10	0.25	-0.08	-0.06	-0.21	-0.18	-0.17	

In addition, we observed that the shortened Partnership Synergy Outcomes and Partnership Synergy Processes sub-scales were strongly correlated with each other ($r=0.61$), and there were few differences in how each of them correlated with the different dimensions of partnership functioning. We consequently chose to collapse the two synergy sub-scales together to a single Partnership Synergy scale (Partnership Synergy) for the analysis of associations between Partnership Synergy and functioning dimensions at the partnership level.

6.5.3 Partnership functioning and synergy at the partnership level

We aggregated the scores at the partnership level for Partnership Synergy Outcomes, Partnership Synergy Processes, Partnership Synergy and the following dimensions of partnership functioning: decision-making, leadership, administration & management, non-financial resources, financial resources and resource utilization. We then ranked the five partnerships on the basis of their aggregate scores. Fig 6-1 displays the comparison of the ranking based on quantitative scores with the independent, qualitative rankings by the content reviewers. The quantitative and qualitative rankings were completely coherent for Partnership Synergy Outcomes, showing that partnership synergy was highest in the Community Outreach partnership and lowest in the Service Linkage partnership. Our one-way analysis of variance was suggestive of statistically significant differences between at least two of the medians of Partnership Synergy Processes ($P=.09$) and Partnership Synergy ($P=.07$). The differences in medians were statistically significant between the following partnerships: Primary Care Connection-Service Linkage, Community Outreach-Community Health Resources, Community Outreach-Diabetes Self-management and Community Outreach-Service Linkage (in decreasing order of magnitude of difference). To further explore the extent to which differences in aggregate scores were meaningful, we calculated and found low to moderate variation for partnership synergy in all partnerships, suggesting that the statistically significant Kruskal-Wallis test of difference between at least two partnerships was not spurious. There was some variation in the content reviewers' ranking of partnership synergy processes and partnership synergy outcomes, that was not reflected in the quantitative scores (see Appendix L), suggesting that the items may not have captured nuances in the construct.

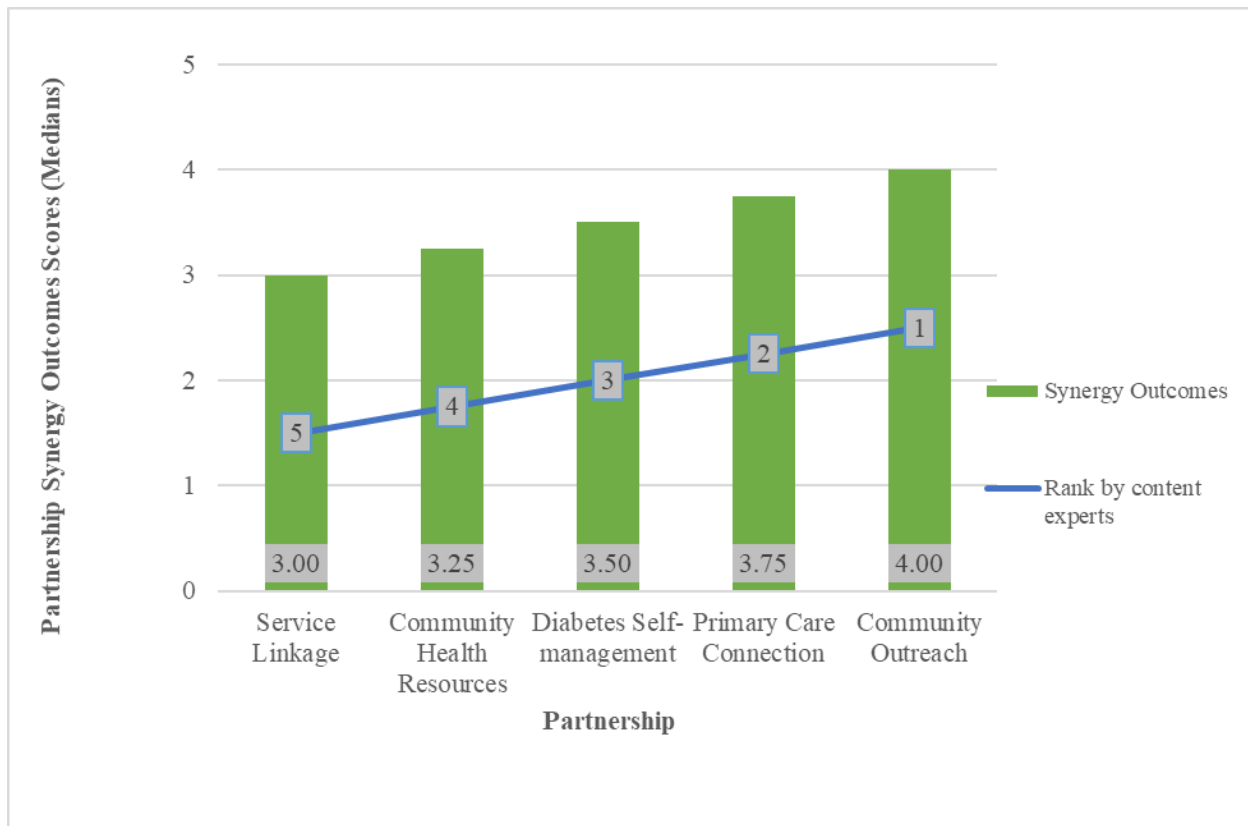


Figure 6-1. Partnership synergy outcomes (partnership-level median scores) and rankings of partnerships based on assessment by content reviewers (highest = 1 to lowest = 5) (N=5)

Fig 6-2 demonstrates that the partnership ranking was generally reflected in the scores of the partnership functioning dimensions, which was largely coherent with the results in Table 6-5 that show moderate to strong correlations between certain dimensions of partnership functioning and Partnership Synergy sub-scales. However, Fig 6-2 also displays a variation in ranking of the dimensions of partnership functioning, suggesting that partnership synergy is not simply another measure of partnership functioning.

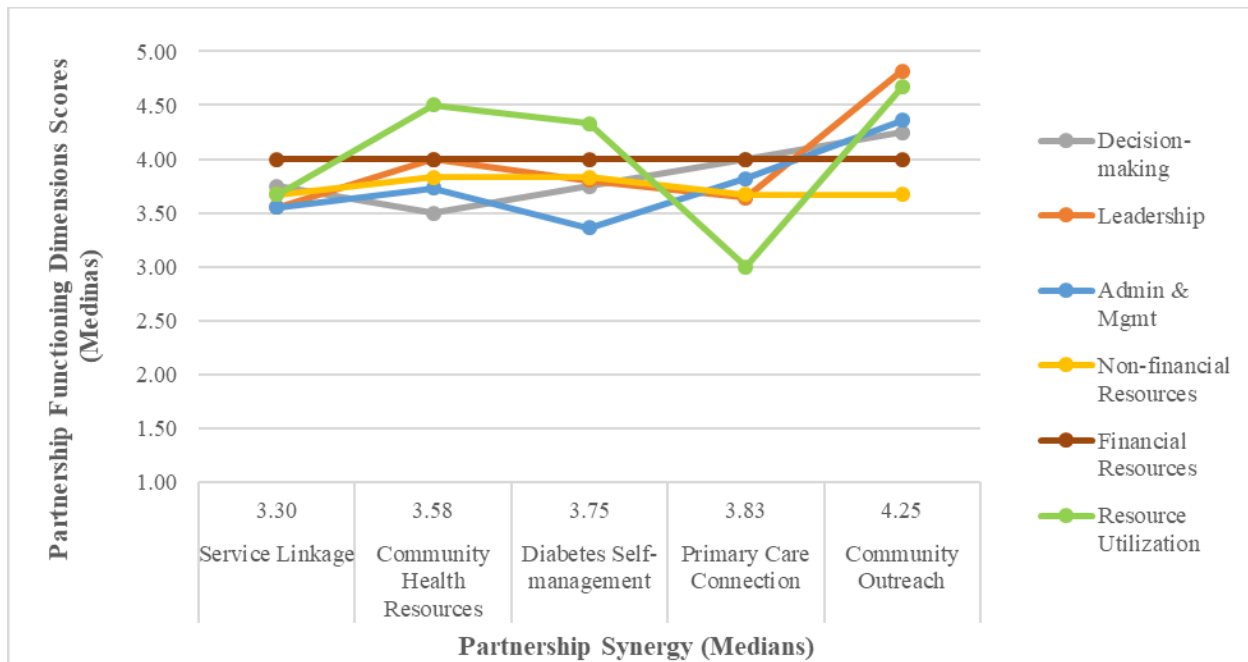


Figure 6-2. Partnership-level scores on dimensions of partnership functioning. Partnerships are ordered by increasing score on partnership synergy (and rank).

Irrespective of the variations in ranking of the different dimensions of partnership functioning, the partnership-level scores for achieving the overall goal of developing a meaningful partnership were largely consistent with partnership-level partnership synergy scores. The majority of respondents in all partnerships reported that a meaningful partnership had been achieved leading to an uninformative median of 4 across all partnerships. However, as shown in Table 6-6, there was considerable variation within the partnerships that was reflected in the means and standard deviations. The metric that corresponds best to both partnership synergy scores and the qualitative ranking is the percentage endorsing that the partnership goal was achieved *very well* or *extremely well*.

Table 6-6. Partnership-level assessment of the extent to which the goal of developing a meaningful partnership has been achieved

Partnership	Not well at all or not so well	Moderately well	Very well or extremely well	Mean (SD)
Service Linkage (n = 9)	2 (22.2%)	3 (33.3%)	4 (44.4%)	3.22 (1.20)
Community Health Resources (n = 15)	0	5 (33.3%)	10 (66.7%)	3.87 (0.74)
Diabetes Self-management (n = 7)	0	2 (28.6%)	5 (71.4%)	3.86 (0.69)
Primary Care Connection (n = 10)	1 (10%)	2 (20%)	7 (70%)	3.60 (0.70)
Community Outreach (n = 7)	0	1 (14.3%)	6 (85.7%)	4.14 (0.69)

6.6 DISCUSSION

This study demonstrated that an adapted version of the PSAT was capable of discriminating between different levels of dimensions of partnership functioning and partnership synergy even in a limited sample of ongoing partnerships working towards improving PHC. The measures are sufficiently reliable to have the capacity to discriminate between individuals' perceptions of the partnerships, and between partnerships based on an aggregated score. The quantitative measures could not distinguish meaningfully between Partnership Synergy Processes and Partnership Synergy Outcomes, and we proposed a single measure of Partnership Synergy. Our new sub-scales on Communication and External Environment did not perform well metrically, but could be further developed. Our findings demonstrate that the PSAT can be a valuable evaluation tool for partnerships that are underway, in that it supports identification of the areas of strength and potential improvement to achieve the collaborative advantage over organizations working on their own, even before achievement of the planned ultimate outcomes can be assessed. The tool requires further refinement and possible elimination of redundancies in order to be administered at several points in the life of partnerships in PHC transformation.

We adapted the PSAT [22] on the basis of findings from a qualitative investigation that preceded this study. Some of the items were adapted based on qualitative codes, and new items were developed for Communication and External Environment. In the 2002 version of the PSAT, item content related to communication was found in the following scales: Synergy, Leadership, and Administration & Management [22]. While we retained these items in the Leadership and

Administration & Management sub-scales, we also developed a separate sub-scale for the domain of communication, for our qualitative data demonstrated the importance of communication as a stand-alone dimension of partnership functioning [35]. Clear, targeted and timely communication via a variety of communication mechanisms was deemed by qualitative study participants to be one of the key drivers in ensuring transparency and enhancing stakeholder engagement. However, the three-item sub-scale that we designed did not perform well metrically based on assessment of item-convergent validity, item-discriminant validity, or internal consistency. This may be because we used a different response approach for each item: a descriptive range for the first question on ways stakeholders were informed about what is happening in the partnership; rating of usefulness of information received; and an assessment of adequacy of quantity of information. Despite various attempts to express the nominal descriptive item in ordinal categories of increasing magnitude, the exercise did not yield satisfactory results, and even after eliminating this poorly functioning item and retaining only two items the internal consistency remained low (0.49). However, the Spearman rank correlations between all three communication items and partnership synergy were statistically significant, different from zero and strong in the Primary Care Connection partnership (0.71) and the Community Health Resources partnership (0.51), upholding our qualitative conclusion that communication was an important dimension of partnership functioning. Future research should develop a more appropriate sub-scale to measure communication as an integral component of partnership functioning.

Similarly, for external environment, our qualitative findings demonstrated that external context had an important impact on the work of the partnerships in the case study [35]. The interventions in both partnerships under qualitative investigation unfolded within the context of significant changes in the respective health care systems. This contextual volatility necessitated ongoing adaptations to interventions to respond to evolving environmental opportunities and threats. However, our newly developed sub-scale on External Environment was not correlated with partnership synergy, nor any other dimension of partnership functioning. This finding is consistent with prior research. A study by Weiss, Anderson and Lasker (2002) revealed that community-related challenges, as measured by a three-item scale that the authors developed, did not have any relationship to synergy. The lack of correlation in our study might, however, have been due to the limitations of the scale used: the internal consistency of the scale that we developed

was unacceptable (-0.74). This negative result might be due to the fact that it is easier to adapt to a smaller number of environmental changes, which would explain the reverse scoring of the two questions. Alternatively, the two items might not be measuring a single construct. The lack of correlation in our study may also be explained by the fact that external environment is more likely to influence how well the partnership achieves its specific objectives but less likely to have an impact on how the partnership achieves the goal of developing a meaningful partnership. In addition, external environment is highly variable and would require tailored adaptation strategies in each case.

Financial Resources was another sub-scale where we observed a low correlation with most other dimensions of partnership functioning and Partnership Synergy Outcomes. The three-item sub-scale assessed the degree to which the following resources were either present or absent: financial support, space, and equipment and goods. This finding was surprising given the results of prior research demonstrating the critical role of financial resources in partnership functioning [36]. In addition, the partnership synergy framework posits that money and other material resources are among the core determinants of synergy [3]. However, a later study by a team that included the authors behind the partnership synergy framework [19] looked at the relationship between partnership synergy and different dimensions of partnership functioning, and omitted financial resources as a dimension of interest. The authors stated that they had not expected money to be related to the ability of partners to achieve partnership synergy and that financial resources would more likely affect synergy indirectly, by enabling the presence of staff and resources to support the work of the partnership [19]. The weak correlation between Partnership Synergy Outcomes and Financial Resources in our study may be due to the limitations of our Partnership Synergy Outcomes sub-scale (Cronbach's $\alpha < 0.70$). The projects undertaken by partnerships in our sample were funded under the envelope of the larger IMPACT program of research. This funding covered the partnerships' coordinating infrastructure/research support, including the partnership coordinator position in each site, as well as the evaluation of the interventions, but not intervention implementation. Partnership stakeholders, other than research coordinators, were not remunerated for the time spent on partnership activities. Each partnership was required to mobilize adequate local resources to respond to regional access needs and to maintain interventions beyond the life of the IMPACT research funding. Our qualitative study revealed the critical importance of

the funded coordinating infrastructure, but that the efforts to secure funding for the interventions had variable success. However, our Financial Resources sub-scale did not make a distinction between different types of funding. This lack of granularity might have affected the uninformative median of 4 for Financial Resources across all five partnerships. In addition, most partnership stakeholders participated on a continuous voluntary basis which suggests that they were driven by considerations other than financial benefit. Future research should focus on further assessing the relationship between financial resources, partnership synergy and different partnership functioning dimensions.

6.6.1 Synergy outcomes and processes

We assessed partnership synergy with two constructs with a limited number of items (two items from the Weiss *et al.* scale and five items from the Jones synergy scale). We were unable to detect a significant distinction between the two Partnership Synergy sub-scales in terms of how strongly each one of them correlated with other dimensions of partnership functioning. This finding is consistent with prior research that suggested that the Weiss *et al.* and Jones synergy scales could be used interchangeably [20]. On the other hand, our inability to distinguish between these sub-scales might be due to the limited number of items that we had retained. However, the qualitative ranking by independent content reviewers highlighted differences between the two constructs, suggesting the need for further development of separate partnership synergy processes and partnership synergy outcomes measures. Further assessment of the applicability of both scales is warranted. The scales could be administered longitudinally, at various stages in the partnership evolution, to determine if one is more applicable within the scope of partnership process improvements and the other – as part of outcome evaluation, and whether both scales yielding similar results only occurs at a certain point in partnership development.

At the partnership level, the partnership with the highest total partnership synergy score (Community Outreach) achieved on average the highest scores for partnership functioning on most dimensions. However, the results in the case of partnerships with lower scores on the Partnership Synergy and partnership functioning sub-scales were mixed. One partnership (Primary Care Connection) achieved a high synergy score despite a number of lower scores on the partnership functioning sub-scales, the most noticeable one of which was Resource Utilization. The sub-scale

Resource Utilization was referred to as “Efficiency” in the 2002 version of the PSAT [22]. Efficiency was conceptualized as the degree to which a partnership optimized the involvement of its partners [3]. The three-item sub-scale assessed how well the partnership used partner’s time, other non-financial resources, and financial resources [22]. Our qualitative investigation revealed that the Primary Care Connection partnership (which scored lower than other partnerships on this sub-scale) experienced difficulty in meaningfully engaging community-based stakeholders from or representing the target population. In addition, the partnership witnessed reduced engagement of some stakeholders, as they reported that the opportunity cost of conducting activities on behalf of the partnership beyond the face-to-face meetings was too great. Moreover, the extent of environmental impact and adaptation in the case of the Primary Care Connection partnership was particularly profound. The partnership had to redesign the intervention several times to respond to evolving environmental opportunities and threats, and lost some key partners as their organizational positions had changed. These developments may have affected the perceived degree to which the use of financial resources and partners’ time were optimized. The relatively high synergy score for this partnership suggests that there might be certain dimensions that are still lacking from our adapted version of the PSAT and that partnership synergy is an important intermediate outcome worthy of more research. Taking into consideration the emphasis that the stakeholders in all five partnerships put on the quality of relationships, we recommend that future research focus on incorporating into a revised iteration of the PSAT an assessment of the quality of stakeholder relationships, including such aspects as trust, as a stand-alone scale or sub-scale.

6.6.2 Practice implications

The PSAT is a generic tool that has demonstrated robustness in assessing the quality of partnership processes in multi-stakeholder partnerships in several areas, including public health [24]. The PSAT has also been identified as a valid tool for measuring group processes in interprofessional health and social service partnerships at the front-line service provider group level [24]. The original creators of the tool argue that it could have an even broader appeal, including partnerships outside of health care [23]. However, the tool was designed for internal evaluation and not for use by external evaluators [6].

The PSAT may need to be tailored to different partnership types and local conditions. For example, community-driven partnerships with fewer resources, a decentralized partnership structure and more distributed decision-making may need to adapt the Leadership and Administration & Management sub-scales. Alternatively, partnerships may prioritise different aspects for evaluation altogether. There is a variety of other partnership assessment tools that may be more or less suitable depending on the purpose of evaluation and the intended users of its results. For example, the Human Services Integration Measure [37] will be more useful in evaluating the structural components of partnerships, whereas the Team Climate Inventory [38] – for assessing the partnership’s climate for innovation.

The utility of the PSAT as a longitudinal measure of change has not yet been established [23]. We contend that once the PSAT tool is refined and validated, it can reasonably be administered at different times in the evolution of the partnership. The original creators of the PSAT caution that the tool is not intended to be administered at the partnership inception stage [23]. The partnerships should have reached a certain degree of maturity: have been in existence for at least six months, have taken steps to implement plans and be comprised of at least five stakeholders who have continually worked together [23]. For newly formed partnerships, other tools (e.g., the Partnership Analysis Tool developed by VicHealth [11] or the Verona Benchmark [12]) would be more appropriate, as an introduction to the basic concepts of partnership and a guide to structured partnership development.

Once the partnership composition is established, and the partners have had the chance to work together (including face-to-face meetings), the revised PSAT can be administered in order to assess how the partnership is evolving and identify any areas for improvement. It may take some partnerships longer than six months to create momentum and therefore the timing of initial administration needs to be determined based on the specific circumstances of each partnership. At the end of the project the tool would benefit from additional sub-scales on effectiveness and sustainability to assess the likelihood of sustainability and impact on the target populations. In longer projects, if time and resources permit, we recommend that the tool be also administered at the mid-project point, to quantify progress related to how the collaboration is working, and identify strengths and areas that would require more work. In multi-partnership projects the tool would have to be administered at relatively similar intervals to ensure comparability across sites.

Partnership self-assessment, including the administration of the tool, its analysis and sharing of results can be time-consuming, costly in terms of resources, and may contribute to participant burden [15, 39]. These factors will affect decisions regarding the tool's recurrent use. However, we are aware of at least one attempt to develop a shorter version of the PSAT [40], which may be more appropriate for a collaboration "health check" [10] at shorter intervals.

6.6.3 Limitations

Our results should be interpreted in light of the study's limitations. The first limitation concerns the generalizability of the study's results. The sample of partnerships is small and the scope is narrow. All participants were sampled from a single international program of research with a targeted scope of implementing organizational interventions to improve the performance of accessibility to PHC, for a particular vulnerable population. Academic representatives constituted the largest single group of respondents in each partnership, which might have influenced our results. Despite the fact that most survey questions were fairly generic, they may have elicited different meaning for different participant groups [41]. For example, different stakeholders may have conceptualized success differently. In addition, it was revealed in the course of our qualitative investigation that academic stakeholders were more likely to have experienced a multi-stakeholder collaborative approach to problem solving and were more familiar with evaluation processes. This may have influenced their willingness to participate in this survey. Secondly, due to the cross-sectional study design, the causality and temporality of associations between the dimensions of partnership functioning and the level of partnership synergy achieved could not be inferred. Taking into consideration that we focused on evolving partnerships, we did not use a separate tool to measure partnership effectiveness. Therefore, we could not demonstrate definitively if partnership synergy was indeed a determinant of partnership effectiveness. In addition, this snapshot assessment might not have captured the holistic nature of partnerships as complex, constantly changing entities. Lastly, while being considered a strength in certain respects, developing the quantitative instrument in both English and French might have resulted in certain inconsistencies when it comes to translating specific terms.

We considered and employed a number of mitigation strategies to overcome some of these limitations. In order to address the issue of small sample size, we used recommended statistical

procedures and supplemented our analyses with qualitative information by independent content reviewers. In terms of the scope of partnership activities, we supplemented our survey data with information generated throughout the qualitative phase that preceded this quantitative study. Despite the specificity of partnerships under investigation, there was enough heterogeneity among them, in terms of their contexts, their composition and how the partnerships evolved, to assess the utility of the tool in comparing partnership performance across various settings. In terms of possible translation limitations, we ensured the accuracy of terminology through cognitive testing. Enriching our analyses with qualitative data from the first phase of this larger study has also allowed us to counter some of the challenges involved in using standardized self-assessment tools to assess partnerships. With regards to the causal relationships between partnership functioning and synergy, the administration of a scale to assess the effectiveness of both processes and outcomes would be warranted as all partnerships have now completed their work. This would allow us to determine whether higher synergy actually leads to better sustainability of interventions and better outcomes for the target populations.

6.7 CONCLUSIONS

We adapted an existing partnership self-assessment tool and administered it to a small sample of developing partnerships. Our findings demonstrate that the tool is suitable for assessing the achievement of partnership synergy and the performance of each partnership along specific indicators of partnership functioning. The tool allowed us to detect meaningful differences between partnerships in how they performed on various dimensions, and corresponded overall to independent qualitative evaluations. The instrument demonstrates good capacity to discriminate between partnerships, and could be applied to assess internal partnership performance on these key indicators across settings, in order to determine if their collaborative process is working well. Therefore, it may have broader applicability to other partnerships in PHC, and arguably beyond PHC. We also propose that additional constructs of quality of partner relationships, communication and external environment could be developed and validated as part of partnership assessment.

In conclusion, this study adds to the growing body of literature on assessing partnership synergy as a predictor of effectiveness of multi-stakeholder partnerships in health care, with a

specific focus on PHC. In general, this work has contributed to the evolving body of knowledge on partnership synergy as a useful framework for studying collaborative ventures and identifying the main ingredients or requirements for synergistic partnerships. These requirements should be considered in order to determine if working in partnership should and can reasonably be pursued.

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CHAPTER 7. Manuscript 3 – Activating Partnership Assets to Produce Synergy in Primary Health Care: A Mixed Methods Study

7.1 PREAMBLE

This is the last of the three manuscripts that are part of this thesis. The manuscript summarises the results from the two preceding manuscripts (Chapters 5. *Manuscript 1* and Chapter 6. *Manuscript 2*), with a particular attention to the description of synergy enabling processes at the interpersonal, organisational and system levels. The manuscript then incorporates a “joint display” of qualitative and quantitative findings and identifies areas of convergence and divergence between them. The manuscript introduces the notion of partnership assets, inspired by resource-based theory, to describe the intangible and tangible partnership inputs. It also includes a proposed modified definition of partnership synergy. The critical contribution of this manuscript is the additional insights into complex and dynamic partnership processes and into how partnership assets are activated to produce partnership synergy.

This manuscript was published in the special issue “Health Care Management and Cost Estimation” of the journal *Healthcare*, in August 2021.

Loban, E., Scott, C., Lewis, V., Law, S., & Haggerty, J. (2021). Activating Partnership Assets to Produce Synergy in Primary Health Care: A Mixed Methods Study. *Healthcare*, 9(8), 1060. doi:10.3390/healthcare9081060

Contribution to the work:

E. Loban – Data curation; Formal analysis; Investigation; Methodology; Project administration; Visualization; Writing – original draft; Writing – review & editing

C. Scott – Funding acquisition; Resources; Supervision; Validation; Writing – review & editing

V. Lewis – Funding acquisition; Resources; Supervision; Validation; Writing – review & editing

S. Law – Supervision; Validation; Writing – review & editing

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Activating Partnership Assets to Produce Synergy in Primary Health Care: A Mixed Methods Study

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7.2 ABSTRACT

Partnerships are an important mechanism to tackle complex problems that extend beyond traditional organizational divides. Partnerships are widely endorsed, but there is a need to strengthen the evidence base relating to claims of their effectiveness. This article presents findings from a mixed methods study conducted with the aim of understanding partnership processes and how various partnership factors contribute to partnership effectiveness. The study involved five multi-stakeholder partnerships in Canada and Australia working towards improving accessibility to primary health care for vulnerable populations. Qualitative data were collected through the observation of 14 partnership meetings and individual semi-structured interviews ($n = 16$) and informed the adaptation of an existing Partnership Self-Assessment Tool. The instrument was administered to five partnerships ($n = 54$). The results highlight partnership complexity and the dynamic and contingent nature of partnership processes. Synergistic action among multiple stakeholders was achieved through enabling processes at the interpersonal, operational and system levels. Synergy was associated with partnership leadership, administration and management, decision-making, the ability of partnerships to optimize the involvement of partners and the sufficiency of non-financial resources. The Partnership Synergy framework was useful in assessing the intermediate outcomes of ongoing partnerships when it was too early to assess the achievement of long-term intended outcomes.

7.3 INTRODUCTION

Despite the widespread endorsement of a partnership approach indicating that collaboration is generally a “good” thing in the context of complex problems, there is a need to strengthen the evidence base relating to claims of its effectiveness [1,2,3,4]. In practice, partnerships that bring different organizations and individuals together can generate a great deal of frustration, and those involved frequently struggle to achieve measurable, beneficial outcomes [5,6,7,8,9]. Estimates from formal evaluations suggest that up to 70% of alliances fail, and those that survive are frequently unable to reach their full potential [8,10,11]. These problems are not surprising given that partnerships are resource intensive, time consuming and require governance, procedures and processes that are very different from the ways independent organizations are run [8]. More research is therefore required to explore the factors, both positive and negative, that influence partnerships and mitigate success; otherwise, advocacy for partnerships will remain “a rhetorical issue with no basis in reality” [10].

This article presents findings from a mixed methods study of multi-stakeholder partnerships involving decision makers, academic representatives, clinicians, health system administrators, patient partners and representatives of health and social service organizations providing services to vulnerable populations with an interest in improving primary health care (PHC) accessibility. The study was conducted between 2016 and 2018 with the aim of understanding partnership processes and how various partnership factors contribute to partnership effectiveness within the context of addressing complex issues in PHC. We define a multi-stakeholder partnership as a complex human system based on voluntary collaborative relationships among stakeholders who agree to work together towards a common purpose, to combine competencies, resources and responsibilities and to share risks and benefits (adapted from [11]).

The focus of the study was on partnerships involving multiple stakeholders across organizations—transcending the boundaries between clinical practice, research, health system management and health care policy—collaborating towards a common goal of transforming PHC. In this study, we used a two-phase, exploratory sequential mixed methods design, embedded in a larger Canada–Australia research and evaluation project, to gain a comprehensive understanding of partnership processes, the interplay of partnership factors and the achievement of intended outcomes. This research adds depth to understanding the processes and approaches that support

partnerships and assesses the relevance of the multi-stakeholder partnership approach in PHC. Equally, this research demonstrates how the application of theoretical frameworks can facilitate a deeper understanding of partnerships.

7.3.1 Primary health care

PHC service delivery is the cornerstone of a high-performing health care system [12,13,14]. Robust PHC serves the following core functions: accessibility, continuity, comprehensiveness and coordination [15]. Among Organization for Economic Co-Operation and Development (OECD) countries, PHC is the first point of access to the health care system. It encompasses continuous and comprehensive care across diverse curative, preventative, educational and rehabilitation services with a person (micro), community (meso) and population (macro) orientation [13,16,17]. The centrality of PHC is underscored by its strategic coordination role that has a ripple effect on other parts of the health care system [18]. Advantages to having a comprehensive, responsive, high-quality PHC include improved population health outcomes, reduced inequities, improved patient and provider experience and satisfaction, lower health system costs and more robust health care systems overall [12,13].

Many countries have seen major improvements in the health of their populations over recent decades. However, progress has not been even across various dimensions relevant to PHC. Accessibility, in particular first-contact accessibility, is an ongoing concern in PHC [18]. Important disparities in equitable access to PHC remain, and there is evidence that gaps among social groups within countries have widened [14]. Several studies [19,20] have demonstrated that these gaps translate into unmet health care needs, delays in obtaining treatment, greater use of emergency departments and hospitalization and poorer health status for these patients. In addition, the resultant disparities present ethical challenges and place an unnecessary economic burden on publicly funded health systems. It is estimated that the direct economic burden of socioeconomic inequalities in health in Canada amounts to approximately \$6.2 billion annually or over 14% of total expenditures on acute care inpatient hospitalizations, prescription medication and physician consultations [21]. In light of the realization of system deficiencies and rising health care expenditures, PHC in OECD countries has recently been the focus of a series of reform and reorganization efforts [22,23].

Canada and Australia have health care systems that aim to provide comprehensive, universal and accessible health care based on equal access for equal need. However, a review of the literature from both countries indicates that the goal of equitable access has not been uniformly achieved, particularly when it comes to lower income members of society such as Indigenous groups and refugees [24]. Both countries have undertaken initiatives to strengthen the PHC sector following findings of commissioned inquiries that highlighted suboptimal performance on many PHC access and quality indicators [25,26,27,28]. Many of these reform efforts have emphasized collaboration and partnerships among health care organizations, regional health authorities and other stakeholders as a way of achieving the goal of comprehensive PHC and delivering better care and implementation of policy [29,30]. This interest in partnerships has been reinforced by published evidence that partnerships involving multiple stakeholders can help people and organizations generate outcomes that are greater than those that can be achieved working independently [8,31,32].

One of the recent international initiatives to address the challenges related to equitable access to PHC was the Innovative Models Promoting Access-to-Care Transformation (IMPACT) program [33]. It was a 5-year (2013–2018) Canadian–Australian funded research program that saw the development of local partnerships as a strategy to enhance access to comprehensive PHC for vulnerable populations. Within the context of IMPACT, vulnerable populations were defined as community members whose demographic, geographic, economic, social and/or cultural characteristics compromised their access to PHC and limited their capacity to maintain health and advocate for themselves in the context of a complex health care system [33]. Six local partnerships in three Australian states (i.e., New South Wales, Victoria and South Australia) and three Canadian provinces (i.e., Ontario, Quebec and Alberta) used a common approach to implement six different interventions designed to address a priority gap in access to appropriate PHC. The interventions ranged considerably in focus and mechanisms (see Table 7-1). The partnerships involved decision makers, researchers, health and social services providers and administrators as well as members of vulnerable communities facing complex challenges to the delivery of community-based PHC. The partnerships identified priority access needs of vulnerable communities, informed the design of interventions based on the local context, engaged in deliberative processes for collective

decision-making, and evaluated both the interventions and the partnerships themselves. The work reported here was conducted within the framework of the IMPACT program.

Table 7-1. Overview of characteristics of interventions in six IMPACT * local partnerships (adapted from [34,35]).

Partnership Title	Service Linkage	Community Health Resources	Diabetes Self-management	Primary Care Connection	Community Outreach	Residential Aged Care
Target population and access problem	Vulnerable clients of community-based chronic disease services without a primary care provider.	Primary care patients with complex health and social needs not receiving available community services that would optimize their illness management.	Patients with low health literacy and other social vulnerabilities presenting to general practice with poorly controlled diabetes.	Unattached patients in high deprivation neighborhoods who have trouble connecting effectively to newly assigned family physicians from centralized wait lists.	Individuals and groups of socially vulnerable populations living in a geographic area with few PHC ** services and high concentration of marginalized populations.	Aged and frail residents of long-term care facilities who have complex chronic health needs.
Type of vulnerability	Low socioeconomic status, social isolation due to the fact of geographic distance/public transport, chronic illness and developmental disability.	Socially complex patients, including one of Canada's linguistic minorities.	Low socioeconomic status, geographic isolation and culturally and linguistically diverse backgrounds.	Low income, unemployment and low social support.	Recent immigrants, Aboriginal people, seniors and homeless persons.	Socially isolated frail elders who rely on others for the provision of care.
Intervention type	Brokerage service to link identified patients to one of a panel of volunteer family practitioners.	Training provided to primary care providers to increase their awareness of community health resources; community-based intervention by a lay patient navigator to facilitate access to these resources.	A website that provides information and referral options to support diabetes self-management.	Telephone outreach by lay volunteer navigators to relay access-related and visit preparation information.	Mobile (pop-up) outreach by a variety of PHC and social service providers catering to the needs of attendees, held at different locations.	Training and policy and procedure redesign in participating long-term care facilities to improve the quality, consistency and responsiveness of PHC **.
Intended consequence	Successful linkage with a PHC ** practice.	Increased referrals to community health resources and improved access to these services.	Successful affiliation to a coordinating primary care physician and improved diabetes self-management skills.	Successful affiliation to a family physician.	Enduring relationships between PCH and social service providers and the users of mobile pop-up services.	Reduction in preventable hospitalizations and improvements in the delivery and management of care to frail elderly residents.

* IMPACT - Innovative Models Promoting Access-to-Care Transformation; ** PHC – Primary Health Care

7.3.2 Partnership evaluation and partnership synergy

Literature from diverse fields describes what constitutes effective as opposed to ineffective partnerships, and outlines strategies to enhance collaborative processes and increase partnership effectiveness [9,36,37,38,39,40]. This literature offers a variety of definitions and conceptualizations of partnership effectiveness. The prevailing approach is to assess partnership effectiveness in terms of its ability to achieve planned outcomes [41], also referred to as “results” or “consequences” [42]. These intended outcomes could be short-term, such as increased knowledge of stakeholders, intermediate, such as capacity building and buy-in, and long-term such as changes in community programs, policies and practices and improvements in health indicators [42,43].

An alternative approach to assessing partnership effectiveness is to focus on effective partnership as an end in itself, and as an intermediate outcome leading to the specific goals of the partnership. The assumption here is that partnerships that have a high level of internal functioning will be more likely to achieve their intended long-term outcomes [36]. The functioning of ongoing partnerships was the focus of this study, and we differentiated between the effectiveness of processes and outcomes. We captured information about the quality of the processes and relationships between partners and the health of the partnership on the one hand, and specific outcomes that could be attributed to the work of the partnerships. In addition, we collected information on the benefits of participating in partnerships for the stakeholders’ respective organizations, in line with the literature that identifies outcomes to partners as an important third strand of effectiveness, different from the strategic goals of the partnership [44].

To assess how a partnership is performing and to identify strengths and areas for improvement, strategies for measuring these multiple partnership dimensions and evaluating progress towards intended outcomes are needed. Partnership evaluation literature offers partnership measurement tools, notably self-assessment tools, that help organizations assess how the partnership is evolving and to stay accountable to the partnership’s stakeholders and funding bodies [45,46,47]. However, there is still ambiguity regarding the relationship among the various factors of a partnership’s work and effectiveness, particularly which partnership factors are more critical to partnership effectiveness [8,48]. Given the complexity and dynamic nature of partnerships and intractable problems they seek to address, inferring causal relationships between

different partnership factors and effectiveness and identifying what percentage of the outcome is attributable to which factor is challenging [36,37]. This challenge is common in evaluating complex human systems that entail a web of interacting feedback loops where cause and effect are not close in time and space [49,50].

The Partnership Synergy framework aims to explain the link between partnership factors and partnership effectiveness [8]. Synergistic partnerships are high-performing partnerships that have created added value by leveraging the resources and capabilities of their partners. We define partnership synergy as the combined effect of complementary tangible and intangible partnership assets and enabling processes that gives partnerships unique advantages over the work of individual people or organizations working towards the same goals (adapted from [8]). Partnership intangible or “soft” assets include human, informational and organizational resources, such as knowledge, competencies, connections, culture, data and information, whereas tangible assets include material and financial resources such as space and funding [51]. While it is widely acknowledged in the field of management that tangible assets are the critical building blocks of organizations and companies, the rapid expansion of the knowledge economy has shed more light on the importance of “intangibles” and the benefits that they generate [51,52,53]. In fact, it has recently been argued that it is the intangible assets, such as skilled employees and unique know-how, that give companies their competitive edge [52]. In the field of partnerships, the critical role of both tangible and intangible assets has been highlighted in prior research [8,54]. It has also been suggested that intangible assets may constitute the outputs of partnership work, as health partnerships entail knowledge-generating activities and do not produce goods but rather knowledge, understanding and relationships [53]. For the purposes of this investigation, we considered intangible assets, produced by partnerships, such as learning, only insofar as they are reinvested back into the partnership and enhance partnership work and the achievement of intended outcomes.

Certain partnership processes enable partnerships to leverage resources successfully and mobilize the complementary knowledge and expertise of all the partners to achieve partnership synergy [6,50]. Examples of enabling processes include leadership, administration and decision-making processes as well as the degree to which a partnership optimizes the involvement of its partners [8,50]. The literature identifying these key precipitators of partnership synergy is growing

[6,50,55,56]. While it is common to refer to these precipitators more broadly as “partnership functioning factors”, we make a distinction between partnership assets that we view as partnership inputs and partnership enabling processes that act upon inputs to produce intended outcomes (adapted from [57]).

It has been proposed to measure partnership assets (such as the sufficiency of resources) and enabling processes, along with partnership synergy, as a predictor of partnership effectiveness [8]. Two validated scales measure partnership synergy: the Weiss et al. scale [50] and the Jones synergy scale [58]. These scales measure partnership synergy in different ways: the Weiss et al. scale, which looks at synergy as a product of a partnership that has achieved its full potential, and the Jones synergy scale that measures synergy as both a partnership process or experience and a partnership product [58]. Both synergy scales are embedded in instruments that include other measures of different partnership factors. The Weiss et al. synergy scale is embedded in the Partnership Self-Assessment Tool (PSAT) [59], and both Weiss et al.’s and Jones’ synergy scales are incorporated in the Partner Questionnaire [6].

We adopted the Partnership Synergy framework to look at the formation and processes of IMPACT program’s multi-stakeholder partnerships. We selected the PSAT with some nuances from the Partner Questionnaire.

7.4 MATERIALS AND METHODS

7.4.1 Study design

The study entailed a two-phase mixed methods sequential exploratory design [60]. A qualitative longitudinal case study [61] ($n = 2$) was followed by a cross-sectional survey of IMPACT collaborative local partnerships ($n = 5$). Figure 7-1 illustrates the mixed methods design. The qualitative phase entailed exploring, in a smaller sample, the different manifestations of partnership synergy, the types of partnership assets and broad categories of partnership processes relevant to multi-stakeholder partnerships PHC [62]. Based on the qualitative findings, the quantitative phase included measuring, in a larger sample of partnerships, the achievement of partnership synergy and exploring associations between partnership synergy, partnership assets

and partnership processes [63]. Qualitative findings and quantitative results were subsequently integrated to obtain a deeper understanding of the multi-stakeholder partnership phenomenon [60].

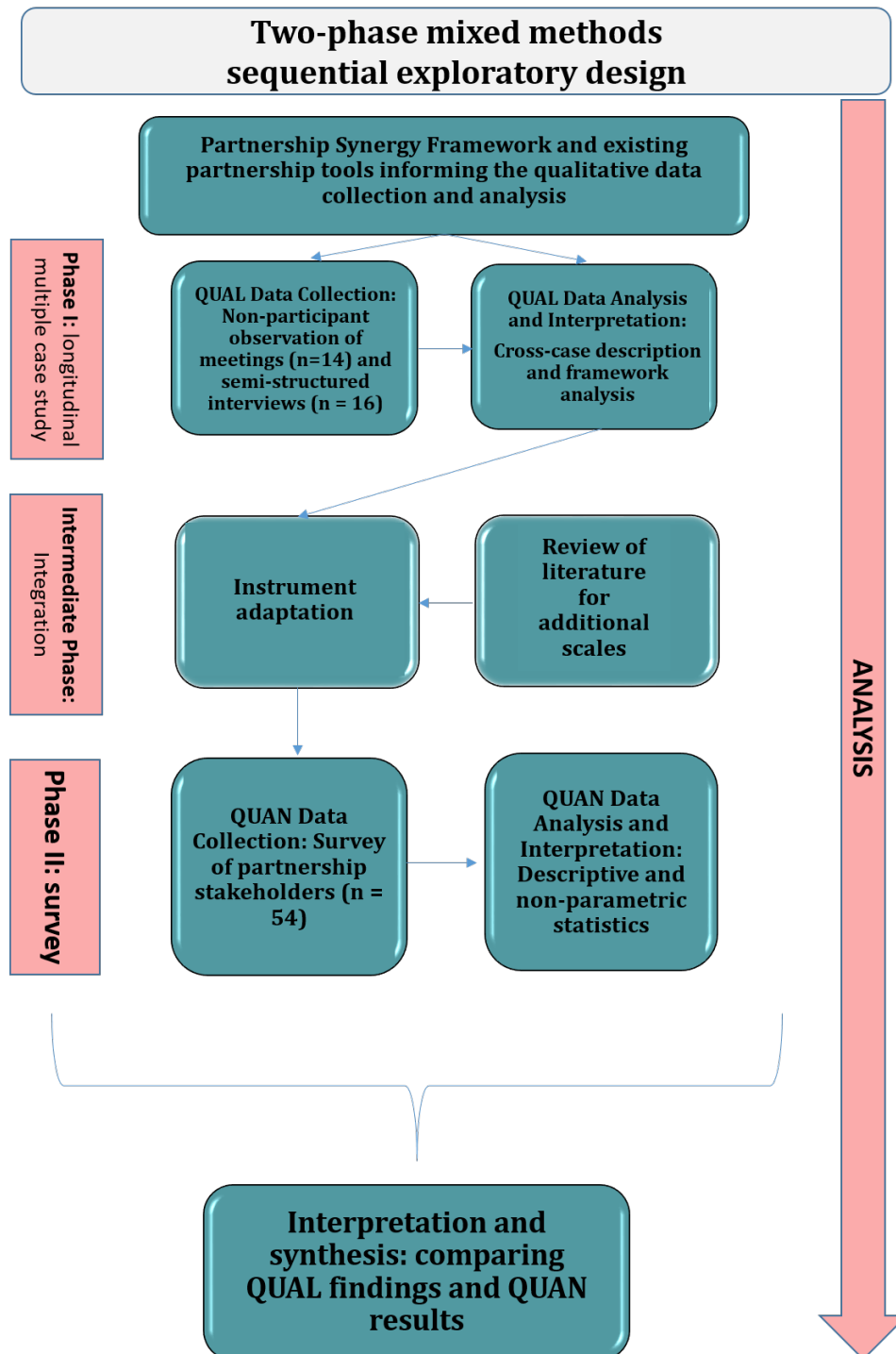


Figure 7-1. Mixed methods sequential exploratory design diagram

7.4.2 Background work

Preliminary data gathering for the project involved the review of minutes of meetings, protocols and reports produced within the scope of the IMPACT program and, more specifically, the two local partnerships, Primary Care Connection and Community Health Resources. The review of documents provided data on the operational elements, participants' roles and responsibilities, the objectives and intended outcomes of each initiative, and how the objectives and the involvement of different stakeholders evolved since the start of the IMPACT research program in 2013. Specific attention was devoted to contextual factors that might have had an influence on the two local partnerships. The information generated from the program's documents allowed the refinement of the study question, in consultation with a number of the program's stakeholders. Institutional ethics approval for the study was obtained from the St. Mary's Hospital Centre Research Ethics Committee (No. SMHC-13-30C) on 10 August 2016.

7.4.3 Phase I: Qualitative data collection and analysis

The longitudinal case study of the two partnerships, the Primary Care Connection Partnership and the Community Health Resources Partnership, was conducted between August 2016 and September 2018. This phase entailed non-participant observation of the partnerships' meetings and semi-structured, in-depth interviews with a sample of the partnerships' stakeholders. The longitudinal aspect allowed capturing the main developments in the life of the partnerships over time.

The non-participant observation of meetings focused on the behaviors of partners and interactions among them. The first author conducted the observation of 11 Primary Care Connection Partnership and three Community Health Resources Partnership meetings. Specific attention was devoted to observing how the agreed upon processes common to all partnerships were implemented and to identifying any new emergent processes influencing the partnerships. The semi-structured interviews offered emic (i.e., through the lens of the participants) insights into partnership processes and helped to identify partnership elements that were relevant to the subsequent, quantitative phase. The first author conducted nine interviews with Primary Care Connection Partnership stakeholders and seven interviews with Community Health Resources

Partnership stakeholders. Interview participants were asked to report on their experiences within their respective partnerships from the beginning of their involvement until and including the period when the interview was conducted.

Interview candidates were purposefully selected [64] on the basis of their roles, and the nature and duration of their engagement with the local partnership. Representatives of each of the stakeholder group (i.e., researchers, research program coordinators, policy makers, clinicians, and organizational representatives/patient partners) were invited to participate in the interviews. Attempts were made to ensure a mix of seasoned and new participants. In addition, attempts were made to invite stakeholders demonstrating both high and low levels of engagement, based on prior observation of meetings.

Candidates selected for interviews were initially invited to participate via blinded group e-mails. Follow up was undertaken in person at the end of partnership meetings, and over e-mail sent directly to the candidates. The duration of interviews was approximately one hour, and they were conducted either in person or over the telephone. The interviews were planned according to existing recommendations on conducting individual interviews in health research [64,65]. The interviews contained predominantly open-ended questions and time was factored in for other questions which arose from the conversation. The questions asked about partnership synergy were inspired by Jones and Barry [58] and Weiss et al. [50]. All interviews were transcribed verbatim. The interview transcripts were not returned to participants for comments.

A hybrid deductive–inductive approach to framework analysis was used to identify patterns within the data [66,67]. The initial coding scheme was developed to reflect the concepts from the partnership synergy framework, including complementarity of skill, experience and work sharing. Words, sentences or paragraphs from transcripts were extracted into pre-determined codes with new codes emerging from the data. The final codes were grouped along the dimensions of partnership synergy and the five families of factors likely to foster partnership synergy: partner characteristics, relationships among partners, partnership characteristics, resources and external context [8]. The data management, coding and analysis were performed using NVivo 12 qualitative analysis software [68]. The transcripts were analyzed by the first author (EL), but the coding was verified by another qualitative researcher (CS). Emerging findings were discussed at regular team

meetings. Phase I resulted in a thick description of the two partnerships as well as on the processes that were employed to enhance the partnerships.

7.4.4 Building on qualitative findings

In line with the exploratory sequential design, the qualitative findings were then used to adapt the PSAT partnership self-assessment instrument by using qualitative codes and themes to select the domains and concepts for inclusion in the quantitative phase [69] (see Appendix M). We selected PSAT scales and items that corresponded to the qualitative codes from the case study and excluded scales and items that were deemed non-relevant. We retained the following PSAT scales: Decision-Making (four items); Leadership (11 items); Administration and Management (11 items); Non-financial Resources (six items); Financial and Other Resources (three items); and Resource Utilization (three items, referred to as “Efficiency” in the PSAT). We also retained questions about perceived Benefits (11 items) and Drawbacks (five items) of participation to stakeholders’ respective organizations and an overall assessment of the benefits compared to the drawbacks (1 item).

We added elements that emerged in the qualitative data but were not part of the 2001 version of the PSAT: new proposed sub-scales for Communication (three items) and External Environment (two items). The case studies spoke to the importance of communication as an integral dimension of partnership work and the critical role of contextual influences. We also added one question to assess the extent to which the goal of developing a meaningful partnership had been achieved as a measure of partnership effectiveness. We supplemented synergy items from the PSAT with synergy items from the Partner Questionnaire [58] to capture more information on partnership processes. Partnership synergy was assessed using two sub-scales: (1) the adapted Partnership Synergy Processes sub-scale incorporating five items from the eight-item synergy scale developed by Jones and Barry [58]; and (2) the adapted Partnership Synergy Outcomes sub-scale retaining two items from the nine-item synergy scale by Weiss et al. [50]. The items from these original scales were selected based upon the relevance to the types of partnerships highlighted throughout the qualitative inquiry, and with a view to reduce participant burden. Finally, the observation data and responses to qualitative interviews guided the choice of language

that was used to elicit descriptive information about the stakeholder (type, role in the organization, length of time in the partnership and frequency of engagement).

7.4.5 Phase II: Quantitative data collection and analysis

Phase II entailed a cross-sectional survey design. The criteria for partnership inclusion in this phase were: (a) the partnerships had at least five active academic and non-academic partners; (b) the partners had continually and collaboratively worked together to develop and modify strategies in order to achieve their goals; (c) the partners had begun to implement their plans. We distributed a self-administered questionnaire to a census sample of all multiple stakeholders within five of the six IMPACT local partnerships. All stakeholders in five of the six IMPACT local partnerships, who were active in the partnerships at the time of administration, were considered eligible and were invited to participate. The sixth partnership did not meet our inclusion criteria. Our final sample included 54 partnership stakeholders representing five IMPACT local partnerships (a response rate of 90%). The questionnaire captured the subjective input from stakeholders, reflecting their assessment of respective partnerships as separate entities, and not their individual experiences. Both paper- and web-based questionnaires were offered, in either English or French, with multiple contacts to maximize the response rate [70]. The electronic questionnaire was hosted on the *Qualtrics* [71] online survey platform.

The scores for each sub-scale were derived through unweighted means and medians of all the component items; scores for a respondent were calculated only if at least 50% of the items in the sub-scale had been completed. We used Spearman correlation coefficients to estimate the correlation between items within purported sub-scales, and between sub-scales, specifically partnership processes and partnership synergy. We examined internal consistency of the purported sub-scales by calculating the Cronbach's Alpha.

At the partnership level, the score for each sub-scale was calculated by aggregating the sub-scale scores of the component member respondents within each partnership. For partnership synergy, the two sub-scales of Partnership Synergy Processes and Partnership Synergy Outcomes were analyzed separately at the level of individual respondents. However, given that they were highly correlated with each other and demonstrated similar correlations with partnership processes, both sub-scales were combined at the level of the partnerships to provide a single score of (total)

Partnership Synergy. We used the non-parametric Kruskal–Wallis test to determine if we were able to detect statistically significant differences in sub-scale scores between any of the partnerships. The ranks of the scores were also derived. SPSS 23 for Windows [72] was used for data analysis.

Parallel to this study, an independent longitudinal qualitative developmental evaluation of the partnerships was undertaken to guide partnership development. The evaluation was designed and led by two of our authors (CS and VL), who subsequently ranked the five partnerships that were the focus of this study, based on the operational definitions and item content of the following sub-scales: Partnership Synergy, Communication, Decision-Making, Problem-Solving, Resource Utilization, and External Environment. We then compared the qualitative and quantitative ranks.

7.5 RESULTS

7.5.1 Study participants

Study participants represented a range of organizational expertise (see Table 7-2). The stakeholders within each partnership included a mix of decision makers, primary care physicians, health care managers, academic representatives (researchers and research coordinators, including partnership coordinators), members of vulnerable populations, and stakeholders from community-based organizations providing services to the vulnerable population. Among interview respondents, academic representatives and decision makers constituted the largest two groups ($n = 10$, 63%). Among survey respondents, academic representatives constituted the largest single group of stakeholders in each partnership. Interview participants and survey respondents were predominantly female (interviews: $n = 13$, 81%, survey: $n = 42$, 78%). Of note, 15 stakeholders participated in both the interviews and the survey.

Table 7-2. Study sample characteristics per partnership ($n = 5$) (reproduced from [63]).

Partnerships	Total number of participants (N=54)	Gender	Mean length of time in partnership	Min/max length of time in partnership	Main role
		Percent female			
Service Linkage	9	78% (7)	3,8 years	2-6 years	Academic representative – 4 Decision maker – 1 Health care manager – 4
Community Health Resources	19	68% (13)	2,6 years	1-4 years	Academic representative – 5 Community organisation representative – 3 Decision maker – 2 Health care manager – 4 Patient representative – 3 Primary care physician – 2
Diabetes Self-management	7	71% (5)	3,1 years	0.7-5 years	Academic representative – 3 Community representative – 1 Decision maker – 1 Health care manager – 1 Primary care physician – 1
Primary Care Connection	12	83% (10)	3 years	1-5 years	Academic representative – 5 Decision maker – 1 Health care manager – 3 Patient representative – 1 Primary care physician – 2
Community Outreach	8	86% (7)	2,8 years	2,5-5 years	Academic representative – 6 Decision maker – 1 Health care manager – 1

7.5.2 Qualitative findings

7.5.2.1 Partnership assets

Our qualitative investigation revealed that both partnerships had a variety of tangible and intangible assets. These assets were either acquired or generated as a result of working in partnership.

7.5.2.1.1 Partnership acquired assets

The main acquired intangible assets in both partnerships were considered by participants to be the resources brought into the partnership by the multiple stakeholders who joined the partnership in order to tackle a complex, multi-faceted issue of common concern—accessibility to PHC for vulnerable populations: *“I think that it’s well organized, and it includes health care*

utilizers as well, so that's important, decision makers, researchers and clinicians. So, I think it's, the structure is aligned well with the area of the study" (Policy maker).

These stakeholders contributed unique perspectives and skills, information and connections to a broader set of stakeholders and health systems exerting influence over the partnerships. The medical practitioners shared their experiences of dealing with vulnerable patients and identified health system opportunities and constraints to accommodate new vulnerable patients and to improve services provided to them. The academic team shared relevant research evidence, facilitated the overall work of partnerships and served as an interface with funding bodies and the larger IMPACT program. The research coordinators in particular supported the various components of the interventions, including communicating with stakeholders, organizing partnership activities, facilitating meetings, proactively conducting outreach and gathering and synthesizing information. Patient partners brought the lived experience point of view. Community organizational representatives shared insights into the challenges experienced by the target populations and available community services and helped the partnerships to align project activities with the priorities and capabilities of organizations serving the target populations. Finally, decision makers and health planners served as a bridge between researchers and policy-making, ensuring that research activities aligned with and responded to health policy priorities and capabilities and, conversely, that health authorities were appraised of research evidence relevant to the project. These unique perspectives and insights were deemed to be complementary in that they allowed for the exploration of issues of access from various angles, to obtain timely information in order to make necessary adaptations to the intervention models, and to attract additional resources. The partnership membership was not static, it evolved as the work of the partnerships progressed, reflecting natural stakeholder attrition and the need to attract additional expertise and resources.

The acquired tangible assets included financial resources obtained through the IMPACT research program's grant funding, space to meet, and information and other project support resources. The partnerships were part of the larger IMPACT research program that received funding in Canada and Australia. This funding covered the partnerships' coordinating infrastructure/support for research such as data collection, including the partnership coordinator position at each site, as well as the evaluation. Partnership stakeholders, other than research

coordinators, were not remunerated for the time spent on partnership activities. However, expenses related to attending partnership face-to-face meetings, disseminating results and promoting the program were covered for most stakeholders. Partnership management activities were carried out by the research teams located at their respective research entities. Face-to-face partnership meetings were organized either at these research entities or at nearby locations, including partner universities, affiliated hospitals, and participating community organizations. Other tangible assets included information resources such as computer software.

7.5.2.1.2 Partnership generated assets

The generated intangible assets included the skills and relationships that the partnerships had invested in and the learning that transpired in the course of partnership work. The partnerships provided several stakeholders with educational and capacity-building opportunities. The coordinators in each partnership were critical resources who offered ongoing support for partnership activities. Given that working in partnership required skills that were different from those employed in the typical running of research projects, the partnerships made strategic financial investments into acquiring these new skills. Instead of outsourcing certain partnership-related tasks, the partnerships built capacity in-house through training. Both partnerships invested in training partnership coordinators in group process facilitation techniques and then provided them with opportunities to facilitate partnership meetings. Some coordinators highlighted the value of experiential learning:

So, I've learned a lot from a research perspective from the research team, and from the LIP Core Team more specifically around just community development and how that works and participatory action research and making sure that everybody has a voice and who needs to be at the table, so that has been really rich, because I knew very little about that when I came on (Research coordinator).

In addition, one of the two partnerships provided its patient partners with opportunities to attend relevant patient engagement training. These training and capacity-building investments

were not only part of incentive management, but also benefitted the partnerships directly through enhanced skills and knowledge that strengthened the partnerships.

Another important generated intangible asset was the collaborative relationships that were formed in the course of partnership work. While some stakeholders had a history of collaborative working relationships, relationships with other stakeholders had to be forged. Each partnership made intentional efforts to strengthen relationships within the respective partnership and with external stakeholders who were critical to partnership efforts. Relationships among some non-academic stakeholders developed more organically as a result of interactions during partnership meetings. These positive relationships benefitted the partnerships by stimulating more open conversations and by contributing to faster and deeper decision-making and enhanced project ownership.

The generated tangible assets included the resources identified to implement and sustain the interventions developed by partnerships. In the absence of funding for intervention implementation under the IMPACT research program's grant funding, each partnership was required to mobilize adequate local resources to respond to regional access needs and to maintain interventions beyond the life of the IMPACT research funding. Both partnerships developed low-cost lay navigator approaches to addressing the access needs of the target populations. In order to sustain the interventions, both worked towards integrating the interventions into existing health system organizational structures, aligning the proposed models with priority health system initiatives. The Community Health Resources Partnership succeeded at securing additional funding for the initiative, which extended the project beyond IMPACT. The additional funding covered a randomized controlled trial to test the effectiveness of the model that the partnership had developed.

7.5.2.2 Partnership enabling processes

Both partnerships that were part of our qualitative study [62] employed specific processes to activate the above-mentioned assets. The following main categories of processes emerged from our data: (1) resource management; (2) leadership; (3) administration and management; (4) communication; (5) decision-making; (6) adapting to the evolving context.

7.5.2.2.1 Resource management

Stakeholder engagement in the two partnerships occurred in a variety of ways. Both partnerships began with deliberative fora involving a broad range of stakeholders to learn about community needs around PHC access, the relevant community organizations and available resources to support interventions. As partnership work progressed, the Primary Care Connection Partnership involved stakeholders in multiple aspects of the research process, with some non-academic stakeholders fulfilling tasks outside the partnership's face-to-face meetings. Conversely, the Community Health Resources Partnership took a more traditional academic approach to collaboration with stakeholders—a research advisory approach, with limited contribution of non-academic stakeholders outside partnership meetings. Both partnerships used regular face-to-face meetings to openly discuss project progress, create a shared understanding of the project and engage in iterative collaborative learning: *“I feel like there's lots of opportunity to share what's on our minds, to express ourselves. I feel that it's a very open to dialogue type of meeting.”* (Representative of a community-based service organization); *“I think there is a lot of discussion [...], we have the freedom to give our opinion, to discuss. I think it is very appropriate”* (Family physician).

The research teams spearheading the initiative capitalized upon the various strengths and perspectives of stakeholders by providing sufficient time to discuss pressing issues, soliciting input from all stakeholders and offering stakeholders different mechanisms to contribute (e.g., large group discussions and small break-out sessions). Participants who could not attend meetings were appraised of what was discussed during meetings and provided with opportunities to contribute electronically. While interview respondents recognized the inherent power inequalities in the partnerships due to the fact that the research teams controlled grant resources and had more to lose if the partnerships did not achieve stated objectives, they acknowledged that the research teams made efforts to address barriers to equitable participation. Examples included the strategic choice of locations for partnership meetings, transportation fees coverage and approaches to elicit input from linguistic minority participants. Both partnerships experienced difficulty with the engagement of community-based stakeholders representing the target populations; however, after they became involved, one Community Health Resources Partnership patient partner stated: *“[...] it's a very nice invitation to have people who are not professionals, who are not involved in that*

kind of world, to be invited in and be allowed to give an opinion or thought or idea. I think it really empowers people” (Patient partner).

7.5.2.2.2 Leadership

Both partnerships were largely driven by the research teams that initiated the partnerships. The leadership approaches in the two partnerships differed. The Primary Care Connection Partnership leveraged the power of leadership distributed among academic and non-academic stakeholders with different stakeholders taking responsibility for various components of the work of the partnership. In the Community Health Resources Partnership, the leadership was centralized within the research team. However, interview participants reported that the research team seemed genuinely interested in hearing from all stakeholders and made efforts to check in with various groups around the partnership table: “[...] *there is a very open kind of environment there and, frankly, and you can tell that the research team really wants to hear what people have to say and so they act [...] and they ask pointed questions*” (Family physician).

Despite these differences, there were a number of common leadership processes. Within the research teams, both partnerships had formal (i.e., academic investigators and co-investigators) and informal (i.e., partnership coordinators) leaders knowledgeable about the context and skilled at mobilizing the various perspectives of stakeholders and forging common ground. The leaders did not possess all of the requisite partnership-related knowledge and skills at the outset but rather continuously learned from best practices in partnership development. The leaders were transparent about their own gaps in knowledge and eagerly welcomed input from different stakeholders. This openness contributed to creating an atmosphere of trust where differences of opinion could be voiced.

7.5.2.2.3 Administration and management

The research teams, comprising academic principal investigators, co-investigators and research coordinators, were responsible for the overall management of the partnerships. Each team had dedicated (i.e., full-time) and part-time research staff supporting the work of the partnerships. The scope of the research teams’ activities was broad. They were responsible for recruiting partnership members; managing information; coordinating communication among partners and

with outside entities; facilitating the selection, adaptation and implementation of interventions at the local level; evaluating the effectiveness and potential for scalability of interventions. Both research teams performed extensive field work, gathering relevant data and promoting the interventions to external parties. The research teams also organized regular meetings of their respective partnerships. This included organizing meeting logistics, facilitating meetings and summarizing discussions in the form of minutes: *“They seem to just be very effective and very planned and organized. So, I’m learning from seeing how a well-organized meeting unfolds”* (Representative of a community-based service organization).

The research teams in both partnerships employed adaptive management approaches to support iterative decision-making and facilitated the ability of partners to contribute meaningfully: *“We share, and then the research team stimulates the discussion between different territories, how can we help you, what can we do to succeed. [...] In addition, the research team is really glued to the team here to see if something is not working well”* (Policy maker). In addition, the Community Health Resources Partnership conducted meeting evaluations at the end of each partnership meeting and made timely adaptations to how the meetings were run and the type of information provided at subsequent meetings.

7.5.2.2.4 Communication

Both partnerships had open and multidirectional channels of communication to communicate internally with stakeholders within the partnership:

Yeah, we get updates, and people are communicating with us. We know that we’re part of the team, we know that we’re being informed, invited to meetings long ahead of time, so there’s lots of opportunity, you know, it’s not a last-minute invitation. So yeah, so those processes are reassuring to see that it’s well run and things are happening in a timely manner (Policy maker).

In-person communication with all stakeholders was mostly confined to regular partnership face-to-face meetings. The research teams synthesized relevant partnership-related information and brought it in condensed verbal and written formats to the attention of the partnership stakeholders. Outside of the meetings, regular contact was supported by partnership coordinators

via electronic communication. These exchanges included minutes of meetings, meeting agendas and brief summaries of key issues upon which decisions would have to be made. In both cases, participants highlighted the importance of learning loops and having a variety of ways of soliciting input from partners. Learning loops involved requesting feedback from participants during meetings around issues relating to the project and being transparent about how this input was subsequently incorporated including being explicit about the reasons why suggestions could not be incorporated.

Partnership external communications were aimed at increasing support for partnership interventions, recruiting medical practices that would be part of the interventions and disseminating information about partnership activities and achievements more broadly to the program's funders and the broader academic and medical community. External communication occurred during conferences in the form of conference posters, oral presentations and workshops as well as during scheduled meetings with relevant external entities. In addition, the Community Health Resources Partnership produced a periodic newsletter regarding project activities with a broader community reach.

7.5.2.2.5 Decision-making

The Primary Care Connection Partnership stakeholders reported that the decision-making process was transparent and inclusive. Main decisions pertaining to the project were taken during face-to-face partnership meetings, by vote, on the basis of information compiled by the research team and following extensive stakeholder consultations: *“Decisions, I think the fact that you go to a vote [...] to decide how to make a change, I think that’s good. They take all opinions into account before making a major decision”* (Family physician). This was particularly apparent in relation to adapting the intervention to its evolving context. Conversely, in the Community Health Resources Partnership the decision-making power was centralized within the research team, which was consistent with the advisory nature of the partnership.

7.5.2.2.6 Contextual adaptation

The activities of both partnerships were unfolding within the context of significant health care system reforms in their respective provinces. While both partnerships had to make adaptations

to the interventions to respond to evolving contextual opportunities and threats, the extent of contextual impact and adaptation was far greater in the case of the Primary Care Connection Partnership: *“Of course, the thing that doesn’t change is the changes in the [health] networks. But this is quite a major change.”* (Policy maker). The partnership made several adaptations to the intervention, including its structure, delivery strategy and personnel resources. The situational analysis involved harnessing the knowledge of multiple stakeholders, instead of using formal environmental scanning analysis approaches. The active engagement in the partnership of policy makers and health system planners was critical in this respect, in that it contributed to an in-depth understanding of the context. Having stakeholders around the table with medium to high level of authority in their respective organizations allowed adaptations to be implemented in a timely manner.

7.5.2.3 Partnership synergy

Partnership synergy manifested itself in the combination of the complementary skills and unique perspectives of the partners: *“I think it’s a really good mix of people, and you can hear it in the discussion. The very different points of view, and they all complement each other very well”* (Representative of a community-based service organization).

I honestly don’t think that there’s any other way to do it, because it’s in primary care, and primary care is incredibly complex, there are so many players involved [...] incredibly complex problems and challenges, you know, particularly more so for the populations we are interested in, vulnerable populations [...] plus things are changing all the time, funding is changing and so on, so we always have to situate our project in a larger context. If we didn’t have those other people at the table, how would we know what’s going on [...] (Research coordinator).

Discussing the added value of partnership work some participants described the alignment of efforts of partnership stakeholders and the richness and integrative nature of collaborative work: *“These [partnership] tables are an example of integration. [...] We become more integrated and stronger, and there is a certain level of coherence between us. It has to be like this”* (Policy maker, emphasis by the participant). *“It is very rich. Not everyone has the same reality, and we inspire*

each other. In understanding the point of view of the other, we advance the discussion” (Policy maker).

[...] Magic happens when you get people who are going in the same direction. So, it’s just about ... it’s analogous to integrating the health care system. If you have a group that is fragmented and they’re doing their own thing separately the result obviously can’t match the result that can happen when you’re working together. So, it’s all about integrating the effort. And so, it has to be better than just doing it on your own (Policy maker).

Partnership synergy was also apparent in a variety of anticipated and actual benefits reported by stakeholders, stemming from their participation in the partnership, and in their sustained commitment to the partnerships: *“And there are different important constituents, it is more than a political representation of organizations, people who have continued to participate because they believe in it”* (Research coordinator).

Participants described more benefits related to their respective organizations than personal benefits, highlighting a fit between the project’s objectives and the organizational priorities of the entities they represented. The mutually beneficial nature of the partnership was reported by participants who stressed mutual and personal learning and satisfaction that stemmed from their involvement in the project: *“The researchers are learning from each other”* (Research coordinator).

For me, this is completely new to me to be part of this type of project, so it’s a learning experience that I’m enjoying tremendously. So, it’s definitely good for my personal development to be part of this, I’m kinda honored to be part of this [...] (Representative of a community-based service organization).

So, to be able to be part of the project which I think that they had a great idea, it’s really smart, and I felt really glad to be part of that. You know because I feel like that’s a good project, this is very helpful, this is a very, you know, significant issue for people. And to be able to be part

of maybe, you know, exploring why it's a problem and offering my insights, I'm very excited to be able to do that (Patient partner).

Partnership synergy was also evident in innovative ideas and new solutions to the presenting challenges: "We are experimenting with innovative practices. Teamwork goes further. Alone we may be faster. Together we go less quickly, but we have good results, and likely sustainable results" (Policy maker).

There was evidence of partnership synergy in the ability of both partnerships to pull resources and problem-solve, to sustain interventions over time, despite contextual challenges and funding gaps:

When the reform arrived, everything changed. We had to redevelop relationships, see who was going to be at the tables, did we want to keep our original territories or expand to the territories of the new [health authority]. [...] We then managed to identify a problem, we identified an intervention, which we put in place, which does not work, which we have adapted and are in the process of putting back in place (Research coordinator).

Partnership synergy also manifested itself in the positive partnership atmosphere, in the feeling of unity, and the relationships that were forged in the process of working together: "[...] *It's a good trusting environment. People are happy to speak up and say what they need to say. Everybody seems to be happy to be involved*" (Policy maker). "*I usually see it as we all come together, sort of. I don't feel [...] that there's some difference between anyone, I feel like we're equally sitting at the same table, like this one single group*" (Patient partner).

Other participants highlighted the "feeling of belonging" (Family physician) and increased project ownership: "The commitment to the project is higher when you have built it together [...] When you have done it in collaboration, it is closer to your heart and I think that this is one of the advantages" (Research coordinator).

7.5.3 Quantitative results

Table 7-3 displays correlations among partnership assets, the various categories of partnership processes and partnership synergy as assessed using Spearman's rank correlation coefficient. We used the following cut-offs for interpreting the scores: 0.10—weak correlation; 0.30—moderate; 0.50—strong (29). The results indicate that partnership synergy outcomes were strongly associated with decision-making, leadership and administration and management, while partnership synergy processes were strongly associated with decision-making, leadership and non-financial resources. Total partnership synergy was strongly associated with decision-making, leadership, administration and management, non-financial resources and resource utilization.

Table 7-3. Spearman rank correlations among partnership synergy outcomes, partnership synergy processes, total partnership synergy and the different partnership assets and processes ($n = 54$). Values shaded in light grey denote weak correlations and in dark grey strong correlations (adapted from [63]).

	Partnership synergy processes	Communication	Decision-making	Leadership	Admin and mgmt	Non-financial resources	Financial resources	Resource utilisation	External environment
Partnership synergy outcomes	0.61	0.34	0.60	0.69	0.60	0.39	0.18	0.46	0.15
Partnership synergy processes		0.44	0.59	0.60	0.48	0.51	0.35	0.45	0.26
Total partnership synergy		0.40	0.66	0.74	0.61	0.51	0.28	0.50	0.22
Communication			0.47	0.50	0.45	0.38	0.32	0.39	0.10
Decision-making				0.65	0.52	0.40	0.07	0.29	0.25
Leadership					0.74	0.42	0.13	0.53	-0.08
Administration and management						0.42	0.05	0.50	-0.06
Non-financial resources							0.56	0.32	-0.21
Financial resources								0.28	-0.18
Resource utilisation									-0.17

We subsequently analyzed the scores for partnership synergy outcomes, partnership synergy processes and total partnership synergy in each of the five partnerships. Our one-way analysis of variance was suggestive of statistically significant differences between at least two of the medians of partnership synergy processes ($p = 0.09$) and (total) partnership synergy ($p = 0.07$). The differences in medians were statistically significant between the following partnerships: Primary Care Connection–Service Linkage, Community Outreach–Community Health Resources, Community Outreach–Diabetes Self-Management and Community Outreach–Service Linkage (in

decreasing order of magnitude of difference). No difference was observed when sub-scales were analyzed separately.

We then ranked the five partnerships on the basis of their aggregate scores for partnership synergy outcomes and processes and compared our results with independent, qualitative rankings of partnerships performed by content reviewers. The quantitative and qualitative rankings were completely coherent for partnership synergy outcomes, showing that partnership synergy was highest in the Community Outreach Partnership and lowest in the Service Linkage Partnership. However, there was a slight difference in the rankings of two partnerships by partnership synergy processes, namely, the Community Health Resources Partnership and the Diabetes Self-Management Partnership.

Our quantitative analysis revealed that Partnership Synergy Outcomes and Partnership Synergy Processes sub-scales were strongly correlated with each other ($r = 0.61$), and there were few differences in how each of them correlated with the different dimensions of partnership work (see Table 7-3). We consequently chose to collapse the two synergy sub-scales together to a single Partnership Synergy scale (Partnership Synergy) for the analysis of associations at the partnership level. We also aggregated the scores at the partnership level for partnership assets and the following categories of partnership processes: non-financial resources, financial resources, resource utilization, decision-making, leadership, and administration and management (see Figure 7-2). Our newly developed sub-scales of Communication and External Environment did not perform well metrically, on assumptions of item-convergent validity, item-discriminant validity, and internal consistency. Therefore, we excluded these sub-scales from partnership-level analysis. The items related to the domains of communication, external environment, and benefits and drawbacks were analyzed independently for descriptive purposes only.

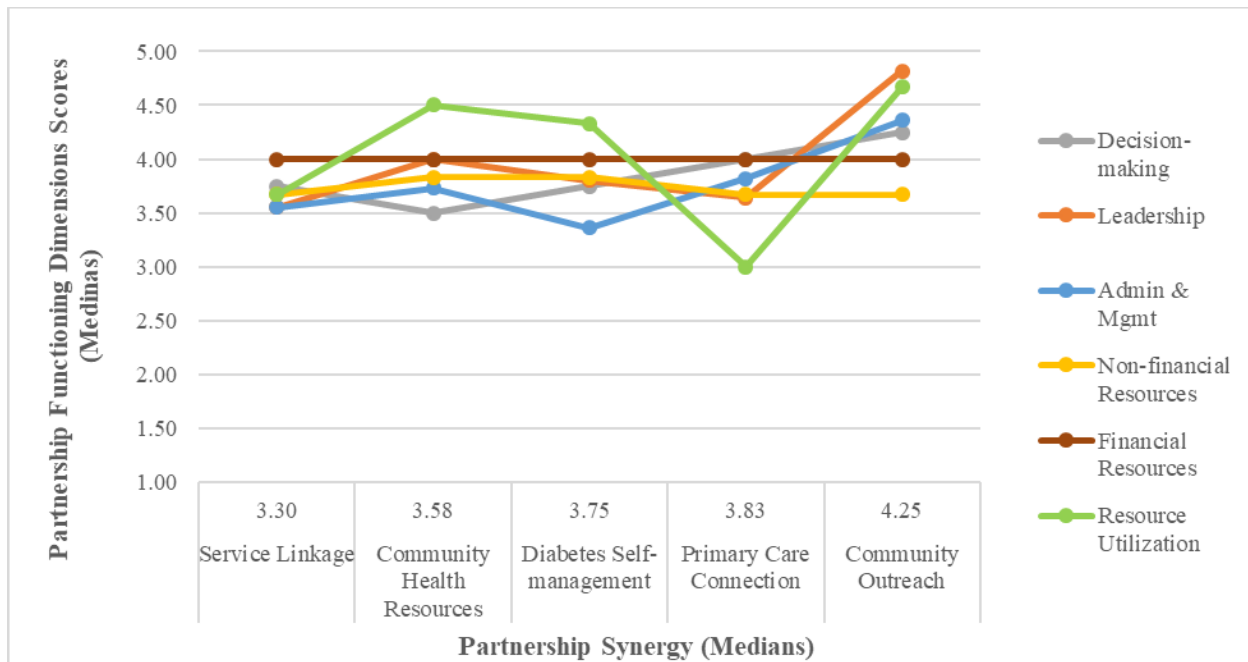


Figure 7-2. Comparison of values of partnership assets, processes and total partnership synergy by partnership ($n = 5$) (reproduced from [63]).

We hypothesized that partnerships exhibiting higher partnership synergy would on average achieve higher scores for partnership assets and processes. On the other hand, partnerships exhibiting lower partnership synergy would on average achieve lower scores across various categories of assets and processes. Our data (Figure 7-2) indicate that stakeholders in the Community Outreach Partnership did report on average the highest scores on all categories of partnership assets and processes, with the exception of non-financial resources, and that the Service Linkage Partnership stakeholders reported on average the lowest or second lowest scores for all categories of assets and processes. Our within partnership correlation analyses to investigate relationships between partnership assets, processes and synergy did not yield conclusive results due to the small number of observations in each partnership.

Figure 7-2 presents the complex picture of partnership work. All partnerships display variable scores, higher in some categories and lower in others. The figure illustrates that the composite elements constituting the performance of each partnership interact in a multitude of ways, and that there is no single path towards achieving a partnership synergy rank. We also

observed that administration and management and decision-making processes appeared to be more critical to establishing the total partnership synergy rank than other processes.

Irrespective of the variations in scores for different partnership assets and processes, the partnership-level scores for achieving the overall goal of developing a meaningful partnership were largely consistent with partnership-level partnership synergy scores. The majority of respondents in all partnerships reported that a meaningful partnership had been achieved leading to an uninformative median of four across all partnerships. However, as shown in Table 7-4, there was considerable variation within the partnerships that was reflected in the means and standard deviations. The metric that corresponded best to both partnership synergy scores and the qualitative ranking was the percentage endorsing that the partnership goal was achieved *very well* or *extremely well*.

Table 7-4. Partnership-level assessment of the extent to which the goal of developing a meaningful partnership was achieved (reproduced from [63]).

Partnership	Not well at all or not so well	Moderately well	Very well or extremely well	Mean (standard deviation)
Service Linkage (n = 9)	2 (22.2%)	3 (33.3%)	4 (44.4%)	3.22 (1.20)
Community Health Resources (n = 15)	0	5 (33.3%)	10 (66.7%)	3.87 (0.74)
Diabetes Self-management (n = 7)	0	2 (28.6%)	5 (71.4%)	3.86 (0.69)
Primary Care Connection (n = 10)	1 (10%)	2 (20%)	7 (70%)	3.60 (0.70)
Community Outreach (n = 7)	0	1 (14.3%)	6 (85.7%)	4.14 (0.69)

7.5.4 Integration of qualitative findings and quantitative results

Tables 7-5 and 7-6, below, provide a comparison of our qualitative findings and quantitative results.

Table 7-5. Presentation of qualitative, quantitative and comparative results related to partnership assets and partnership synergy

Determinants of partnership synergy	Phase I Qualitative Findings based on 14 meeting observations and 16 interviews in two multi-stakeholder partnerships	Phase II Quantitative Results based on survey of 54 partnership stakeholders representing five multi-stakeholder partnerships	Comparison of qualitative findings and quantitative results - comments
Partnership Assets			
Intangible assets – non-financial resources - Can be acquired or generated	Main acquired intangible assets: • Heterogeneous and complementary perspectives, skills and information reflected in partnership composition; • Connections to a broader set of stakeholders and influence; • Changes in stakeholders brought in new assets as needed for complexity and scope of the task; • Stable assets assured by core stakeholders, consistent over time. Generated intangible assets: • Training in skills specific to partnership project; • Collaborative relationships intentionally built; • Collaborative learning evidenced in deeper knowledge and enhanced skills.	• Significant intangible assets were reported across all five partnerships. • 84% of survey respondents reported that their respective partnerships had <i>most</i> or <i>all</i> of the needed skills and expertise to work well. • 75.9% of survey respondents reported that the skills and unique perspectives of partners complemented each other <i>often</i> or <i>always</i>. • There was a strong association between partnership synergy and non-financial resources ($r_s=.51$).	Both qualitative and quantitative findings suggest that intangible assets contributed to partnership synergy through having appropriately complementary and heterogeneous skill sets. Heterogeneity and complementarity were achieved by having a dynamic group composition that reflected the critical dimensions of the problem to be addressed and of the context that was likely to affect the work of the partnership.
Tangible assets – financial and other capital resources	• Research funding facilitated partnership activities; other partners contributed in-kind resources such as time and space to meet and conduct partnership activities. • Partners leveraged adequate financial resources to sustain interventions and partnership activities.	• The majority of survey respondents (96%) reported the presence of financial and other capital resources across all five partnerships. • There was a weak association between partnership synergy and financial and other capital resources ($r_s=.28$).	Qualitative and quantitative findings are partially consistent, suggesting that the importance of financial resources for partnership synergy related principally to supporting the coordinating infrastructure and a number of partnership activities (such as evaluation and outreach). Non-financial resources seemed to be more critical for partnership synergy than financial resources.

Table 7-6. Presentation of qualitative, quantitative and comparative results related to enabling processes and partnership synergy

Determinants of partnership synergy	Phase I Qualitative Findings based on 14 meeting observations and 16 interviews in two multi-stakeholder partnerships	Phase II Quantitative Results based on survey of 54 partnership stakeholders representing five multi-stakeholder partnerships	Comparison of qualitative findings and quantitative results - comments
Partnership Enabling Processes			
Asset/Resource Management	- A variety of engagement mechanisms, consistent with partnership configuration and mandates, to solicit input from stakeholders within and outside the partnerships. - Evidence of partnership synergy in the integration of non-financial and financial resources: in optimal and sustained level of commitment to the initiatives for most stakeholders, in collaborative learning relationships, in a variety of reported benefits for stakeholders' respective organisations, and in the ability of partners to leverage adequate financial resources. - Difficulty meaningfully engaging community-based stakeholders from or representing the target population, for both partnerships, and reduced engagement of some academic stakeholders in the Primary Care Connection Partnership.	- The majority of survey respondents reported high levels of engagement in partnership activities. - The majority of survey respondents reported that their respective partnerships made very <i>good</i> or <i>excellent</i> use of their time (70%, excluding Primary Care Connection and Service Linkage) and other non-financial resources (67% excluding Primary Care Connection), with the highest rates reported in the partnership with the highest total partnership synergy score (Community Outreach). - When asked how well the partners were able to include the views and priorities of the people affected by the partnership's work, the majority of survey respondents (59.2%) stated <i>not so well</i> or <i>moderately well</i>. - There was a strong association between partnership synergy and resource utilisation ($r_s=.50$). - The majority of respondents (78%) stated that the benefits of participating for the organisations that the stakeholders were representing in the partnership <i>exceeded</i> or <i>greatly exceeded</i> the drawbacks. - The partnership with the highest total partnership synergy score reported, on average, the highest score for benefits, and the partnership with the lowest total partnership synergy score – the lowest.	Both qualitative and quantitative results indicate that high levels of stakeholder engagement were important to achieve partnership synergy. The nature of engagement has to be aligned with the function of the partnership and the need to fulfil project objectives, with particular attention to meaningful engagement of end users and addressing disengagement. Benefits related to respective organisations seem to be more critical than personal benefits. Managing incentives, so that benefits outweigh costs, is an important consideration.

Determinants of partnership synergy	Phase I Qualitative Findings based on 14 meeting observations and 16 interviews in two multi-stakeholder partnerships	Phase II Quantitative Results based on survey of 54 partnership stakeholders representing five multi-stakeholder partnerships	Comparison of qualitative findings and quantitative results - comments
Partnership Enabling Processes			
Leadership	- Research teams assumed leadership of processes in both partnerships. - Leaders capitalised upon the various strengths and perspectives of stakeholders, contributing to partnership synergy. - The Primary Care Connection Partnership leveraged the power of leadership distributed among academic and non-academic stakeholders.	- The partnership with the highest score on the partnership synergy scale (4.25) achieved the highest score on the leadership scale (4.82). The results for partnerships with lower partnership synergy scores were more mixed. - Primary Care Connection achieved a higher partnership synergy score (3.83) than Community Health Resources (3.58) but a lower score on the leadership scale (3.64 vs 4.00). - There was a strong association between partnership synergy and leadership ($r_s=.74$).	Qualitative and quantitative results suggest that partnership synergy was facilitated by leadership capable of mobilising the various perspectives of stakeholders. Qualitative results also highlight the contribution to partnership synergy of more distributed forms of leadership, however, quantitative results suggest limitations of the scale in terms of assessing the extent to which leadership was distributed.
Administration & management	- Research teams, including dedicated partnership resources, responsible for the operational running of the partnerships. - Adaptive management approaches, employed by the research teams, supported the work of the partnerships and facilitated the ability of partners to engage meaningfully, contributing to partnership synergy.	There was a strong association between partnership synergy and administration & management ($r_s=.61$).	Qualitative and quantitative results highlight the importance for partnership synergy of a core infrastructure and adaptive management approaches to support the work of the partnerships and facilitate the ability of partners to contribute meaningfully.
Communication	- Regular face-to-face meetings and timely and varied communication mechanisms employed by both partnerships. - Open and multidirectional channels of communication and learning loops allowed all stakeholders to stay informed and engaged, contributing to partnership synergy.	- The majority of respondents reported being <i>adequately</i> or <i>always informed</i> regarding partnership's activities. - Our newly developed communication scale did not perform well metrically.	Qualitative findings point to the importance of timely and varied communication mechanisms in synergistic partnership learning. However, quantitative results were limited, precluding definitive conclusions regarding the contribution of communication to partnership synergy.

Determinants of partnership synergy	Phase I Qualitative Findings based on 14 meeting observations and 16 interviews in two multi-stakeholder partnerships	Phase II Quantitative Results based on survey of 54 partnership stakeholders representing five multi-stakeholder partnerships	Comparison of qualitative findings and quantitative results - comments
Partnership Enabling Processes			
Decision-making	- The Primary Care Connection Partnership harnessed the power of distributed decision-making and collaborative problem-solving, contributing to synergy. Stakeholders participated actively in the co-construction of the various aspects of the project, and some non-academic stakeholders fulfilled tasks outside the steering committee meetings. - Decision-making power centralised within the research team in the Community Health Resources Partnership, consistent with the advisory nature of the partnership.	- Partnerships with higher scores on the partnership synergy scale achieved higher scores on the decision-making scale. - There was a strong association between partnership synergy and decision-making ($r_s=.66$).	Qualitative and quantitative findings highlight the importance to partnership synergy of distributed decision-making and collaborative approaches to problem-solving.
Contextual adaptation	- Both partnerships made ongoing adaptations to the interventions to respond to evolving contextual opportunities and threats. - The extent of contextual impact and adaptation was far greater in the case of Primary Care Connection (in comparison to Community Health Resources). - Primary Care Connection demonstrated synergy in its ability to adapt to its changing context. The contextual adaptation was facilitated by having a variety of key stakeholders with medium to high decision-making power in respective organizations, open, timely dialogue about the evolving context, and transparent and inclusive processes of decision-making.	- The majority of stakeholders in two of the five partnerships (Primary Care Connection (75%) and Service Linkage (67%)) reported that their partnership had been affected <i>a lot or a great deal</i> by external factors, beyond the control of the partnership. - The majority of Primary Care Connection respondents (75%) reported that the partnership had adapted to these external influences <i>very well</i> or <i>extremely well</i>. - Our newly developed sub-scale on external environment was not correlated with partnership synergy, nor any other dimension of partnership work.	Qualitative findings suggest that recognizing and dealing with changes in partnership context are important to achieve partnership synergy. Quantitative findings were limited in terms of assessing the contribution of external context to partnership synergy.

7.6 DISCUSSION

This empirical exploratory study provided insights into complex and dynamic partnership processes and into how partnership assets are activated to produce partnership synergy. The Partnership Synergy framework posits that “[...] synergy is the degree to which the partnership combines the complementary strengths, perspectives, values and resources of all partners in the search for better solutions and is generally regarded as a product of a partnership” [6]. We have expanded this definition to incorporate the contribution of enabling (facilitating) processes in combining the tangible and intangible assets that are the inputs of the partnership. It is the combined effect of the inputs and enabling processes that confers advantages over the work of individual agents. Our first key finding of this study relates to the association between partnership synergy, tangible and intangible partnership assets and enabling collaborative processes. While enabling collaborative processes could be both operational and interpersonal in nature [5], this study focused primarily on operational facilitators and system-level processes geared towards making ongoing adaptations to the evolving context. We assessed the role of facilitative leadership, supportive administration and management approaches, mechanisms of engaging partners and capitalizing on partners’ resources, communication, and collaborative approaches to managing change. Our results (Table 7-3) indicate that partnership synergy was associated with partnership dimensions of leadership, administration and management, decision-making, and the ability of partnerships to optimize the involvement of its partners (referred to as “Efficiency” in the Partnership Synergy framework and referred to as “Resource Utilization” in our study). It was also associated with the sufficiency of non-financial resources. We could not perform correlation analyses to investigate relationships between partnership assets, processes and synergy at the partnership level due to the limited number of observations in each partnership. However, our comparison of values for partnership processes, the sufficiency of partnership assets and total partnership synergy by partnership (Figure 7-2) indicates that among the partnership enabling processes investigated in our study administration and management and decision-making seem to be more critical to determining the achievement of partnership synergy. Our study findings also support the importance of recruiting partnership stakeholders with varied but complementary expertise and of benefits to the stakeholders’ respective organizations.

Our Communication and External Environment sub-scales did not perform well metrically [63]. However, the Spearman rank correlations between all three communication items and partnership synergy were moderate, supporting our qualitative conclusion that communication was an important dimension of partnership functioning. Conversely, our newly developed sub-scale of External Environment was not correlated with partnership synergy nor any other dimension of partnership functioning. The lack of correlation may be explained by the limitations of the sub-scale used. Alternatively, the lack of correlation in our study may be explained by the fact that the interface between a partnership and its context is complex and difficult to capture with standardized tools. Our qualitative investigation revealed that recognizing and dealing with changes in partnership context were important to achieve partnership synergy [62]. In addition, the synergy generated in both partnerships under the qualitative investigation facilitated adaptation to the challenging contextual circumstances and allowed the partnerships to continue. How these variables will interact under different types of contextual threats, such as the global COVID-19 pandemic, needs to be further examined. Given the importance of face-to-face interactions highlighted by our study participants, generating partnership synergy may be more challenging when moving to virtual forms of communication and interactions necessitated by the pandemic. Moreover, in our study, the nucleus of each partnership, which included the research team and a number of key non-academic stakeholders, remained consistent over time, while new members were invited to join based on the evolution of the projects and the need to attract specific expertise and additional resources at different points in time. Maintaining the consistent continuous core of members who provide continuity and keep the collaboration going may be impossible to achieve when there are sudden changes in priorities at all levels of the system and when key personnel and other resources need to be re-deployed. Changes in government priorities and policies may lead to a redefinition of partnership goals or may mean that the specific concerns driving the partnership have ceased to exist altogether [73]. However, the synergy generated by a well-functioning partnership that is already underway may help partners to quickly mobilize their strengths and reposition the partnership to tackle new priorities and vulnerabilities exposed by the pandemic.

Our findings are consistent with prior research that has assessed relationships among different partnership functioning factors and partnership synergy [6,50]. This research has analyzed the associations between partnership functioning factors, partnership synergy and the

following partnership outcomes: effectiveness in the delivery of chronic illness care [56], sustainability of innovative programs in community care [55] and perceived partnership sustainability and perceived community outcomes in sport-for-health partnerships [74]. Applying similar measures of partnership functioning and partnership synergy, studies demonstrated that partnership synergy was associated with the effectiveness of partnership leadership [6,50,55], partnership efficiency [6,50], the effectiveness of administration and management [50] and the sufficiency of non-financial resources [50,56]. It has also been established that partnership synergy acted as a mediator between partnership functioning and partnership outcomes (e.g., [56]). In our study, partnership synergy emerged as an intermediate outcome of partnership functioning, before the intended outcomes related to PHC access could be assessed. Given the stage at which the partnerships were studied, and that identifying causal pathways was beyond the scope of this research, the study did not incorporate a separate effectiveness assessment of the intended outcomes. It therefore could not demonstrate definitively whether higher levels of partnership synergy precipitated better achievement of intended outcomes. However, the majority of survey respondents in all studied partnerships reported having developed a meaningful partnership that achieved both added value and benefits that largely outweighed the drawbacks of participation. In addition, a recent parallel study of IMPACT produced evidence that the intended goals of the program were largely met through partnerships [75]. The study by Spooner et al. [75] found that all IMPACT sites observed changes in patient abilities to access PHC and in provider capabilities to address the health care needs of vulnerable populations, even in interventions where there was no activity intentionally targeting provider behaviors. These findings are indicative that the partnerships were effective in reaching the intended outcomes.

Our comparison of qualitative and quantitative findings revealed additional nuances in relation to the type of leadership that was employed in the partnerships that were the focus of our qualitative investigation. Prior studies have highlighted the critical importance of leadership to partnership synergy [6]. The study by Weiss et al. (2002), using the same PSAT leadership scale, found that leadership was the dimension that was most closely associated with partnership synergy. The type of leadership that partnerships necessitate is facilitative and “boundary-spanning”—enabling those in charge to appreciate and bridge the diverse perspectives of various stakeholders [8]. It needs to be shared formally and informally among stakeholders, even though there may be

one “lead” organization [6]. This type of leadership, referred to with a variety of terms including “plural”, “collective” or “distributed” leadership or simply DL, is located at the other end of the spectrum from individual leadership [76,77,78]. It refers to a “collective phenomenon that is distributed or shared among different people, potentially fluid, and constructed in interaction” [77]. The partnership that fit this definition based on our qualitative findings did not achieve the expected higher score for leadership. This observation suggests that while the leadership sub-scale used in our study tapped into its facilitative and boundary spanning nature, it might not have reflected its distributed power. Given the centrality of leadership to multi-stakeholder partnerships in general and partnership synergy in particular, future research should explore how the PSAT leadership scale could be amended to reflect DL. Taking into consideration the temporal and contingent nature of leadership, whereby certain situations and earlier partnership phases will require more centralized forms of leadership [76,79], it might not be possible to develop an all-encompassing leadership scale. This challenge may be addressed through the assessment of the various partnership components longitudinally and with the use of mixed methods, allowing the collection of different types of data.

Our qualitative and quantitative results were also less consistent in relation to the dimension of financial resources. Our qualitative investigation demonstrated the critical importance of the funded coordinating infrastructure and that partnerships were capable of mobilizing adequate tangible resources to sustain service interventions. Our quantitative results revealed a high score for financial resources across all studied partnerships but a low correlation with most other dimensions of partnership functioning and Partnership Synergy Outcomes. This low correlation suggests that the Financial Resources sub-scale that we used might not have reflected the complexity in the types of tangible resources that were at play in IMPACT partnerships [63]. Alternatively, it may be explained by the fact that some multi-stakeholder health partnerships have few tangible resources. While financial and other capital resources are some of the building blocks sustaining partnership operations and partnership service interventions, the essence of partnership work lies in the production of knowledge and in relationship building. In fact, partnerships can be viewed as “knowledge organizations” that utilize intangible assets, such as the skills and expertise of partners, to convert information into knowledge [53]. While financial and other capital resources are important, non-financial resources seem to be more critical to

creating partnership value including the ability of partnerships to make decisions, effective leadership and partnership management and administration. This finding is consistent with resource-based theory that suggests that intangible resources may be more valuable for they are more difficult to acquire and replicate [51].

Our second key finding relates to the contingent nature of partnership work and organizing to operationalize the partnership. We hypothesized that partnerships exhibiting higher partnership synergy would, on average, report higher levels of partnership functioning across various dimensions. On the other hand, partnerships exhibiting lower partnership synergy would, on average, report lower levels of partnership functioning across various dimensions. Our results indicate that the partnership with the highest total partnership synergy score achieved, on average, the highest scores for partnership functioning on most studied dimensions. Conversely, the partnership with the lowest total partnership synergy score achieved, on average, the lowest or second lowest scores for partnership functioning on all dimensions. However, the results for partnerships with middle total partnership synergy scores were more varied. The Primary Care Connection Partnership achieved a high synergy score despite a number of lower scores on some partnership functioning sub-scales. On the other hand, the Community Health Resources Partnership that achieved the second lowest total partnership synergy score performed well on some of the partnership functioning dimensions (such as resource utilization). These findings reinforce contingency theory concepts [80,81], in that they reflect the complexity in partnership work and suggest that there is more than one way of organizing and reaching partnership synergy. They also suggest that there might be certain partnership dimensions that are still lacking from our analysis. Taking into consideration the emphasis that the stakeholders in all five partnerships put on the quality of relationships, our assessment could have benefitted from incorporating measures of interpersonal collaborative processes and the quality of stakeholder relationships including such aspects as trust. In fact, prior research has highlighted relational factors, such as high levels of trust, to be important ingredients in a well-functioning partnership [82,83,84], and trust has been identified as a critical determinant of partnership synergy [6].

A third key finding highlights the importance of assessing partnership synergy as an indicator of the health of the partnership. It might not be feasible or necessary to capture all possible dimensions of partnership functioning to be studied or assessed with standardized scales,

for partnership synergy amounts to more than the sum of its parts [8,50,85]. Given that partnerships are inherently complex, highly contextual and constantly evolving organic entities, different factors may be more or less relevant depending on the specific circumstances and the goals of a partnership [78,86]. At the start of the IMPACT program, the sites agreed to work with their respective local constituents *in partnership*. As the time progressed each partnership under our investigation evolved in different ways, addressing distinct PHC access needs, applying different ways of engaging stakeholders and developing unique ways of responding to contextual challenges. Therein lies the value of assessing partnership synergy as an important intermediate partnership outcome and a barometer for the health of the partnership. Confining partnership evaluation to assessing performance on individual partnership functioning indicators would provide important but partial information on how a partnership scored vis-à-vis set performance targets or, in comparative research, other partnerships. This partial analysis may lead us to argue that the Primary Care Connection Partnership that achieved lower partnership functioning scores on a number of dimensions did not perform well. However, the high partnership synergy score for this partnership depicts a different picture, pointing to the effectiveness of dynamics and processes and a more “holistic” view of the partnership. We could not assess partnership synergy longitudinally because this study commenced when the partnerships had already achieved maturity. Evaluating partnership synergy, qualitatively and quantitatively, as an evolving indicator of partnership health, at different points in the partnership’s life, would allow the collection of data on other processes that might have contributed to higher (or lower) levels of partnership synergy over time. In addition, observing fluctuations in partnership synergy and partnership functioning dimensions scores may allow researchers to infer the relative importance of these dimensions to synergy.

Initiating and sustaining partnerships is not easy; it is a complex, dynamic and time-consuming process that involves multiple tasks and requires certain vital components [36,46]. This study contributes to the evolving body of knowledge on partnership synergy as a useful framework for studying collaborative ventures and identifies some of the critical requirements for synergistic partnerships. These requirements should be considered in order to determine if working in partnership should and can reasonably be pursued. Though the transferability and generalizability of this study’s findings may be limited due to the small sample size, the findings are likely robust

for academic partnerships with partners in the formal health care system. Despite the specificity of partnerships under this investigation, there was enough heterogeneity among them in terms of their contexts, their composition and how the partnerships evolved, suggesting relevance of these findings across various settings. It has been argued in the partnership literature that despite the diversity of partnerships, there are a number of common features influencing their effectiveness, and that the underlying principles behind creating and sustaining effective partnerships are generic [87]. The concepts used in this study in general and the PSAT in particular have demonstrated robustness in assessing the quality of partnership processes and outcomes in multi-stakeholder partnerships in several areas including public health, health promotion and chronic illness care [2,6,56]. The PSAT has also been identified as a valid tool for measuring group processes in interprofessional health and social service partnerships at the front-line service provider group level [2]. However, the evaluation approach and the PSAT will need to be tailored to different partnership types and local conditions. For example, community-driven partnerships with fewer resources, a decentralized partnership structure and more distributed decision-making may need to adapt the Leadership and Administration and Management sub-scales. Alternatively, partnerships may prioritize different aspects for evaluation altogether. The list of variables offered by the Partnership Synergy framework allows partnership practitioners and evaluators to select those relevant to a particular partnership.

7.6.1 Limitations

The findings of this research need to be considered in light of its limitations. First, our findings are based on a relatively small sample of partnership stakeholders who were part of a single funded program of research with a specific focus of enhancing accessibility to PHC for vulnerable populations. Caution is warranted when transferring these findings to partnerships operating in different political, resource and health care delivery environments. Second, the statistical power of our quantitative conclusions is limited due to the small sample size. Third, while we made attempts to ensure the collection of a diversity of opinions, given the voluntary nature of engagement and the timing of data collection, such that those who did not see value in the partnerships would have resigned, participants may have provided a more favorable assessment of their respective partnerships. Finally, our analysis only included a number of constructs, based

on the selected theoretical frameworks and on our qualitative data. We may not have captured all of the manifestations of partnership synergy, assets and processes.

7.7 CONCLUSIONS

This research was conducted with the aim of understanding partnership processes and how various partnership factors contribute to partnership effectiveness. The partnerships involved stakeholders from different organizations with an interest in implementing organizational solutions that enhance access to primary health care for vulnerable populations. Effectiveness was conceptualized both in terms of the achievement of intended outcomes and the effectiveness of processes (the internal health of the partnership). This research offers several original contributions to the theory and practice of multi-organizational multi-stakeholder health partnerships. First, it demonstrated the applicability of and further refined the theoretical concept of partnership synergy as an indicator of the health of a partnership and an intermediate outcome of working in partnership. Second, the research affirmed the importance of investing in the assessment of partnerships and contributed to the emerging knowledge on how to evaluate them. Third, by demonstrating an association between partnership assets, enabling processes and synergy, this research underlined the operational importance of investing in and paying attention to partnership processes as part of achieving both partnership synergy and the intended outcomes of multi-stakeholder partnerships.

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CHAPTER 8. Discussion

The research reported in this thesis was conducted with the aim of understanding partnership processes and how various partnership factors contribute to partnership effectiveness. The partnerships involved stakeholders from different organisations with an interest in implementing organisational solutions that enhance access to primary health care (PHC) for vulnerable populations. Effectiveness was conceptualised both in terms of the achievement of intended outcomes and the effectiveness of processes (the internal health of the partnership).

This research offers several original contributions to the theory and practice of multi-organisational multi-stakeholder health partnerships. First, it demonstrates the applicability of and further refines the theoretical concept of partnership synergy as an intermediate outcome of partnership work. Second, the research affirms the importance of investing in the assessment of partnerships, and contributes to the emerging knowledge about how to evaluate them. Third, by demonstrating an association between partnership assets, enabling processes and synergy, the research underlines the operational importance of investing in and paying attention to partnership processes as part of achieving both partnership synergy and the intended outcomes of multi-stakeholder partnerships. The sections below explore these contributions in more detail. This chapter also discusses the limitations of this research and the aspects requiring further investigation in the area of multi-stakeholder partnerships in PHC.

8.1 PARTNERSHIP SYNERGY – AN IMPORTANT INTERMEDIATE OUTCOME OF PARTNERSHIP WORK

8.1.1 Refining the partnership synergy definition

The concept of “partnership synergy” has recently gained traction in several health-related fields to describe the added value of collaborative work between members of different organisations. Despite its increasing importance the concept remains fluid, referring in broad terms to the reinforcing combination of partners’ strengths, perspectives, values, skills and resources (Jones & Barry, 2011a; Lasker & Committee on Medicine and Public Health, 1997). Lasker et al.’s frequently cited definition describes partnership synergy as “the breakthroughs in thinking and action that are produced when a collaborative process successfully combines the complementary

knowledge, skills, and resources of a group of participants” (Lasker & Weiss, 2003, p. 121). The main argument is that by combining these unique but complementary contributions “the group creates something new and valuable together – a whole that is greater than the sum of its individual parts” (Lasker et al., 2001).

This empirical exploratory study provides additional insights into the dynamic interactions of partnership synergy with enabling processes and partnership assets. Inspired by resource-based theory and based on the findings of this study reported in Chapters 5 and 6 (*Manuscripts 1* and *2*, respectively), the doctoral candidate has proposed to refine the definition of partnership synergy to: 1) conceptually group the unique contributions of partners into tangible and intangible assets, and 2) incorporate the contribution of enabling processes. The proposed refined definition as documented in Chapter 7 (*Manuscript 3*) is:

Partnership synergy is the combined effect of complementary tangible and intangible partnership assets and enabling collaborative processes that gives partnerships unique advantages over the work of individual people or organisations working towards the same goals. It is achieved when partnership assets are leveraged to produce outcomes that are greater than those that would be expected from individual players.

According to this definition, the assets contributed by partners are viewed as the inputs of partnership, and it is the combined effect of the inputs and enabling processes that confers advantage over the work of individual organisations or people. In this sense, the definition indicates the elements of a roadmap to synergy, which will be further discussed in the sections below. In broad terms, the definition accommodates the situational idiosyncrasies of different partnerships by referring to broad categories of assets and processes instead of enumerating individual asset and process variables and manifestations of synergies that are common in existing definitions.

8.1.2 Partnership synergy as a multi-dimensional and dynamic indicator of partnership health

Lasker et al. (Lasker et al., 2001) operationalised the concept of partnership synergy within the field of public health, suggesting that it be viewed as a “product of the group interaction” (p. 187) and as a link between partnership processes and partnership effectiveness. The understanding of partnership synergy has evolved since the 2001 publication of Lasker et al.’s seminal work. Jones

& Barry proposed in 2011 that synergy was both a product and a process (Jones & Barry, 2011a). More recent research has highlighted synergy's dynamic and cumulative nature, demonstrating its capacity to build over time and its role as an evolving indicator of effectiveness and sustainability (Brush, Baiardi, & Lapides, 2011; Jagosh et al., 2012). The qualitative findings of this doctoral investigation as reported in Chapter 5 (*Manuscript 1*) affirm the recent findings by revealing the complexity in partnership synergy.

First, this study highlights partnership synergy's multi-dimensional nature. Synergy manifests itself in different ways. The following four areas where partnership synergy is apparent were identified during the qualitative phase of this research: a) the integration of non-financial and financial resources; b) partnership atmosphere; c) reported benefits; and d) a partnership's capacity for adaptation to context. Complex interactions were observed between these four areas. These inter-connections suggest that synergy components are not static, nor independent. Consistent with Jones et al.'s findings, this research identified both the process (high levels of internal functioning) and outcomes (partners are accomplishing more by working together than working independently) dimensions of synergy. Based on the replies of interview respondents during early to mid-stages of partnership development, the process elements appeared to be more relevant than outcome elements. This was then reflected in the retention of a greater number of process-related items from the Jones synergy scale that measures synergy as both a partnership process or experience and as a partnership product (see Chapter 6. *Manuscript 2*). Arguably, the measures of partnership synergy outcomes become more relevant as part of partnership outcome evaluation.

Second, the qualitative study reveals that partnership synergy fluctuated as partnerships evolved, increasing and weakening depending on internal and external factors. Both partnerships started with a group of individuals with common interests (low synergy) and evolved into entities with a requisite degree of openness, inter-dependence and enhanced understanding of presenting issues (higher synergy) – all of which contributed to deeper decision-making and effective adaptations to intervention models. Conversely, partnership synergy could weaken, as was illustrated with an example of the profound impact on the Primary Care Connection Partnership of its volatile context. As such, manifestations of synergy functioned as a dynamic indicator of partnership health.

Third, the findings of this study support the results of prior research (Corbin & Mittelmark, 2008; Jagosh et al., 2012) demonstrating that partnership synergy can feed back into the partnership positively. The study by Corbin and Mittelmark (Corbin & Mittelmark, 2008) identified synergy's capability to affect partnership functioning, enhancing partnership's ability to attract additional resources. Similarly, Jagosh et al. (Jagosh et al., 2012) found that synergy facilitated recruitment capacity. In the study described here, partnership synergy fed back into the partnership in the Primary Care Connection Partnership, allowing it to survive the impact of the challenging contextual circumstances. As such, it functioned as a partnership facilitator, contributing to sustaining the partnership. However, what differentiates this synergy process from other partnership processes such as leadership processes is that it cannot be planned.

In this study, partnership synergy emerged as an intermediate outcome of partnership functioning, before the intended outcomes related to PHC access could be assessed. Given the stage at which the partnerships were studied and that identifying causal pathways was beyond the scope of this research, the study did not incorporate a separate effectiveness assessment of the intended outcomes. It therefore could not demonstrate definitively whether higher levels of partnership synergy precipitated better achievement of intended outcomes. However, the majority of survey respondents in all studied partnerships reported having developed a meaningful partnership that achieved both added value and benefits that largely outweighed the drawbacks of participation. In addition, a recent parallel study of IMPACT produced evidence that the intended goals of the programme were largely met through partnerships (Spooner et al., 2021). The study by Spooner et al. found that all IMPACT sites observed changes in patient abilities to access PHC and in provider capabilities to address the health care needs of vulnerable populations, even in interventions where there was no activity intentionally targeting provider behaviours. These findings are indicative that the partnerships were effective in reaching the intended outcomes.

Lasker et al. (Lasker et al., 2001) describe five determinants of partnership synergy: resources; partner characteristics; relationships among partners; partnership characteristics; and external environment. Guided by Lasker et al.'s typology, this doctoral study isolated a series of partnership enabling processes and grouped them into interpersonal, operational and system level categories. The findings of the study reveal that these processes facilitated the ability of multiple stakeholders to achieve partnership synergy, by interacting with partnership inputs (tangible and

intangible resources). It is important to acknowledge that there is a variety of interactions between these partnership components even though not all of them were explored in detail in this study. As mentioned in sub-section 3.3.1 above (*Partnership synergy*) and documented in the recent study by Corbin et al. (Corbin et al., 2018) interactions between partnership inputs and processes may be additive, synergistic or antagonistic. The additive effect is observed when the efforts of partners have not been mediated by the work of the partnership. In the IMPACT study, the additive effect was identified when partners contributed resources and ideas that had not yet been leveraged by the partnership. Antagonism denotes a negative outcome, when resources of partners have been wasted. Antagonism could be influenced by context (Corbin et al., 2018) which was the case in the Primary Care Connection Partnership that invested energy and resources into the development of an initial version of an intervention that was discontinued due to contextual changes. Based on the framework by Huxham and Vaugen (Huxham & Vaugen, 2000) (referred to in section 2.4. *Partnership Challenges*), there is a fourth potential interaction of partnership inputs and processes – inertia – denoting a zero or negligible effect. Attending meetings that are not contributing to building relationships or to any progress on outcomes would be one of the examples of collaborative inertia, which is arguably more likely when the partners are involved as representatives of organisations but have not fully committed to the partnership. These four possible collaborative outputs – synergy ($1+1=3$), additive effect ($1+1=2$), inertia (0) and antagonism ($1+1=-x$) – would have to be explored in more detail in subsequent research. Partnerships are likely to experience all of these effects at some point in their trajectory.

Given that partnerships are located at the far end of the collaborative spectrum representing a greater level of organisational commitment to joint working and sharing of resources, partnerships that are purposefully planned and implemented have greater potential to reach synergistic outcomes. Networks of personal professional relationships that do not involve organisational commitment, or contractual relationships where different benefits accrue to different partners (Audit Commission, 1998) are more likely to produce zero or additive effects. Any continuum of joint effort such as the one referred to by the Human Service Partnership Implementation Committee (2009) mentioned in section 2.2 above (*The Concept of Partnership*) should therefore reflect synergy as a vital component of collaborative work. The potential to achieve synergistic (not additive) outcomes increases as one moves along this continuum.

8.2 PARTNERSHIP ASSESSMENT

The second key contribution of this research consists of affirming the importance of investing in the assessment of partnerships, including partnership synergy and enabling processes. An original contribution of the study is advancement of knowledge on evaluation of partnerships. The intentional decision within the IMPACT programme of research to invest in the evaluation of its partnerships as part of the programme's effort to support them is an example of this. In particular, the IMPACT programme chose to conduct longitudinal developmental evaluation which, in contrast with summative and formative types of programme evaluation, is better suited to supporting innovative undertakings in dynamic and complex contexts (Patton, 2011). The longitudinal developmental evaluation of all six IMPACT partnerships ran parallel to both the IMPACT action research and this doctoral study.

8.2.1 The importance of longitudinal mixed methods partnership evaluation driven by theory

This research demonstrates the value of assessing multi-stakeholder partnerships 1) longitudinally, 2) with the use of mixed methods and 3) guided by theoretical frameworks. This three-pronged approach was found to be well suited for capturing the holistic and complex nature of partnerships, despite its drawbacks of being more resource and time-consuming than studying partnerships either qualitatively or quantitatively and at a single point in time.

The longitudinal case study of the two partnerships, namely the Primary Care Connection Partnership and the Community Health Resources Partnership, was conducted between August 2016 and September 2018. This length of time allowed the doctoral candidate to understand partnership processes over time; to trace contextual changes that affected the partnerships and identify how the partnerships responded to these changes; and to understand how the different structures and processes contributed to partnership synergy and the achievement of intended outcomes. The modified version of the PSAT was not administered longitudinally because the quantitative phase of the doctoral study coincided with the wrap-up of the IMPACT local interventions. The PSAT tool can reasonably be administered at different times in the evolution of the partnership, for internal partnership evaluation; it will become even more useful as it is further refined and validated. Once the partnership composition is established, and the partners have had

the chance to work together (including face-to-face meetings), the revised PSAT can be administered in order to quantify progress related to how the collaboration is working, and to identify strengths and areas that would require improvement. An important part of this assessment is evaluating partnership synergy, both qualitatively and quantitatively, as an evolving indicator of partnership health at different points in the partnership's life. This would also allow the collection of data on partnership functioning dimensions that contribute to higher (or lower) levels of partnership synergy over time. In addition, observing fluctuations in partnership synergy and partnership functioning dimensions scores may allow researchers to infer the relative importance of these dimensions to synergy.

Applying mixed methods enabled a deeper and more accurate assessment of partnership synergy and partnership facilitating processes. The sequential exploratory mixed methods design was deemed to be most appropriate for this investigation, given the complexity and structure of the IMPACT programme and the objectives of this study, whereby the first phase of research had to be devoted to understanding the programme in general and two partnerships in particular before deciding which variables to study quantitatively.

One of the strengths of mixed methods research lies in its ability to compensate for the limitations of qualitative or quantitative methods used in isolation (Pluye & Hong, 2014). Partnerships are inherently multifaceted, highly contextual and constantly evolving organic entities. Trying to capture these dynamics solely with the use of standardised assessment tools would have inevitably resulted in omitting important pieces of evidence, such as contextual data to frame numerical survey replies (Joss & Keleher, 2011). Conversely, solely using qualitative methods would have hampered the ability to quantify progress and compare partnership performance across several sites. Indeed, there have been strong calls in the partnership literature for mixed methods evaluation, and the evidence base on the value of applying mixed methods in partnership research is growing (El Ansari et al., 2001; El Ansari & Weiss, 2006; Gillies, 1998; Lucero et al., 2018).

However, the greatest value of mixed methods research, as documented in Chapter 7 (*Manuscript 3*), transpired in providing additional insights in the case of conflicting qualitative and quantitative findings. For example, based on qualitative findings from the two partnerships, the partnership that exhibited a higher partnership synergy score was expected to achieve a higher

score for leadership than was reported in the questionnaire. These findings prompted a more in-depth analysis of the PSAT leadership sub-scale leading to a conclusion that it did not reflect the distributed type of leadership that was observed in that partnership, and that the sub-scale would need to be tailored to partnerships exhibiting less centralised leadership types. Another example occurred while comparing partnership scores from the survey with the independent qualitative assessment of the same criteria from two content reviewers – academic investigators who led the developmental evaluation of all IMPACT local partnerships. While the quantitative data did not detect a distinction between the sub-scales of Partnership Synergy Processes and Partnership Synergy Outcomes, the reviewers’ qualitative ranking of partnerships did discriminate between partnerships for the two constructs, suggesting the need for further development of separate quantitative measures of partnership synergy processes and partnership synergy outcomes.

Finally, a theory-based study of partnerships enabled focus on a select number of key variables and deeper, more coherent findings. In a field that has been criticised for too much methodological and conceptual diversity (as per section 2.2. *The Concept of Partnership*), starting with theory allowed building on prior work, maintaining the thread of arguments and deepening the theory of partnership synergy. The main advantage of selecting partnership synergy as a theory was the availability of well-defined conceptual variables that were further refined during the qualitative phase, as well as the availability of validated measurements of these constructs. As the qualitative and quantitative data gathering progressed, contingency and resource-based theories were drawn upon to help frame emerging findings. More specifically, contingency theory allowed the candidate to understand that a more centralised form of leadership and a greater degree of formalisation were appropriate in the relatively stable environment of the Community Health Resources Partnership. Conversely, the more organic structure and decentralised leadership in the Primary Care Connection Partnership fit its volatile context and allowed it to remain nimble and responsive to change (see Chapter 5. *Manuscript 1*). Resource-based theory informed the conceptual grouping of input variables under tangible and intangible assets, and enabled rendering this explicit within the new definition of partnership synergy (see Chapter 7. *Manuscript 3*).

8.2.2 The value of the PSAT and assessing partnership synergy

This study demonstrated that the PSAT was a suitable evaluation tool for assessing the achievement of partnership synergy and the performance of specific indicators of partnership functioning. This study demonstrated that an adapted version of the PSAT was capable of discriminating between different levels of partnership functioning and partnership synergy even in a limited sample of ongoing partnerships working towards improving PHC. The tool supports identification of the areas of strength and potential improvement to achieve the collaborative advantage. The tool may have broader applicability to partnerships in PHC, and arguably beyond PHC.

As highlighted above, partnership synergy, one of the elements assessed by the PSAT, is dynamic. When partnerships experience decreased synergy, the PSAT may be useful as a diagnostic tool allowing the identification of the sources of partnership functioning problems. The study's findings also suggest that there may be certain partnership dimensions that are still lacking from the evolving partnership synergy model described here. However, it may not be feasible or even desirable to assess quantitatively all possible dimensions of partnership functioning, because partnership synergy amounts to more than the sum of its parts. Different factors may be more or less relevant depending on the specific circumstances and the goals of a partnership. The advantage of assessing partnership synergy is that it takes into account the dimensions of partnership functioning that are not assessed by standardised tools.

In conclusion, the partnership synergy framework is useful in assessing the intermediate outcomes of ongoing partnerships when it is too early to assess the achievement of long-term intended outcomes. Partnership synergy, partnership structures, enabling processes and tangible/intangible assets appear to be critical contributors to partnership effectiveness, and their assessment should be incorporated into routine partnership evaluation starting with baseline assessment. However, just as there is no single best way to organise a partnership, there is no "one size fits all" approach to evaluation (El Ansari et al., 2001). Ultimately, the evaluation approach adopted will depend on the availability of resources in a given partnership, the purpose of evaluation and the intended users of its results.

8.3 THE IMPORTANCE OF ASSESSING PARTNERSHIP PROCESSES AND TAKING STOCK OF ASSETS AND BENEFITS

This investigation also offers several contributions to understanding partnership processes among stakeholders collaborating towards a common goal of transforming PHC. By demonstrating an association between synergy and enabling processes, this research underlines the operational importance of investing in and paying attention to partnership processes as part of achieving both partnership synergy and the intended outcomes of the multi-stakeholder partnership. Although there was variation between individual partnerships in the emphasis of different processes, overall some key processes emerged.

The qualitative part of this study revealed that synergistic action among multiple stakeholders was achieved through enabling processes at the interpersonal, operational and system levels. The subsequent quantitative study focussed primarily on operational processes for feasibility reasons. Survey results revealed that partnership synergy was associated with the following dimensions of partnership functioning: leadership, administration and management, decision-making, and the ability of partnerships to optimise the involvement of its partners. The dimensions of administration and management and decision-making appeared to be more critical to determining the achievement of partnership synergy.

The study findings also support the importance of recruiting partnership stakeholders with varied, but complementary expertise. Both qualitative and quantitative results revealed that the level of partnership synergy was associated with the sufficiency of non-financial or intangible resources. The findings were more mixed in relation to tangible resources. While the qualitative findings pointed to the critical importance of the (research-funded) coordinating infrastructure and demonstrated that partnerships were capable of mobilising tangible resources to sustain service interventions, the quantitative results revealed a low correlation between financial resources and most other dimensions of partnership functioning and Partnership Synergy Outcomes. This low correlation suggests that while financial and other capital resources are important, non-financial resources, such as the skills and expertise of partners, may be more critical to creating partnership value. This finding is consistent with resource-based theory that suggests that intangible resources may be more valuable because they are more difficult to acquire and replicate (Barney & Clark, 2007; Das & Teng, 2000; Dierickx et al., 1989; Lev, 2004; Prahalad & Hamel, 1990).

Additionally, both qualitative and quantitative findings of this study underscore the importance of assessing the benefits of participating in the partnerships. While performing a detailed cost-benefit or cost-effectiveness analysis was beyond the scope of this study, the study generated preliminary insights into incentivising partnership participation. Among the different benefits identified, the benefits of participation to the stakeholders' respective organisations seemed to be more important than personal benefits. While many participants attested to individual learning, discussions regarding benefits tended to be framed around the fit between the strategic objectives of the partnerships and those of the groups or organisations that stakeholders represented. This finding is not surprising, given that partnership stakeholders in this study did not join the partnership as separate individuals. The finding resonates with existing literature that identifies benefits to partner organisations as a distinct arm of effectiveness, different from the achievement of intended goals of the partnership (Clarke & MacDonald, 2019). It also suggests that incentive management – the process of continuously ensuring that incentives of participation outweigh the costs – is an important consideration in maintaining effective partnerships.

Incentive mechanisms are important when PHC stakeholders first consider partnering and subsequently in deciding to continue their involvement over the length of time that is required to produce change (Keleher, 2015a). Partnership literature stresses that incentives need to be tailored to the specific needs and realities of the different partnership stakeholders (Prestby, Wandersman, Florin, Rich, & Chavis, 1990). According to the typology of Clark and Wilson (Clark & Wilson, 1961), incentives could be material (tangible incentives such as remuneration), solidarity (intangible incentives such as a sense of group membership and identification), and purposive (intangible incentives, related to the ends being sought, e.g., elimination of inefficiency or corruption in the public service). The Romanow report (Romanow, 2002) outlined a series of incentives applicable more broadly to the field of primary health care: financial incentives (e.g., the way health care personnel are remunerated); certainty and stability (e.g., that new models of care will not be quickly replaced); recognition (e.g., of the value of front-line staff); work-life conditions (e.g., more variety in the type of work); and quality of care (better quality care as a strong incentive for both health care providers and patients). Incentives for participating in a multi-stakeholder health partnership range from the prospect of meeting specific organisational targets

in relation to reducing unmet PHC needs to an opportunity for a face-to-face exchange with other key stakeholders in the PHC field.

Two disincentives associated with partnerships mentioned in the course of qualitative interviews were the required time partnerships take and the expense of participation – a finding that is consistent with the literature (Dowling et al., 2004). Meetings between stakeholders are expensive, requiring resources for coordination and presence of organisational employees, and they are also time-consuming representing opportunity cost. In the case of any disagreement between stakeholders, these costs are even higher (Dowling et al., 2004). For primary care physicians who are remunerated on a fee-for-service basis, the time that is required for preparatory work, for attending the meetings and for any necessary follow-up represents a loss of income. In the university environment, incentives for faculty members include tenure, promotion and merit increases, most of which are based on research outputs that cannot be easily achieved by partaking in activities off-campus; partnerships usually take time to yield any publication benefits (Cortes, 1998). This structure of incentives creates disincentives for researchers, particularly early-career investigators, to participate in partnerships.

According to most participants in this study, the benefits of participation outweighed the drawbacks. One of the vivid examples came from the Primary Care Connection Partnership that was unfolding in the climate of a significant health reform. Primary care physicians had been mandated by the Minister of Health to ensure that 85 percent of the province's residents were assigned to family physicians by the end of 2017. The intervention of the IMPACT local partnership in this Canadian province had been designed to facilitate this uptake, by providing support to family physicians in the process of accepting new vulnerable patients. This purposive incentive appeared to outweigh the costs of partnership participation associated with the loss of income for family doctors who worked within the fee-for-service remuneration structure.

In sum, the findings of this study are coherent with the literature that emphasises the importance of partnership enabling processes, membership dynamics and process evaluation (Israel et al., 2010; Lindquist-Grantz & Vaughn, 2016; Schulz, Israel, & Lantz, 2003). Devising solid processes at the start, then paying ongoing attention to how they are implemented – especially formally evaluating them – allows partnerships to overcome specific challenges including conflict between members and lack of stakeholder engagement. It is critical to reflect on all necessary

process steps associated with each partnership development stage as outlined in section 2.5 (*Conceptualising Effective Partnerships*), with an understanding that the progression is not linear and some process steps may have to be repeated. The importance of partnership processes also lies in their ability to serve as intuitive intermediate indicators of whether the partnership is working well, before evaluation, including the assessment of synergy, can be undertaken (Lindquist-Grantz & Vaughn, 2016). Indeed, in the absence of formal progress indicators, many interview respondents in this study evaluated partnership progress based upon their perceptions of how well partnership processes were unfolding. Examples included consistent ongoing communication about partnership activities and processes to facilitate continued stakeholder engagement, such as checking in with every stakeholder attending a partnership meeting, to ensure that all voices were heard.

This study highlights the importance of intentionality in ensuring that partnership processes work well. Due to the organisational structure and type of IMPACT funding, the partnerships were largely driven by the research teams. The onus to ensure that partnership processes were followed fell on the research teams. Part of this intentionality was the periodic evaluation of the health of the partnerships.

8.4 LIMITATIONS

The results of this research need to be interpreted in light of the study's limitations. Table 8-1 below outlines the limitations and the mitigation strategies that were considered and applied to minimise the impact of these limitations.

Table 8-1. Study limitations and mitigation strategies to overcome some of these limitations

Category	Limitation	Mitigation Strategy
Investigator bias	The study of the partnership aspects was conducted by one doctoral candidate. Individual biases may have affected the coding and interpretation of data.	The candidate is experienced in qualitative and quantitative data gathering, coding and analysis. The following strategies were employed to reduce the effect of potential investigator bias: a) triangulation from multiple sources of evidence; b) explicit acknowledgement of researcher's beliefs and assumptions; c) keeping an "audit trail" to document decisions made throughout the research process; and d) detailed descriptions of methodology and methods to allow peer scrutiny (Shenton, 2004). The coding frames and analytic plan, as well as quantitative data analysis approach were developed and validated with supervisors.
Positive response bias	Participants may have provided a more favourable assessment of the partnerships, given the voluntary nature of engagement and the stage of the partnerships by which those who did not see value in participating would have resigned. In addition, participants may have provided socially desirable (van de Mortel, 2008) replies in their self-reports. The quantitative results demonstrated adequate variability and range in responses, suggesting that the mitigation strategies allowed differentiation between partnerships.	The use of purposive sampling for qualitative data collection entailed selecting a mix of seasoned and new partnership participants to be interviewed. Attempts were made to invite stakeholders demonstrating high and low levels of participation, based on prior observation of meetings. The semi-structured interview format allowed the interviewer to explore negative cases. In the quantitative phase, the use of items that would encourage social desirability was minimised.

Category	Limitation	Mitigation Strategy
Limited transferability/generalisability	The samples for both phases of the study were small. The statistical power is limited in quantitative results. Moreover, participants were sampled from a single funded international programme of research with a targeted scope of implementing organisational interventions to improve accessibility to PHC, for a particular vulnerable population. Though the transferability and generalisability of the study's findings may be limited, the findings are likely robust for academic partnerships with partners in the formal health care system around PHC access.	Contextual descriptions were provided for each of the two IMPACT local partnerships that were part of the qualitative investigation, allowing other scholars and partnership practitioners to determine whether and how the results might be applicable in different contexts. For the quantitative phase, recommended statistical procedures were used and the analysis was supplemented with qualitative information by independent content reviewers. In addition, survey data were supplemented with information generated throughout the qualitative phase. Despite the specificity of partnerships under investigation, there was enough heterogeneity among them, in terms of their contexts, their composition and how the partnerships evolved, to assess partnership performance across various settings. The commonality of overall objective and harmonisation of processes within the research programme was a strength rather than a weakness in this case, in that the common framework allowed the differences to be more evident and for the researcher to be more confident in identifying where there were divergences in processes.
Overrepresentation of one group of stakeholders	Academic representatives constituted the largest single constituent group in the partnerships and of survey respondents in each partnership, which might have influenced the results. Despite the fact that most survey questions were fairly generic, they may have elicited different meaning for different participant groups (El Ansari et al., 2001). The survey was nonetheless able to differentiate between partnerships; it is unclear whether increasing non-academic responses would increase or decrease capacity to discriminate between partnerships.	As per recommendations in the literature (Dillman et al., 2014), several reminders were sent to non-academic survey respondents. Subsequent research needs to focus on devising strategies to encourage more non-academic stakeholders to participate in the survey exercise.

Category	Limitation	Mitigation Strategy
Single theoretical focus	The study, especially the survey, focussed on the partnership manifestations identified in partnership synergy theory. Some important aspects of partnership functioning may have remained unexplored. Additional theories were found to be appropriate at the analysis and synthesis stage.	The partnership dimensions were selected in alignment with the chosen theoretical framework and based on observations of partnership meetings. Other aspects of partnership will have to be explored in future studies.
Limited capacity to make causal inference	Due to the single administration of the PSAT, the causality and temporality of associations between the dimensions of partnership functioning and the level of partnership synergy achieved could not be inferred (nor was it an intent). Taking into consideration that the partnerships were evolving, a separate tool to measure the effectiveness of partnership outcomes was not used. Therefore, it was not possible to demonstrate definitively that partnership synergy was a determinant of partnership effectiveness.	The mixed methods nature of the study allowed to generate insights into the contribution of several factors to partnership synergy. The results pertaining to the outcomes of the developed IMPACT interventions are reported elsewhere (Spooner et al., 2021). The association between partnership functioning dimensions and partnership synergy is worthy of more research.
Cross-language research	Conducting this research in both English and French may have resulted in certain lack of equivalence in translating specific terms for the survey, or attaching French interview elements to English coding.	The translation of the interview guide was outsourced to a professional medical translation service. The interview protocol and the questionnaire underwent cognitive testing in both languages with professionals familiar with the terminology, to ensure comprehensibility and to capture all of the nuances in both languages. As per the recommendations in the literature, the analysis of data was undertaken in the language that participants used, in order to reduce the loss of meaning (van Nes, Abma, Jonsson, & Deeg, 2010). Translation of quotations was delayed until later stages of the research, for knowledge transfer purposes.

8.5 CONSIDERATIONS FOR FUTURE LINES OF INQUIRY

Although the phenomenon of multi-stakeholder partnerships has received a great deal of attention across a wide spectrum of disciplines, there are a number of areas that require further exploration. The first line of inquiry concerns the phenomenon of partnership synergy. Taking into consideration the highly contingent nature of partnerships, future empirical studies should describe other manifestations of partnership synergy. In terms of the relationship between partnership assets, processes and synergy, future studies could examine how partnership synergy fluctuates based upon partnership inputs and describe the contextual and internal conditions under which synergy is more likely to emerge.

Gaining a deeper understanding of the various expressions of partnership synergy would inform the refinement of its measures. Chapter 6 (*Manuscript 2*) referred to differences between the constructs of synergy process and outcomes, suggesting the need for further development of separate partnership synergy processes and partnership synergy outcomes measures. Once refined, the synergy process and outcomes sub-scales could be administered longitudinally, at various stages in the partnership evolution, to determine if one is more applicable within the scope of partnership process improvements, and the other as part of outcome evaluation; and whether both sub-scales yielding similar results only occurs at a certain point in partnership development.

This study demonstrated the utility of one partnership self-assessment tool, namely the PSAT, even in a limited sample of ongoing partnerships working towards improving PHC. However, the sub-scales of Communication and External Environment had limitations and this research could not demonstrate definitively that partnership synergy was a precursor of partnership effectiveness. In addition, the PSAT was not administered longitudinally. Future research can focus on refining the PSAT further and establishing the tool's utility as a longitudinal measure of change. The tool would benefit from an addition of validated sub-scales measuring communication and the influence of external context. It could also incorporate a separate measure of effectiveness reflecting all three dimensions of partnership effectiveness (outcomes, processes and benefits to partners). This measure of effectiveness would be relevant in the latter stages of the partnership life cycle and would allow drawing quantitative conclusions about the relationship between partnership synergy and effectiveness. Based upon conclusions regarding leadership (outlined in Chapter 7. *Manuscript 3*) more research is required to support a revision of the PSAT Leadership

sub-scale, which presently does not reflect the distributed and contingent nature of partnership leadership.

This research has also demonstrated the importance of assessing the structural components of partnerships, particularly in comparative research. However, the assessment of structure was confined to the qualitative phase of the project. Tools to identify, describe and evaluate structural elements of partnerships exist (for example, Browne et al., 2004) and future empirical research should incorporate these tools in their assessment of partnerships.

The success of any partnership is contingent not only on the achievement of the intended outcomes, but also on each partner or stakeholder group realising positive results from the partnership (Clarke & MacDonald, 2019). While some aspects of incentive management were described in this research, a more comprehensive analysis of the role of incentive management in multi-stakeholder partnerships is warranted.

Finally, the in-depth exploration of the challenges of partnering was beyond the scope of this research. Given that this research adopted an appreciative, asset-based stance, it primarily focussed on the facilitators of synergy. Multi-stakeholder partnerships are inherently complex and unpredictable (Henderson et al., 2020). While Chapter 5 (*Manuscript 1*) described the impact of the changing context on synergy, exploration of how partners dealt with such stressors as internal conflict was limited. Future research could document the role of conflict in contributing to either partnership synergy or antagonism (a cumulative effect that is less than the sum of the parts) (Folt et al., 1999).

CHAPTER 9. Conclusions

This doctoral research focussed on understanding multi-stakeholder partnership processes and how various partnership factors contribute to partnership effectiveness. The focus of the study was on partnerships involving multiple stakeholders working across the boundaries between clinical practice, research, health system management and health care policy – collaborating towards a common goal of improving accessibility to PHC for vulnerable populations. The partnerships were analysed using partnership synergy, contingency theory and resource-based frameworks. This investigation offers several theoretical and practical contributions aiming to improve understanding, practice and evaluation of resource requirements and processes and outcomes of partnerships in primary health care. Based on the findings of this empirical exploratory mixed methods research, the following conclusions were obtained:

1. Partnership synergy is multi-dimensional and dynamic. It manifests in different ways and fluctuates as partnerships evolve, increasing and weakening depending on internal and external factors.
2. Partnership synergy contributes to sustaining partnerships, by acting as a partnership facilitator.
3. The ability of multiple stakeholders to achieve partnership synergy is enabled by processes at interpersonal, operational and system levels. In this study, partnership synergy was associated with the following dimensions of partnership functioning: leadership, administration & management, decision-making, and the ability of partnerships to optimise the involvement of its partners. It was also associated with sufficiency of non-financial resources or intangible assets. Administration & management and decision-making seemed to be more critical to determining achievement of partnership synergy. The study findings also support the importance of recruiting partnership stakeholders with varied, but complementary expertise and of benefits to the stakeholders' respective organisations.
4. Evaluating partnership synergy, qualitatively and quantitatively, as an evolving indicator of partnership health, at different points in the partnership's life would allow collection of data on other processes that might have contributed to higher (or lower) levels of partnership synergy over time. In addition, observing fluctuations in partnership synergy

and partnership functioning dimensions scores may allow researchers to infer the relative importance of these dimensions to synergy.

5. It may not be feasible or necessary to capture all possible dimensions of partnership functioning to be studied or assessed, for partnership synergy amounts to more than the sum of its parts. Given that partnerships are inherently complex, highly contextual and constantly evolving organic entities, different factors may be more or less relevant depending on the specific circumstances and the goals of a partnership.
6. The partnership synergy framework is useful in assessing the intermediate outcomes of ongoing partnerships when it is too early to assess the achievement of long-term intended outcomes.
7. Assessment of partnership synergy, along with partnership processes and the sufficiency of partnership assets, should be incorporated into routine partnership evaluation starting with baseline assessment.
8. The PSAT is a valuable evaluation tool. It is suitable for assessing achievement of partnership synergy and the performance of partnerships along specific indicators of partnership functioning in partnerships that are underway. The tool supports identification of areas of strength and potential improvement to achieve collaborative advantage. The tool may have broader applicability to partnerships in PHC, and arguably beyond PHC.
9. The holistic nature of partnerships is effectively captured through assessment of various partnership components longitudinally and by using mixed methods to allow for collection of different types of data.

In conclusion, this work has contributed to the evolving body of knowledge on partnership synergy as a useful framework for studying collaborative ventures and identified the main ingredients or requirements for synergistic partnerships. These requirements should be considered in order to determine if working in partnership should and can reasonably be pursued. This study could not demonstrate definitively if partnership synergy was indeed a determinant of partnership effectiveness (i.e., the achievement of intended outcomes). However, most survey respondents in all studied partnerships reported the achievement of both added value and the goal of developing a meaningful partnership, and that the benefits of participation largely outweighed the drawbacks.

When partnerships experience decreased synergy, the evolving synergy model proposed in this research may be useful as a diagnostic tool allowing the identification of sources of partnership functioning problems and solutions to address them, paying particular attention to the interplay of variables. Optimal configurations of these processes and their interaction with partnership assets and context can be highly variable, depending on the specifics of each partnership. These findings reinforce contingency theory concepts, in that they reflect the complexity in partnership work and suggest that there is more than one way of organising and reaching partnership synergy.

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Appendix A. E-mail Consent from Co-authors to Include Manuscripts in the Thesis

Dr. Catherine Scott

From: Cathie Scott <cathie@k2aconsulting.ca>

Sent: Monday, August 9, 2021 4:01 PM

To: Jeannie Haggerty, Dr. <jeannie.haggerty@mcgill.ca>

Cc: Catherine Scott <cmscott@ucalgary.ca>; Katya Loban <ekaterina.loban@mail.mcgill.ca>; Susan Law <susan.law@utoronto.ca>; Virginia Lewis <V.Lewis@latrobe.edu.au>

Subject: Re: Consent from co-authors to include manuscripts in thesis

I also consent to the inclusion of the manuscripts in your dissertation.

Cathie

Dr. Jeannie Haggerty

From: Jeannie Haggerty, Dr. <jeannie.haggerty@mcgill.ca>

Sent: Monday, August 9, 2021 9:37 AM

To: Susan Law <susan.law@utoronto.ca>; Katya Loban <ekaterina.loban@mail.mcgill.ca>; Cathie Scott - K2A <cathie@k2aconsulting.ca>; Catherine Scott <cmscott@ucalgary.ca>; Virginia Lewis <V.Lewis@latrobe.edu.au>

Subject: RE: Consent from co-authors to include manuscripts in thesis

This is to confirm that I consent to the inclusion of the below-mentioned manuscripts in your doctoral thesis.

Jeannie Haggerty

Research Chair in Family & Community Medicine at St. Mary's

McGill Department of Family Medicine.

Mobile +1-514-608-8352

Jeannie.haggerty@mcgill.ca

Dr. Virginia Lewis

From: Virginia Lewis <V.Lewis@latrobe.edu.au>

Sent: Sunday, August 8, 2021 8:02 PM

To: Katya Loban <ekaterina.loban@mail.mcgill.ca>

Subject: RE: Consent from co-authors to include manuscripts in thesis

Dear Katya,

I consent to inclusion of the manuscripts below in your doctoral thesis.

Best wishes,

Virginia

Professor Virginia Lewis, PhD

Research Chair in Community Health

Head, Centre for Health Systems Development

Appendix A. E-mail Consent from Co-authors to Include Manuscripts in the Thesis

Australian Institute for Primary Care & Ageing
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College of Science, Health & Engineering
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www.latrobe.edu.au/aipca

Editor-in-Chief Australian Journal of Primary Health <http://www.publish.csiro.au/py> Subscribe
to early alert
Call for papers for Special Issues: <http://www.publish.csiro.au/py/content/CallforPapers>

Dr. Susan Law

From: Susan Law <susan.law@utoronto.ca>

Sent: Sunday, August 8, 2021 6:53 PM

To: Katya Loban <ekaterina.loban@mail.mcgill.ca>; Jeannie Haggerty, Dr.
<jeannie.haggerty@mcgill.ca>; Cathie Scott - K2A <cathie@k2aconsulting.ca>; Catherine Scott
<cmscott@ucalgary.ca>; Virginia Lewis <V.Lewis@latrobe.edu.au>

Subject: Re: Consent from co-authors to include manuscripts in thesis

With thanks Katya, this is to confirm that I consent to the inclusion of the manuscripts in your thesis. ☺

Regards, Susan

Susan Law, PhD, MHSc
Managing Director & Knowledge Mobilization Lead for CanCOVID
Associate Professor, IHPME, University of Toronto
Senior Scientist, Trillium Health Partners – Institute for Better Health
Adjunct Professor, Department of Family Medicine, McGill University

Original Request

From: Katya Loban <ekaterina.loban@mail.mcgill.ca>

Date: Sunday, August 8, 2021 at 6:10 PM

To: Jeannie Haggerty, Dr. <jeannie.haggerty@mcgill.ca>, Cathie Scott - K2A
<cathie@k2aconsulting.ca>, Catherine Scott <cmscott@ucalgary.ca>, Susan Law
<susan.law@utoronto.ca>, Virginia Lewis <V.Lewis@latrobe.edu.au>

Subject: Consent from co-authors to include manuscripts in thesis

Dear Co-authors,

In compliance with the regulations of Graduate and Postdoctoral Studies of McGill University
(<https://www.mcgill.ca/gps/thesis/thesis-guidelines/general-requirements>
), I would like to request your written consent to include the manuscripts that you co-authored as
part of my doctoral thesis.

Appendix A. E-mail Consent from Co-authors to Include Manuscripts in the Thesis

The manuscripts in question are:

Manuscript 1:

Loban, E., Scott, C., Lewis, V., Law, S., & Haggerty, J. Improving primary health care through partnerships: Key insights from a cross-case analysis of multi-stakeholder partnerships in two Canadian provinces. Submitted to *Health Science Reports*.

Manuscript 2:

Loban, E., Scott, C., Lewis, V., & Haggerty, J. (2021). Measuring partnership synergy and functioning: Multi-stakeholder collaboration in primary health care. *PLOS One*, 16(5), e0252299. doi:10.1371/journal.pone.0252299

Manuscript 3:

Loban, E., Scott, C., Lewis, V., Law, S., & Haggerty, J. Activating partnership assets to produce partnership synergy in primary health care: A mixed methods study. Submitted to *Healthcare*.

A reply to this e-mail with your full name and confirmation that you provide consent would suffice.

Thank you,
Katya

Ekaterina (Katya) Loban, MA, LLM
Doctoral Student / Étudiante au doctorat
Department of Family Medicine / Département de médecine de famille
McGill University / Université McGill
St. Mary's Research Centre / Centre de Recherche de St. Mary
Contributing Editor, *CFP* / Collaboratrice de rédaction, *MFC*

Health Promotion Partnerships

Partner questionnaire¹

Dr Jacky Jones
Functional Manager Health Promotion
Health Promotion Services
Health Service Executive West
West City Centre
Seamus Quirke Road
Galway
Republic of Ireland

If you need any information about this survey, please contact me at:

Tel + 353 91 548320/548322
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Email Jacky.Jones@hse.ie

¹ Changes have been made to the original questionnaire following the successful completion of PhD.
Superfluous questions have been removed and scales given are those which emerged from the factor analysis.

Appendix B. Partner Questionnaire

Thank you for agreeing to complete this questionnaire and participating in my study on partnership working.

This number is to help me when I am analysing the results. No individual person or partnership will be identified anywhere in the final report.

Questionnaire No.			

Please answer the following questions in relation to _____

- Answer most questions by circling the number beside the response that you think is most applicable
- Where appropriate, please write your answers in the space provided
- Be sure to read all the answer choices before making your answer

Q1 What is your **main** role in the partnership?
PLEASE CIRCLE ONE ANSWER ONLY

Member	1
Chair	2
Lead person	3
Paid staff	4
If other, please say what your role is:	

Q2 How many **hours per month** do you devote to the activities of the partnership?

_____ Approximate hours per month

Appendix B. Partner Questionnaire

Q3 Which is the **main** organisation that you represent on the partnership?

PLEASE CIRCLE ONE ANSWER ONLY

Health Service Executive	1
Education (schools)	2
Government agency	3
Community/Voluntary group	4
Local authority	5
Sports sector	6
Member of the public	7
University sector	8
Private sector	9
Youth sector	10
An Garda Síochána	11
Professional organisation	12
General Practitioner	13
Church	14
If other, please say what it is	

Q4 If you represent a particular profession or discipline on the partnership (e.g. dietitian, nurse, etc.), please say what it is:

Q5 How long have you been employed in your current discipline?

_____ Please give your answer in years

Appendix B. Partner Questionnaire

- Q6 How often do you report back to your own **organisation** about the partnership's activities? **PLEASE CIRCLE ONE ANSWER ONLY IN EACH COLUMN**

Frequency of reporting	Report back to organisation
After every meeting	5
Every month	4
About every three months	3
About every six months	2
Once a year	1
I do not report back	0
If other, please say how often:	

- Q7 Does the partnership do any of the following to help people understand each other's unique contribution better?

PLEASE CIRCLE AS MANY AS APPLY

At the beginning of the partnership asking partners to state their unique contribution	1
Day out/away days	2
Social events	3
Dinner/lunch together	4
Celebrate together	5
Planning days	6
Presentations from partners on their organisations	7
Share tasks or work together on the work of the partnership	8
Having ground rules (e.g. confidentiality)	9
Time to talk before and after meetings	10
Clarify the language of different organisations	11
Bring in a facilitator if necessary	12
If other, please say what:	

Appendix B. Partner Questionnaire

Q8 For each of the following, to what extent does your partnership have what it needs to work effectively? **PLEASE CIRCLE AS MANY AS APPLY**

CODE IN GRID (PLEASE CIRCLE NUMBER)

Unique contribution	All of what it needs	Most of what it needs	Some of what it needs	Almost none of what it needs	None of what it needs	Don't know
Scientific/technical expertise	5	4	3	2	1	0
Links to other groups and target populations	5	4	3	2	1	0
Legal authority	5	4	3	2	1	0
Convening power	5	4	3	2	1	0
The public's perspective	5	4	3	2	1	0
Data and information necessary	5	4	3	2	1	0
Buildings, accommodation, equipment, space	5	4	3	2	1	0
Financial support	5	4	3	2	1	0
Local knowledge	5	4	3	2	1	0
Creativity	5	4	3	2	1	0
Credibility with the people affected by the partnership's work	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q9 For each of the following skills, to what extent does your partnership have what it needs to work effectively? **PLEASE CIRCLE AS MANY AS APPLY.**

CODE IN GRID (PLEASE CIRCLE NUMBER)

Skills	All of what it needs	Most of what it needs	Some of what it needs	Almost none of what it needs	None of what it needs	Don't know
Strategic thinking skills	5	4	3	2	1	0
Ability to see new opportunities	5	4	3	2	1	0
Mediation skills	5	4	3	2	1	0
Problem-solving skills	5	4	3	2	1	0
Consensus building skills	5	4	3	2	1	0
Networking skills	5	4	3	2	1	0
Group development skills	5	4	3	2	1	0
Influencing skills	5	4	3	2	1	0
Policy development skills	5	4	3	2	1	0
Interpersonal skills	5	4	3	2	1	0
Trust-building skills	5	4	3	2	1	0
Conflict resolution skills	5	4	3	2	1	0
Negotiating skills	5	4	3	2	1	0
Ability to work effectively with the community	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q10 How often does the following happen in your partnership?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Always	Often	Sometimes	Rarely	Never	Don't know
Partners have hidden agendas and bring these into the partnership	5	4	3	2	1	0
The contributions of all partners are valued equally, irrespective of whether a majority agree or disagree with their point of view	5	4	3	2	1	0
Partners can be relied on to do what they say they will do for the partnership	5	4	3	2	1	0
Partners meet in unofficial groups to progress their own agenda with a view to undermining the main partnership agenda	5	4	3	2	1	0
The partnership is highly productive in relation to the work of the partnership	5	4	3	2	1	0
Partners withhold information of relevance to the partnership	5	4	3	2	1	0
Partners eagerly volunteer to take on tasks associated with the partnership	5	4	3	2	1	0
Partners' time and energy are wasted due to mistrust	5	4	3	2	1	0
Partner organisations behave in ways that benefit the partnership as a whole	5	4	3	2	1	0
The purpose of the partnership is clearly understood by all the partners	5	4	3	2	1	0
Partners are guarded about putting their ideas forward for discussion	5	4	3	2	1	0
Partners' roles are clearly understood and they fulfil these roles	5	4	3	2	1	0
Partners are supportive of each other	5	4	3	2	1	0
Partners keep the promises they make to the partnership	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q11 When **working together**, how often does your partnership experience the following?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Always	Often	Sometimes	Rarely	Never	Don't know
Feelings of energy, excitement and passion	5	4	3	2	1	0
Extra outcomes are achieved as a result of working in partnership	5	4	3	2	1	0
Work as a partnership to effectively problem-solve and overcome difficulties	5	4	3	2	1	0
Experience personal satisfaction and fulfilment from the activities of the partnership	5	4	3	2	1	0
The partnership is making ongoing progress towards its goals	5	4	3	2	1	0
All partners are benefiting from the activities of the partnership	5	4	3	2	1	0
The skills and unique perspectives of the partners complement each other	5	4	3	2	1	0
The work of the partnership is broken down and shared by all the partners	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q12 Please think about all of the people and organisations that are participants in your partnership. By working together how well are these partners able to ...?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Extremely well	Very well	Somewhat well	Not so well	Not well at all	Don't know
Identify new and creative ways to solve problems	5	4	3	2	1	0
Include the views and priorities of the people affected by the partnership's work	5	4	3	2	1	0
Develop goals that are widely understood and supported among partners	5	4	3	2	1	0
Identify how different services and programmes relate to the problems the partnership is trying to address	5	4	3	2	1	0
Respond to the needs and problems of the people affected by the partnership's work	5	4	3	2	1	0
Implement strategies that are most likely to work for the people affected by the partnerships work	5	4	3	2	1	0
Obtain support from individuals and organisations that can either block the partnership's plans or help move them forward	5	4	3	2	1	0
Carry out comprehensive activities that connect multiple services, programmes, or systems	5	4	3	2	1	0
Clearly communicate to the people affected by the partnership's work how the partnership's actions will address problems that are important to them	5	4	3	2	1	0

Appendix B. Partner Questionnaire

- Q13 Please describe the working of the partnership using an **image** from the natural world or a **metaphor** that you think best describes it. For example, “*when it’s working well this partnership is an orchestra*” or “*this partnership is like a well tended garden*”. Also please say why.

When it’s working well this partnership is a ... _____

- Q14 Please think of all of the people who provide either formal or informal leadership in your partnership. Please rate the **total effectiveness** of your partnership’s **leadership** in each of the following areas:

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Excellent	Very good	Good	Fair	Poor	Don’t know
Taking responsibility for the partnership	5	4	3	2	1	0
Inspiring or motivating people involved in the partnership	5	4	3	2	1	0
Empowering people involved in the partnership	5	4	3	2	1	0
Communicating the vision of the partnership	5	4	3	2	1	0
Working to develop a common language within the partnership	5	4	3	2	1	0
Fostering respect, trust, inclusiveness and openness in the partnership	5	4	3	2	1	0
Creating an environment where differences of opinion can be voiced	5	4	3	2	1	0
Resolving conflict among partners	5	4	3	2	1	0
Combining the perspectives, resources and skills of partners	5	4	3	2	1	0
Helping the partnership to look at things differently and be creative	5	4	3	2	1	0
Recruiting diverse people and organisations into the partnership	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q15 Please rate the **effectiveness** of the partnership in carrying out each of the following activities:

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Excellent	Very good	Good	Fair	Poor	Don't know
Coordinating communication among partners	5	4	3	2	1	0
Coordinating communication with people and organisations outside the partnership	5	4	3	2	1	0
Organising partnership activities, including meetings and projects	5	4	3	2	1	0
Applying for and managing grants and funds	5	4	3	2	1	0
Preparing materials that inform partners and help them make timely decisions	5	4	3	2	1	0
Performing secretarial duties	5	4	3	2	1	0
Providing orientation to new partners as they join the partnership	5	4	3	2	1	0
Evaluating the progress and impact of the partnership	5	4	3	2	1	0
Minimising the barriers to participating in the partnership's meetings and activities (e.g. by holding them at convenient places and times, and by providing transportation and childcare, etc.)	5	4	3	2	1	0
Accurately reflecting discussions and decisions in the minutes of meetings or other documentation	5	4	3	2	1	0

Q16 What is the **main** way decisions are made in the partnership? **PLEASE CIRCLE ONE ANSWER ONLY.**

Consensus (discussion and then everyone agrees)	5
Voting/show of hands	4
Official subcommittees decide	3
Chair/leader decides	2
Made by a few partners outside the partnership meetings	1
Don't know	0
If other, please say what it is:	

Appendix B. Partner Questionnaire

Q17 How **efficiently** does your partnership use the following partnership resources?

	Very efficiently	Efficiently	Neither efficiently or inefficiently	Inefficiently	Very inefficiently	Don't know
Financial resources (including those of any partners)	5	4	3	2	1	0
In-kind resources (partners' skills, experience, knowledge, etc.)	5	4	3	2	1	0
Partners' and partnership time	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q18 Here is a list of people that may have a role in partnerships for health. In your partnership, which partners, **not currently present**, could have a unique contribution to make to your partnership? **PLEASE CIRCLE AS MANY AS APPLY.**

Partners	Extra partners that could benefit the partnership
Unemployed people	1
Parents	2
Business people	3
Doctors	4
Army	5
Low-income people	6
Culture/arts/theatre groups	7
Young people	8
Older people	9
Drinks industry	10
Food industry	11
Local authorities	12
Policy makers	13
Farmers	14
Teachers/education sector	15
Students/pupils	16
Justice system	17
Banks	18
Media	19
Building industry	20
Self-help groups	21
Community and voluntary groups	22
Researchers	23
Members of the public(s)	24
Trade unions	25
Tourism industry	26
University and third level partners	27
Transport sector	28
Church	29
Green/ecology movements	30
Employers	31
Minority Ethnic Groups	32
If other, please say who they are:	

Appendix B. Partner Questionnaire

- Q19 Has anyone in your organisation used the work of the partnership to progress the overall aims of your organisation?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Yes	No	Don't know
Myself	2	1	0
My line manager	2	1	0
Other managers within my organisation	2	1	0
Other employees of my organisation	2	1	0

- Q20 To what extent do you agree or disagree with the following in relation to the way your partnership works?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Strongly agree	Agree	Neither agree not disagree	Disagree	Strongly disagree	Don't know
Partners draw their own 'patch' to the detriment of the work of the partnership	5	4	3	2	1	0
Partners from different sectors have been trained to cooperate and this helps to progress the partnership	5	4	3	2	1	0
The way health professionals have been trained and socialised 'on the job' is a barrier to partnership working	5	4	3	2	1	0
The way the health services are perceived by the partners is a help to effective partnership	5	4	3	2	1	0
The partnership has a common language for talking about health	5	4	3	2	1	0
The different 'world views' and 'mind sets' of the partners impedes partnership working	5	4	3	2	1	0
Professionals have been trained in a discipline but not in working together and this impedes the progress of the partnership	5	4	3	2	1	0
Professionals on the partnership have a tendency to assume they know the answers before the questions have even been asked	5	4	3	2	1	0
The partners bring their own organisation's cultures to the partnership and this makes the work very easy	5	4	3	2	1	0

Appendix B. Partner Questionnaire

Q21 When working together, how often do the following happen in your partnership?

CODE IN GRID (PLEASE CIRCLE NUMBER)

	Always	Often	Sometimes	Rarely	Never	Don't know
Credit is shared among all the partners	5	4	3	2	1	0
Partners try to control access to those who are seen to have power, to the detriment of the partnership	5	4	3	2	1	0
Power is shared equally between partners	5	4	3	2	1	0
Partners withhold their expertise or apply it arrogantly	5	4	3	2	1	0
Partners act or speak inconsistently so others don't know what to expect	5	4	3	2	1	0
Partners don't contribute even when their contribution would benefit the partnership	5	4	3	2	1	0
Partners can choose their level of involvement in the work of the partnership and have that choice respected	5	4	3	2	1	0
One or more partners abuse their power in the partnership	5	4	3	2	1	0
Decisions are made by a minority of partners outside of the main partnership meetings	5	4	3	2	1	0

Q22 Does the partnership undertake research and evaluation into whether the goals of the partnership are being achieved?

Yes	1
No	2
Don't know	0

Appendix B. Partner Questionnaire

Q23 To date, has your partnership achieved **measurable** outcomes for any of the following:
(‘Outcome’ meaning the effect on the people affected by the partnership’s work)

CODE IN GRID (PLEASE CIRCLE NUMBER)

Achievements	Yes	No	Did not actually measure outcomes	Don’t know
Change in the health status of individuals	1	2	3	0
Change in the capacity of community members	1	2	3	0
Environment changes that positively affected the community	1	2	3	0
Policy changes that affected people in a positive way	1	2	3	0
Service changes that affected people in a positive way	1	2	3	0
Skill changes in people affected by the partnership’s work	1	2	3	0
Behaviour changes in people affected by the partnership’s work	1	2	3	0
Attitude changes in people affected by the partnership’s work	1	2	3	0
Knowledge changes in people affected by the partnership’s work	1	2	3	0
Other, please specify:				

Finally, some personal questions.

Q24 Are you ...?

Female	1
Male	2

Q25 How old are you?

Under 20	1
20-29	2
30-39	3
40-49	4
50-59	5
60-69	6
70 years or over	7

Appendix B. Partner Questionnaire

Q26 What is your education level? **PLEASE CIRCLE THE HIGHEST THAT APPLIES**

Primary school	1
Intermediate/Junior Certificate	2
Leaving Certificate or equivalent	3
Third level – Certificate	4
Third level – Diploma	5
Third level – Primary Degree	6
Third level – Higher Diploma	7
Third level – Masters Degree	8
If other, please state:	

Q27 Is there anything else you would like me to know about your experiences in this partnership?

Please check that you have answered all questions.

Thank you for completing this questionnaire.

PARTNERSHIP

SELF-ASSESSMENT

TOOL

Questionnaire

Instructions

This questionnaire asks questions about different aspects of your partnership. It will take about 15 minutes to complete.

The questionnaire allows you to express your opinions and provide information about your experiences anonymously. **DO NOT WRITE YOUR NAME ANYWHERE ON THE QUESTIONNAIRE** and your name will not be attached in any way to the responses you give.

By answering the questions, you will help your partnership learn about its strengths and weaknesses and about steps that your partnership can take in order to improve the collaboration process. The answers that people in your partnership give will be used to generate a report for your partnership. Only the people in your partnership will have access to this report.

There are no right or wrong answers to the questions. Thoughtful and honest responses will give your partnership the most valuable information. **Please answer every question, and please check only one answer per question.**

To complete the questionnaire:

- Please use a BLUE or BLACK ink pen.
- Be sure to read all the answer choices before marking your answer.
- Answer each question by placing a legible check mark or “X” in the box to the left of your answer, like this:

[√] Extremely well

OR

[X] Extremely well

- Please return the completed questionnaire in a manner that protects your anonymity, as instructed by your coordinator.

Appendix C. PSAT

Synergy

Please think about the people and organizations that are participants in your partnership.

- a. By working together, how well are these partners able to identify new and creative ways to solve problems?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- b. By working together, how well are these partners able to include the views and priorities of the people affected by the partnership's work?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- c. By working together, how well are these partners able to develop goals that are widely understood and supported among partners?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- d. By working together, how well are these partners able to identify how different services and programs in the community relate to the problems the partnership is trying to address?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- e. By working together, how well are these partners able to respond to the needs and problems of the community?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

Appendix C. PSAT

- f. By working together, how well are these partners able to implement strategies that are most likely to work in the community?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- g. By working together, how well are these partners able to obtain support from individuals and organizations in the community that can either block the partnership's plans or help move them forward?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- h. By working together, how well are these partners able to carry out comprehensive activities that connect multiple services, programs, or systems?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

- i. By working together, how well are these partners able to clearly communicate to people in the community how the partnership's actions will address problems that are important to them?

☐ Extremely well
☐ Very well
☐ Somewhat well
☐ Not so well
☐ Not well at all

Appendix C. PSAT

Leadership

Please think about all of the people who provide either formal or informal leadership in this partnership. Please rate the total effectiveness of your partnership's leadership in each of the following areas:

a. Taking responsibility for the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

b. Inspiring or motivating people involved in the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

c. Empowering people involved in the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

d. Communicating the vision of the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

e. Working to develop a common language within the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Appendix C. PSAT

Please rate the total effectiveness of your partnership's leadership in:

f. Fostering respect, trust, inclusiveness, and openness in the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

g. Creating an environment where differences of opinion can be voiced

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

h. Resolving conflict among partners

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

i. Combining the perspectives, resources, and skills of partners

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

j. Helping the partnership be creative and look at things differently

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Appendix C. PSAT

Please rate the total effectiveness of your partnership's leadership in:

- k. Recruiting diverse people and organizations into the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Efficiency

1. Please choose the statement that best describes how well your partnership uses the partners' financial resources.

- ☐ The partnership makes excellent use of partners' financial resources.
- ☐ The partnership makes very good use of partners' financial resources.
- ☐ The partnership makes good use of partners' financial resources.
- ☐ The partnership makes fair use of partners' financial resources.
- ☐ The partnership makes poor use of partners' financial resources.

2. Please choose the statement that best describes how well your partnership uses the partners' in-kind resources (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods).

- ☐ The partnership makes excellent use of partners' in-kind resources.
- ☐ The partnership makes very good use of partners' in-kind resources.
- ☐ The partnership makes good use of partners' in-kind resources.
- ☐ The partnership makes fair use of partners' in-kind resources.
- ☐ The partnership makes poor use of partners' in-kind resources.

3. Please choose the statement that best describes how well your partnership uses the partners' time.

- ☐ The partnership makes excellent use of partners' time.
- ☐ The partnership makes very good use of partners' time.
- ☐ The partnership makes good use of partners' time.
- ☐ The partnership makes fair use of partners' time.
- ☐ The partnership makes poor use of partners' time.

Appendix C. PSAT

Administration and Management

We would like you to think about the administrative and management activities in your partnership. Please rate the effectiveness of your partnership in carrying out each of the following activities:

a. Coordinating communication among partners

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

b. Coordinating communication with people and organizations outside the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

c. Organizing partnership activities, including meetings and projects

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

d. Applying for and managing grants and funds

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

e. Preparing materials that inform partners and help them make timely decisions

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Appendix C. PSAT

Please rate the effectiveness of your partnership in:

f. Performing secretarial duties

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

g. Providing orientation to new partners as they join the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

h. Evaluating the progress and impact of the partnership

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

i. Minimizing the barriers to participation in the partnership's meetings and activities (e.g., by holding them at convenient places and times, and by providing transportation and childcare)

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

Appendix C. PSAT

Non-financial Resources

A partnership needs non-financial resources in order to work effectively and achieve its goals. For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

- a. Skills and expertise (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, community organizing)
 - ☐ All of what it needs
 - ☐ Most of what it needs
 - ☐ Some of what it needs
 - ☐ Almost none of what it needs
 - ☐ None of what it needs
 - ☐ Don't know

- b. Data and information (e.g., statistical data, information about community perceptions, values, resources, and politics)
 - ☐ All of what it needs
 - ☐ Most of what it needs
 - ☐ Some of what it needs
 - ☐ Almost none of what it needs
 - ☐ None of what it needs
 - ☐ Don't know

- c. Connections to target populations
 - ☐ All of what it needs
 - ☐ Most of what it needs
 - ☐ Some of what it needs
 - ☐ Almost none of what it needs
 - ☐ None of what it needs
 - ☐ Don't know

- d. Connections to political decision-makers, government agencies, other organizations/groups
 - ☐ All of what it needs
 - ☐ Most of what it needs
 - ☐ Some of what it needs
 - ☐ Almost none of what it needs
 - ☐ None of what it needs
 - ☐ Don't know

Appendix C. PSAT

For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

e. Legitimacy and credibility

- ☐ All of what it needs
- ☐ Most of what it needs
- ☐ Some of what it needs
- ☐ Almost none of what it needs
- ☐ None of what it needs
- ☐ Don't know

f. Influence and ability to bring people together for meetings and activities

- ☐ All of what it needs
- ☐ Most of what it needs
- ☐ Some of what it needs
- ☐ Almost none of what it needs
- ☐ None of what it needs
- ☐ Don't know

Financial and Other Capital Resources

A partnership also needs financial and other capital resources in order to work effectively and achieve its goals. For each of the following types of resources, to what extent does your partnership have what it needs to work effectively?

a. Money

- ☐ All of what it needs
- ☐ Most of what it needs
- ☐ Some of what it needs
- ☐ Almost none of what it needs
- ☐ None of what it needs
- ☐ Don't know

b. Space

- ☐ All of what it needs
- ☐ Most of what it needs
- ☐ Some of what it needs
- ☐ Almost none of what it needs
- ☐ None of what it needs
- ☐ Don't know

Appendix C. PSAT

For the following type of resources, to what extent does your partnership have what it needs to work effectively?

c. Equipment and goods

- ☐ All of what it needs
- ☐ Most of what it needs
- ☐ Some of what it needs
- ☐ Almost none of what it needs
- ☐ None of what it needs
- ☐ Don't know

Decision Making

a. How comfortable are you with the way decisions are made in the partnership?

- ☐ Extremely comfortable
- ☐ Very comfortable
- ☐ Somewhat comfortable
- ☐ A little comfortable
- ☐ Not at all comfortable

b. How often do you support the decisions made by the partnership?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost none of the time
- ☐ None of the time

c. How often do you feel that you have been left out of the decision making process?

- ☐ All of the time
- ☐ Most of the time
- ☐ Some of the time
- ☐ Almost none of the time
- ☐ None of the time

Appendix C. PSAT

Benefits of Participation

For each of the following benefits, please indicate whether you have or have not received the benefit as a result of participating in the partnership.

- a. Enhanced ability to address an important issue

☐ Yes

☐ No

- b. Development of new skills

☐ Yes

☐ No

- c. Heightened public profile

☐ Yes

☐ No

- d. Increased utilization of my expertise or services

☐ Yes

☐ No

- e. Acquisition of useful knowledge about services, programs, or people in the community

☐ Yes

☐ No

- f. Enhanced ability to affect public policy

☐ Yes

☐ No

- g. Development of valuable relationships

☐ Yes

☐ No

- h. Enhanced ability to meet the needs of my constituency or clients

☐ Yes

☐ No

- i. Ability to have a greater impact than I could have on my own

☐ Yes

☐ No

Appendix C. PSAT

As a result of your participation in the partnership, have you experienced the following benefits:

- j. Ability to make a contribution to the community

☐ Yes
☐ No

- k. Acquisition of additional financial support

☐ Yes
☐ No

Drawbacks of Participation

For each of the following drawbacks, please indicate whether or not you have or have not experienced the drawback as a result of participating in this partnership.

- a. Diversion of time and resources away from other priorities or obligations

☐ Yes
☐ No

- b. Insufficient influence in partnership activities

☐ Yes
☐ No

- c. Viewed negatively due to association with other partners or the partnership

☐ Yes
☐ No

- d. Frustration or aggravation

☐ Yes
☐ No

- e. Insufficient credit given to me for contributing to the accomplishments of the partnership

☐ Yes
☐ No

- f. Conflict between my job and the partnership's work

☐ Yes
☐ No

Comparing Benefits and Drawbacks

So far, how have the benefits of participating in this partnership compared to the drawbacks?

- ☐ Benefits greatly exceed the drawbacks
- ☐ Benefits exceed the drawbacks
- ☐ Benefits and drawbacks are about equal
- ☐ Drawbacks exceed the benefits
- ☐ Drawbacks greatly exceed the benefits

Satisfaction with Participation

- a. How satisfied are you with the way the people and organizations in the partnership work together?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

- b. How satisfied are you with your influence in the partnership?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

- c. How satisfied are you with your role in the partnership?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

- d. How satisfied are you with the partnership's plans for achieving its goals?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied

Appendix C. PSAT

e. How satisfied are you with the way the partnership is implementing its plans?

- ☐ Completely satisfied
- ☐ Mostly satisfied
- ☐ Somewhat satisfied
- ☐ A little satisfied
- ☐ Not at all satisfied



Partnership Questionnaire

This questionnaire asks questions about the different aspects of your IMPACT Local Innovation Partnership (LIP) Core Team.

By answering the questions, you will help us to understand how the LIP Core Team's processes and approaches contribute to the achievement of the partnership's intended outcomes.

Before you answer, please remember:

- you are free to fill in the questionnaire or not, but if you complete it we will assume that you have consented freely to participate;
- your answers will be completely confidential; in reports your name will never be linked to any information you provide;
- there are no “right” or “wrong” answers; we only want your opinion.

For each question, please select the answer that best corresponds to your experience.

Your opinion is very important! Thank you for your time!

About you and your organization

The IMPACT LIP Core Team (referred to as “the partnership” in this questionnaire) is a group of managers, clinician leaders, researchers and (sometimes) community members who collaborate to identify the local access needs and co-design an intervention to increase access to primary health care for socially vulnerable populations. In this section, tell us a little bit about your role in this partnership and about the organization you represent.

1. Which is the main organization that you represent on the partnership? *Check only one answer*

- ☐ Community and social services
- ☐ Family Medicine practice
- ☐ Government agency
- ☐ Local health authority
- ☐ Member of the public
- ☐ Private sector
- ☐ Research institution
- ☐ Other, please specify_____

2. What is the main organizational expertise that you bring to the partnership table? *Check only one answer*

- ☐ Community organization representative
- ☐ Decision-maker
- ☐ Healthcare manager
- ☐ Patient representative
- ☐ Primary Care Physician
- ☐ Academic investigator
- ☐ Research Administrator
- ☐ Other, please specify_____

3. How long have you been involved with the partnership for? ____years ____months

Appendix D. MSP Questionnaire – English

4. Over the time of your involvement in this partnership, what phrase(s) would describe your level of engagement? *Check all that apply*

- ☐ Attended most meetings/events
- ☐ Rarely attended meetings/events
- ☐ Consistently reviewed information generated from the project
- ☐ Occasionally reviewed information generated from the project
- ☐ Responded most of the time when asked to provide input
- ☐ Occasionally responded when asked to provide input
- ☐ Participated in activities between meetings (e.g., made presentations)

5. How often do you report back to your organization about the partnership? *Check only one answer*

- ☐ After every meeting
- ☐ Periodically. Please say how frequently: every _____
- ☐ When asked
- ☐ I do not report back

6. In your own words, what is the goal of this partnership?

Thinking about how partners communicate

Please think about communication and information sharing in your partnership.

7. How do you learn about what is happening in the partnership? *Check all that apply*

- ☐ Updates during in-person meetings
- ☐ Minutes of previous meetings
- ☐ Electronic updates between meetings (e.g., newsletter)
- ☐ Verbal unstructured information sharing by partners
- ☐ External conferences and events
- ☐ Other, please specify _____

8. How useful is the information that you receive?

- ☐ Not very useful
- ☐ A little useful
- ☐ Moderately useful
- ☐ Useful
- ☐ Very useful
- ☐ I do not recall receiving any information

9. Do you receive enough information regarding partnership's activities?

- ☐ No, but I do not need more information
- ☐ No, and I would have liked more information
- ☐ Yes, mostly I am adequately informed
- ☐ Yes, I am always informed

Thinking about how decisions are made

Please think about how decisions are made and challenges are resolved in your partnership.

10. What are the top two ways in which decisions are made in the partnership?

- ☐ Consensus: discussion and then everyone agrees to support the decision
- ☐ Majority rule: voting/show of hands
- ☐ Executive: chair/leader decides
- ☐ Expert: decision delegated to a small subgroup
- ☐ Default: action/inaction forces a conclusion

11. How comfortable are you with the way decisions are made in the partnership?

- ☐ Not very comfortable
- ☐ A little comfortable
- ☐ Moderately comfortable
- ☐ Comfortable
- ☐ Very comfortable

Appendix D. MSP Questionnaire – English

12. How often do you feel that you are included in the decision-making process?

- ☐ None of the time
- ☐ Almost none of the time
- ☐ Some of the time
- ☐ Most of the time
- ☐ All of the time

13. How well does the partnership address problems?

- ☐ Not well at all
- ☐ Not so well
- ☐ Moderately well
- ☐ Very well
- ☐ Extremely well

Thinking about the partnership's leadership

Please think about all the people who provide either formal or informal leadership in your partnership.

14. Who do you consider to be the leaders (formal or informal) in your partnership? *You can use names of people or their position titles*

Appendix D. MSP Questionnaire – English

15. How would you rate your partnership's leadership in each of the following areas:

	Poor	Fair	Good	Very Good	Excellent
Taking responsibility for the partnership	☐	☐	☐	☐	☐
Communicating the vision of the partnership	☐	☐	☐	☐	☐
Working to develop a common language within the partnership	☐	☐	☐	☐	☐
Building on the perspectives, resources and skills of partners	☐	☐	☐	☐	☐
Helping the partnership to look at things differently	☐	☐	☐	☐	☐
Fostering respect, trust, inclusiveness and openness in the partnership	☐	☐	☐	☐	☐
Creating an environment where differences of opinion can be voiced	☐	☐	☐	☐	☐
Inspiring or motivating people involved in the partnership	☐	☐	☐	☐	☐
Empowering people involved in the partnership	☐	☐	☐	☐	☐
Resolving conflict among partners	☐	☐	☐	☐	☐
Recruiting diverse people and organizations into the partnership	☐	☐	☐	☐	☐
	Poor	Fair	Good	Very Good	Excellent

Appendix D. MSP Questionnaire – English

Thinking about the partnership's administration/management

Within the framework of IMPACT the administrative and management activities in your partnership have mostly been undertaken by the research teams.

16. How would you rate the administration/management's performance in each of the following areas:

	Poor	Fair	Good	Very Good	Excellent
Coordinating communication among partners	☐	☐	☐	☐	☐
Coordinating communication with people and organizations outside the partnership	☐	☐	☐	☐	☐
Informing partners on how their input is being integrated	☐	☐	☐	☐	☐
Organizing the overall work of the partnership	☐	☐	☐	☐	☐
Performing secretarial duties	☐	☐	☐	☐	☐
Preparing materials that inform partners and help them make timely decisions	☐	☐	☐	☐	☐
Providing orientation to new partners as they join the partnership	☐	☐	☐	☐	☐
Minimizing barriers to participation in meetings and activities (e.g., meetings at convenient places and times, providing transportation, etc.)	☐	☐	☐	☐	☐
Facilitating meetings	☐	☐	☐	☐	☐
Accurately reflecting discussions and decisions in the minutes of meetings or other documentation	☐	☐	☐	☐	☐
Evaluating the progress and impact of the partnership	☐	☐	☐	☐	☐
	Poor	Fair	Good	Very Good	Excellent

Non-financial resources

A partnership needs non-financial resources in order to work effectively and achieve its goals.

17. To what extent does your partnership have the skills and expertise to work well (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, etc.)?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

18. To what extent does your partnership have the data and information to work well (e.g., statistical data, information about community perceptions, values, resources and politics)?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

19. To what extent does your partnership have the connections to target populations to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

Appendix D. MSP Questionnaire – English

20. To what extent does your partnership have the connections to political decision-makers, government agencies, other organizations/groups to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

21. To what extent does your partnership have legitimacy and credibility to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

22. To what extent does your partnership have the convening power (influence and ability to bring people together for meetings and activities) to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

Financial and other resources

A partnership also needs financial and other capital resources in order to work effectively and achieve its goals.

23. To what extent does your partnership have financial support that it needs to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

Appendix D. MSP Questionnaire – English

24. To what extent does your partnership have the space that it needs to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

25. To what extent does your partnership have the equipment and goods that it needs to work well?

- ☐ None of what it needs
- ☐ Little of what it needs
- ☐ Some of what it needs
- ☐ Most of what it needs
- ☐ All of what it needs

Efficiency

Please think about the degree to which various partnership resources are optimized.

26. Please choose the statement that best describes how well your partnership uses its non-financial resources (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods, etc.).

- ☐ The partnership makes poor use of its non-financial resources
- ☐ The partnership makes fair use of its non-financial resources
- ☐ The partnership makes good use of its non-financial resources
- ☐ The partnership makes very good use of its non-financial resources
- ☐ The partnership makes excellent use of its non-financial resources
- ☐ I do not know how the partnership uses its non-financial resources

27. Please choose the statement that best describes how well your partnership uses the partners' time.

- ☐ The partnership makes poor use of partners' time
- ☐ The partnership makes fair use of partners' time
- ☐ The partnership makes good use of partners' time
- ☐ The partnership makes very good use of partners' time
- ☐ The partnership makes excellent use of partners' time
- ☐ I do not know how the partnership uses partners' time

28. Please choose the statement that best describes how well your partnership uses its financial resources, including those of any partner.

- ☐ The partnership makes poor use of its financial resources
- ☐ The partnership makes fair use of its financial resources
- ☐ The partnership makes good use of its financial resources
- ☐ The partnership makes very good use of its financial resources
- ☐ The partnership makes excellent use of its financial resources
- ☐ I do not know how the partnership uses its financial resources
- ☐ Not applicable, there are no financial resources

The partnership's external influences

Please think about all the external influences that your partnership has experienced (e.g., changes in the funding landscape, policy changes) that have had an impact on the partnership or achievement of its goals.

29. To what extent has the partnership been affected by external factors, beyond the control of the partnership?

- ☐ Not at all
- ☐ A little
- ☐ Moderately
- ☐ A lot
- ☐ A great deal

30. How well has the partnership adapted to these external influences?

- ☐ Not well at all
- ☐ Not so well
- ☐ Moderately well
- ☐ Very well
- ☐ Extremely well

Partnership's value

Please think about the people and organizations that are participants in your partnership.

31. By working together, how well are these partners able to identify new and creative ways to solve problems?

- ☐ Not well at all
- ☐ Not so well
- ☐ Moderately well
- ☐ Very well
- ☐ Extremely well

32. By working together, how well are these partners able to include the views and priorities of the people affected by the partnership's work?

- ☐ Not well at all
- ☐ Not so well
- ☐ Moderately well
- ☐ Very well
- ☐ Extremely well

Now, thinking about how often things happen.

33. When working together, how often do you feel that the partnership is making good progress towards its goals?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

34. When working together, how often do you feel that added value is achieved as a result of working in this partnership?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

35. When working together, how often do you feel that the skills and unique perspectives of the partners complement each other?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

36. When working together, how often do you feel that all partners are benefiting from the activities of the partnership?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

37. When working together, how often does the partnership experience feelings of energy, excitement and passion?

- ☐ Never
- ☐ Rarely
- ☐ Sometimes
- ☐ Often
- ☐ Always

Appendix D. MSP Questionnaire – English

Benefits of participation

Please think about the benefits of participating in this partnership for the organization that you are representing.

38. For each of the following benefits, please indicate whether the organization that you are representing has benefitted from:

	No, not at all	No, not really	Yes, a little	Yes, definitely
Enhanced ability to address an important issue	☐	☐	☐	☐
Development of new skills	☐	☐	☐	☐
Heightened public profile of the organization	☐	☐	☐	☐
Increased understanding of partners of my organization's expertise and services	☐	☐	☐	☐
Acquisition of useful knowledge about services, programs or people represented in the partnership	☐	☐	☐	☐
Enhanced ability to affect public policy	☐	☐	☐	☐
Development of valuable relationships	☐	☐	☐	☐
Enhanced ability to meet the needs of my organization's constituency or clients	☐	☐	☐	☐
Ability to have a greater impact than we could have on our own	☐	☐	☐	☐
Ability to make a contribution to the community	☐	☐	☐	☐
Acquisition of additional financial support	☐	☐	☐	☐
	No, not at all	No, not really	Yes, a little	Yes, definitely

Appendix D. MSP Questionnaire – English

Drawbacks of participation

Please think about the drawbacks of participating in this partnership for the organization that you are representing.

39. For each of the following drawbacks, please indicate whether the organization that you are representing has experienced the following:

	No, not at all	No, not really	Yes, a little	Yes, definitely
Diversion of time and resources away from other priorities or obligations	☐	☐	☐	☐
Insufficient influence in partnership activities	☐	☐	☐	☐
Negative publicity due to association with other partners or the partnership	☐	☐	☐	☐
Insufficient credit given to my organization for contributing to the accomplishments of the partnership	☐	☐	☐	☐
Conflict between the demands of this partnership and other projects within my organization	☐	☐	☐	☐
	No, not at all	No, not really	Yes, a little	Yes, definitely

Comparing benefits and drawbacks

40. On the whole, how do the benefits of participating in this partnership compare to the drawbacks?

- ☐ Benefits greatly exceed the drawbacks
- ☐ Benefits exceed the drawbacks
- ☐ Benefits and drawbacks are about equal
- ☐ Drawbacks exceed the benefits
- ☐ Drawbacks greatly exceed the benefits

Appendix D. MSP Questionnaire – English

Other comments

41. Overall, how well has the goal of developing a meaningful partnership been achieved?

- ☐ Not well at all
- ☐ Not so well
- ☐ Moderately well
- ☐ Very well
- ☐ Extremely well

42. Is there anything that you wanted to say about this partnership that you were unable to communicate in your answers to this questionnaire?

This image shows a single sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins or other markings on the paper.

Thank you very much!

Your participation is very much appreciated.

The information you are giving us is extremely important for
our study!



Please return your completed questionnaire in the stamped, addressed envelope provided.

The questionnaire is part of a research study conducted on behalf of the IMPACT team by Ekaterina (Katya) Loban, a doctoral student in the Department of Family Medicine, McGill University

QUESTIONS?

If you have any questions, please contact:

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Questionnaire sur le partenariat

Ce questionnaire aborde différents aspects du comité de pilotage du partenariat local pour l'innovation (PLI) du programme de recherche IMPACT.

En répondant aux questions, vous nous aiderez à comprendre comment les processus et les approches du comité de pilotage du programme IMPACT contribuent à la réalisation des résultats attendus pour le partenariat.

Avant de répondre, nous voudrions vous rappeler que:

- vous êtes libre de remplir le questionnaire ou non, mais si vous le remplissez, nous supposons que vous avez consenti librement à participer;
- vos réponses seront complètement confidentielles; dans les rapports, votre nom ne sera jamais lié aux informations que vous fournissez;
- Il n'y a pas de bonnes ou de mauvaises réponses; nous voulons seulement connaître votre opinion.

Pour chaque question, veuillez sélectionner la réponse qui correspond le mieux à votre expérience.

Votre opinion est très importante! Merci pour votre contribution!

A propos de vous et de votre organisation

Le comité de pilotage du PLI Québec (appelé «le partenariat» dans ce questionnaire) est un groupe de gestionnaires, de clinicien(ne)s responsables, de chercheur(e)s et (parfois) de membres de la communauté qui collaborent pour identifier les besoins d'accès locaux et pour concevoir conjointement une intervention visant à améliorer l'accès aux soins de santé de première ligne pour les populations socialement vulnérables. Dans cette section, parlez-nous un peu de votre rôle dans ce partenariat et de l'organisation que vous représentez.

1. Quelle organisation représentez-vous principalement au sein du partenariat? *Cochez une seule réponse*

- ☐ Agence gouvernementale
- ☐ Autorité locale de la santé
- ☐ Institution de recherche
- ☐ Membre du public
- ☐ Pratique de médecine familiale/GMF/Clinique
- ☐ Secteur privé
- ☐ Services sociaux et communautaires
- ☐ Autre, veuillez préciser _____

2. Quelle expertise organisationnelle principale apportez-vous à la table du partenariat? *Cochez une seule réponse*

- ☐ Administrateur/administratrice de recherche
- ☐ Chercheur(e) académique
- ☐ Décideur
- ☐ Gestionnaire de la santé
- ☐ Médecin en soins de première ligne
- ☐ Représentant(e) des patients
- ☐ Représentant(e) d'organisme communautaire
- ☐ Autre, veuillez préciser _____

3. Depuis combien de temps êtes-vous impliqué dans le partenariat? ____ans ____mois

4. Quels énoncés décrivent votre niveau d'engagement dans ce partenariat au courant de votre implication? *Cochez tout ce qui s'applique*

- ☐ Assisté à la plupart des réunions / événements
- ☐ Rarement assisté à des réunions / événements
- ☐ Constamment examiné les informations générées au cours du projet
- ☐ Examiné les informations générées au cours du projet à l'occasion
- ☐ Répondu la plupart du temps quand on m'a demandé de fournir des commentaires
- ☐ Répondu à l'occasion quand on m'a demandé de fournir des commentaires
- ☐ Participé à des activités entre les réunions (e.g., fait des présentations)

5. À quelle fréquence rapportez-vous l'information sur le partenariat à votre organisation?

Cochez une seule réponse

- ☐ Après chaque réunion
- ☐ Périodiquement. Veuillez dire à quelle fréquence: tous les _____
- ☐ Lorsque demandé
- ☐ Je ne rapporte pas l'information

6. Utilisez vos propres mots pour décrire l'objectif de ce partenariat?

En pensant à la façon dont les partenaires communiquent

Veuillez penser à la communication et au partage d'informations dans votre partenariat.

7. Comment apprenez-vous ce qui se passe dans le partenariat? *Cochez tout ce qui s'applique*

- ☐ Mises à jour lors de réunions en face-à-face
- ☐ Procès-verbal des réunions précédentes
- ☐ Mises à jour électroniques entre les réunions (par exemple, bulletin d'information)
- ☐ Partage verbal non structuré d'informations entre partenaires
- ☐ Conférences et événements externes
- ☐ Autre, veuillez préciser _____

8. À quel point l'information que vous recevez est-elle utile?

- ☐ Pas très utile
- ☐ Un peu utile
- ☐ Moyennement utile
- ☐ Utile
- ☐ Très utile
- ☐ Je ne me rappelle pas avoir reçu d'information

9. Recevez-vous suffisamment d'informations sur les activités du partenariat?

- ☐ Non, mais je n'ai pas besoin de plus d'informations
- ☐ Non, et j'aurais aimé plus d'informations
- ☐ Oui, la plupart du temps je suis informé(e) adéquatement
- ☐ Oui, je suis toujours informé(e)

En pensant à la manière dont les décisions sont prises

Veuillez penser à la manière dont les décisions sont prises et les problématiques sont résolues dans votre partenariat.

10. Quels sont les deux moyens principaux par lesquels les décisions sont prises au sein du partenariat?

- ☐ Consensus: discussion puis tout le monde accepte d'appuyer la décision
- ☐ Règle de la majorité: vote / à main levée
- ☐ Exécutif: le président / responsable décide
- ☐ Expert: décision déléguée à un petit sous-groupe
- ☐ Défaut: action / inaction force la conclusion

11. À quel point êtes-vous à l'aise avec la façon dont les décisions sont prises dans le partenariat?

- ☐ Pas très à l'aise
- ☐ Un peu à l'aise
- ☐ Moyennement à l'aise
- ☐ À l'aise
- ☐ Très à l'aise

12. À quelle fréquence avez-vous le sentiment d'être inclus dans le processus décisionnel?

- ☐ Jamais
- ☐ Rarement
- ☐ Parfois
- ☐ La plupart du temps
- ☐ Tout le temps

13. À quel point le partenariat résout-il bien les problèmes?

- ☐ Pas bien du tout
- ☐ Pas très bien
- ☐ Moyennement bien
- ☐ Très bien
- ☐ Extrêmement bien

En pensant au leadership du partenariat

Veuillez penser à toutes les personnes qui assurent un leadership formel ou informel dans votre partenariat.

14. Qui considérez-vous être les leaders (formels ou informels) de votre partenariat? *Vous pouvez utiliser les noms ou les titres des personnes*

Appendix E. MSP Questionnaire – French

15. Comment évalueriez-vous le leadership de votre partenariat dans chacun des domaines suivants:

	Faible	Passable	Bon	Très bon	Excellent
Prendre la responsabilité pour le partenariat	☐	☐	☐	☐	☐
Communiquer la vision du partenariat	☐	☐	☐	☐	☐
Travailler à développer un langage commun au sein du partenariat	☐	☐	☐	☐	☐
Bâtir sur les perspectives, les ressources et les compétences des partenaires	☐	☐	☐	☐	☐
Aider le partenariat à voir les choses différemment	☐	☐	☐	☐	☐
Favoriser le respect, la confiance, l'inclusion et l'ouverture au sein du partenariat	☐	☐	☐	☐	☐
Créer un environnement où les différences d'opinion peuvent s'exprimer	☐	☐	☐	☐	☐
Inspirer ou motiver les personnes impliquées dans le partenariat	☐	☐	☐	☐	☐
Valoriser et stimuler les personnes au sein du partenariat	☐	☐	☐	☐	☐
Résoudre les conflits entre partenaires	☐	☐	☐	☐	☐
Recruter diverses personnes et organisations dans le partenariat	☐	☐	☐	☐	☐
	Faible	Passable	Bon	Très bon	Excellent

En pensant à l'administration / la gestion du partenariat

Dans le cadre d'IMPACT, les activités d'administration et de gestion de votre partenariat ont été principalement entreprises par l'équipe de recherche.

16. Comment évalueriez-vous la performance de l'administration / direction dans chacun des aspects suivants:

	Faible	Passable	Bon	Très bon	Excellent
Coordonner la communication entre les partenaires	☐	☐	☐	☐	☐
Coordonner la communication avec les personnes et les organisations <u>en dehors</u> du partenariat	☐	☐	☐	☐	☐
Informar les partenaires sur la manière dont leur contribution est intégrée	☐	☐	☐	☐	☐
Organiser l'ensemble du travail du partenariat	☐	☐	☐	☐	☐
Effectuer des tâches de secrétariat	☐	☐	☐	☐	☐
Préparer du matériel qui informe les partenaires et les aide à prendre des décisions en temps opportun	☐	☐	☐	☐	☐
Fournir une orientation aux nouveaux partenaires lorsqu'ils rejoignent le partenariat	☐	☐	☐	☐	☐
Réduire au minimum les obstacles à la participation aux réunions et aux activités (par exemple, des réunions à des endroits et des horaires convenables, assurer le transport, etc.)	☐	☐	☐	☐	☐
Faciliter les rencontres	☐	☐	☐	☐	☐
Refléter avec précision les discussions et les décisions dans les procès-verbaux des réunions ou d'autres documents	☐	☐	☐	☐	☐
Évaluer les progrès et l'impact du partenariat	☐	☐	☐	☐	☐
	Faible	Passable	Bon	Très bon	Excellent

Ressources non financières

Un partenariat a besoin de ressources non financières pour travailler efficacement et atteindre ses objectifs.

17. Dans quelle mesure votre partenariat dispose-t-il des compétences et de l'expertise nécessaires pour bien fonctionner (leadership, administration, évaluation, droit, politique publique, compétence culturelle, formation, etc.)?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

18. Dans quelle mesure votre partenariat dispose-t-il de données et d'information pour bien fonctionner (par exemple, des données statistiques, des informations sur les perceptions de la communauté, ses valeurs, ses ressources et sa politique)?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

19. Dans quelle mesure votre partenariat a-t-il des liens avec les populations cibles pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

20. Dans quelle mesure votre partenariat a-t-il des liens avec les décideurs politiques, les agences gouvernementales et autres organisations / groupes pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

21. Dans quelle mesure votre partenariat a-t-il la légitimité et la crédibilité pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

22. Dans quelle mesure votre partenariat a-t-il le pouvoir de rassembler (influence et capacité de réunir des personnes pour des réunions et des activités) pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

Ressources financières et autres

Un partenariat a aussi besoin de ressources financières et autres pour travailler efficacement et atteindre ses objectifs.

23. Dans quelle mesure votre partenariat dispose-t-il de soutien financier dont il a besoin pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

24. Dans quelle mesure votre partenariat dispose-t-il de l'espace nécessaire pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

25. Dans quelle mesure votre partenariat dispose-t-il du matériel et de l'équipement nécessaire pour bien fonctionner?

- ☐ Pas du tout
- ☐ Un peu
- ☐ En partie
- ☐ En grande partie
- ☐ Totalement

Effacité

Veuillez réfléchir au degré d'optimisation de diverses ressources du partenariat.

26. Veuillez choisir l'énoncé qui décrit le mieux la manière dont votre partenariat utilise ses ressources non financières (compétences, expertise, informations, données, connexions, influence, espace, équipement, biens, etc.).

- ☐ Le partenariat utilise mal ses ressources non financières
- ☐ Le partenariat utilise ses ressources non financières de manière passable
- ☐ Le partenariat utilise bien ses ressources non financières
- ☐ Le partenariat utilise très bien ses ressources non financières
- ☐ Le partenariat utilise ses ressources non financières de manière excellente
- ☐ Je ne sais pas comment le partenariat utilise ses ressources non financières

27. Veuillez choisir l'énoncé qui décrit le mieux la manière dont votre partenariat utilise le temps des partenaires.

- ☐ Le partenariat utilise mal le temps des partenaires
- ☐ Le partenariat utilise le temps des partenaires de manière passable
- ☐ Le partenariat utilise bien le temps des partenaires
- ☐ Le partenariat utilise très bien le temps des partenaires
- ☐ Le partenariat utilise le temps des partenaires de manière excellente
- ☐ Je ne sais pas comment le partenariat utilise le temps des partenaires

28. Veuillez choisir l'énoncé qui décrit le mieux la manière dont votre partenariat utilise ses ressources financières, y compris celles de tout partenaire.

- ☐ Le partenariat utilise mal ses ressources financières
- ☐ Le partenariat utilise ses ressources financières de manière passable
- ☐ Le partenariat utilise bien ses ressources financières
- ☐ Le partenariat utilise très bien ses ressources financières
- ☐ Le partenariat utilise ses ressources financières de manière excellente
- ☐ Je ne sais pas comment le partenariat utilise ses ressources financières
- ☐ Non applicable, il n'y a pas de ressources financières

Influences externes au partenariat

Veuillez penser à toutes les influences externes que votre partenariat a subies (changements dans le financement, changements de politiques, etc.) qui ont eu un impact sur le partenariat ou sur la réalisation de ses objectifs.

29. Dans quelle mesure le partenariat a-t-il été affecté par des facteurs externes, hors de son contrôle?

- ☐ Pas du tout
- ☐ Un peu
- ☐ Moyennement
- ☐ Beaucoup
- ☐ Énormément

30. Dans quelle mesure le partenariat s'est-il adapté à ces influences externes?

- ☐ Pas bien du tout
- ☐ Pas très bien
- ☐ Moyennement bien
- ☐ Très bien
- ☐ Extrêmement bien

Valeur du partenariat

En pensant aux personnes et aux organisations qui participent à votre partenariat.

31. Dans quelle mesure les partenaires sont-ils capables d'identifier de nouvelles manières créatives de résoudre les problèmes en travaillant ensemble?

- ☐ Pas bien du tout
- ☐ Pas très bien
- ☐ Moyennement bien
- ☐ Très bien
- ☐ Extrêmement bien

32. En travaillant ensemble, dans quelle mesure les partenaires sont-ils capables d'intégrer les points de vue et les priorités des personnes touchées par le travail du partenariat?

- ☐ Pas bien du tout
- ☐ Pas très bien
- ☐ Moyennement bien
- ☐ Très bien
- ☐ Extrêmement bien

En pensant maintenant à la globalité de votre expérience de collaboration.

33. En travaillant ensemble, à quelle fréquence sentez-vous que le partenariat progresse bien vers ses objectifs?

- ☐ Jamais
- ☐ Rarement
- ☐ Parfois
- ☐ Souvent
- ☐ Toujours

34. En travaillant ensemble, sentez-vous qu'une valeur ajoutée a été obtenue grâce au partenariat?

- ☐ Jamais
- ☐ Rarement
- ☐ Parfois
- ☐ Souvent
- ☐ Toujours

35. En travaillant ensemble, sentez-vous que les compétences et les perspectives uniques des partenaires se complètent?

- ☐ Jamais
- ☐ Rarement
- ☐ Quelquefois
- ☐ Souvent
- ☐ Toujours

36. En travaillant ensemble, sentez-vous que tous les partenaires bénéficient des activités du partenariat?

- ☐ Jamais
- ☐ Rarement
- ☐ Quelquefois
- ☐ Souvent
- ☐ Toujours

37. En travaillant ensemble, à quelle fréquence est-ce que des sentiments d'énergie, d'enthousiasme et de passion ont été ressentis au sein du partenariat?

- ☐ Jamais
- ☐ Rarement
- ☐ Parfois
- ☐ Souvent
- ☐ Toujours

Appendix E. MSP Questionnaire – French

Avantages liés à la participation

En pensant aux avantages de participer à ce partenariat pour l'organisation que vous représentez.

38. Pour chacun des avantages suivants, veuillez indiquer si l'organisation que vous représentez a bénéficié ou non:

	Non, pas du tout	Non, pas vraiment	Oui, un peu	Oui, certainement
D'une meilleure capacité de régler un problème important	☐	☐	☐	☐
Du développement de nouvelles compétences	☐	☐	☐	☐
D'une visibilité accrue de l'organisation	☐	☐	☐	☐
D'une meilleure compréhension par les partenaires de l'expertise et des services de mon organisation	☐	☐	☐	☐
De l'acquisition de connaissances utiles sur les membres, services et programmes des partenaires	☐	☐	☐	☐
D'une meilleure capacité d'influencer les politiques publiques	☐	☐	☐	☐
Du développement de relations utiles	☐	☐	☐	☐
D'une meilleure capacité à répondre aux besoins de la clientèle ou des membres de mon organisation	☐	☐	☐	☐
D'une capacité à avoir un impact plus grand que nous pourrions avoir par nous-mêmes	☐	☐	☐	☐
D'une capacité à apporter une contribution à la communauté	☐	☐	☐	☐
De l'acquisition d'un soutien financier supplémentaire	☐	☐	☐	☐
	Non, pas du tout	Non, pas vraiment	Oui, un peu	Oui, certainement

Inconvénients liés à la participation

En pensant aux inconvénients liés à la participation à ce partenariat pour l'organisation que vous représentez.

39. Pour chacun des inconvénients suivants, veuillez indiquer si l'organisation que vous représentez a rencontré les situations suivantes:

	Non, pas du tout	Non, pas vraiment	Oui, un peu	Oui, certainement
Diversion de temps et de ressources au détriment d'autres priorités ou obligations	☐	☐	☐	☐
Influence insuffisante dans les activités de partenariat	☐	☐	☐	☐
Publicité négative due à une association avec d'autres partenaires ou au partenariat	☐	☐	☐	☐
Crédit insuffisant accordé à mon organisation pour sa contribution aux réalisations du partenariat	☐	☐	☐	☐
Conflit entre les exigences de ce partenariat et d'autres projets au sein de mon organisation	☐	☐	☐	☐
	Non, pas du tout	Non, pas vraiment	Oui, un peu	Oui, certainement

Comparaison des avantages et des inconvénients

40. Dans l'ensemble, comment les avantages de la participation à ce partenariat se comparent-ils aux inconvénients?

- ☐ Les avantages dépassent largement les inconvénients
- ☐ Les avantages dépassent les inconvénients
- ☐ Les avantages et les inconvénients sont à peu près égaux
- ☐ Les inconvénients dépassent les avantages
- ☐ Les inconvénients dépassent largement les avantages

Autres commentaires

41. Dans l'ensemble, à quel point l'objectif de développement d'un partenariat significatif a-t-il été atteint?

- ☐ Pas bien du tout
- ☐ Pas très bien
- ☐ Moyennement bien
- ☐ Très bien
- ☐ Extrêmement bien

42. Y a-t-il quelque chose que vous vouliez dire au sujet de ce partenariat que vous n'avez pas pu communiquer dans vos réponses à ce questionnaire?

[illegible]

Merci beaucoup!
Votre participation est très appréciée.
Les informations que vous nous
communiquez sont extrêmement
importantes pour notre étude!



S'il vous plaît retourner votre questionnaire rempli dans l'enveloppe adressée et prépayée fournie.

Ce questionnaire fait partie d'une étude de recherche menée pour le compte de l'équipe d'IMPACT par Ekaterina (Katya) Loban, étudiante au doctorat au département de médecine familiale de l'Université McGill.

QUESTIONS?

Si vous avez des questions, veuillez contacter:

Katya Loban

Courriel: ekaterina.loban@mail.mcgill.ca

Cellulaire: 514-576-4671



Appendix F. Ethics and Scientific Approval 2016

Centre intégré
universitaire de santé
et de services sociaux
de l'Ouest-de-
l'Île-de-Montréal



Centre hospitalier de St. Mary

August 9, 2016

Jeannie Haggerty
Principal Investigator
St. Mary's Hospital Center
Research Center

RE: Full Institutional Approval of SMHC # 13-30C
Entitled: *"Multi-stakeholder Partnerships to Promote Access to Primary Health Care for Vulnerable Populations: A Mixed Methods Study."*
Principal Investigator: Jeannie Haggerty
Project Coordinator: Katya Loban

Dear Dr. Haggerty,

We are pleased to inform you that the above-mentioned protocol has received **ethic and scientific approval** from St. Mary's Hospital Center Research Ethic Committee. This approbation has been given by the Chair of the REC on August 9, 2016. This approval is valid for a period of one year from August 9, 2016 to August 8, 2017.

The following documents were approved:

- 1) Form A: Research Protocol Registration Form, dated: July 14, 2016.
- 2) Protocol, dated: July 11, 2016.
- 3) English Consent form*, received: August 5, 2016.
- 4) French Consent form*, received: August 5, 2016.
- 5) Interview guide, received: July 14, 2016.
- 6) Budget, dated: August 3, 2016.
- 7) CV of Principal Investigator, received: July 14, 2016.

You are responsible for submitting the following forms, when applicable:

Any changes made to approved documents or any other aspects of the study that require immediate reporting on the **Form E - Immediate Reporting & Amendment Form**;

Should you wish to continue the project beyond the approval period, you must complete and submit the **Form F - Interim Report Form** at least 30 days prior to expiration of the Full Institutional Approval;

The termination of the study on the **Form G - Termination Report Form**.

The above-mentioned forms are available on the department website (<http://smhc.ca/en/research/research-review/post-approval-requirements>) or you may contact the Research Review Office in order to have them sent to you electronically.

DATA CONSERVATION:

The original study information (e.g. approved ethics application, all supporting documents, signed consent forms, immediate reporting and amendment form, interim reports, termination reports, and subject logs) must be kept for a minimum of 5 years after the termination date of the study. You are responsible for following any other

Appendix F. Ethics and Scientific Approval 2016

Centre intégré
universitaire de santé
et de services sociaux
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l'Île-de-Montréal

Québec

Centre hospitalier de St. Mary

document conservation requirements applicable to your study (i.e. funding bodies may have different document conservation requirements that may be longer than the standard conservation period mentioned above).

CONSENT FORM:

The English/French consent forms (dated: August 5, 2016) have been stamped to indicate the Research Ethics Committee approval. Make copies of these stamped consent forms for use in your study, and note that only stamped copies of these consent forms should be used in your study. All participating subjects should receive an original version of their signed consent form.

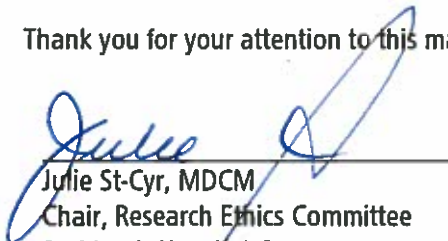
RESEARCH SUBJECT LOG:

As per Ministry guidelines, all researchers are required to keep subject logs of all human subjects (patients, staff, residents, other caregivers, family, etc.) participating in their study. You may be required to submit a subject log at the request of the Research Ethics Committee.

Use the electronic version of the log sheet found on the SMHC research website (<http://smhc.ca/en/research/research-review/post-approval-requirements>). Sign and date Appendix A1 of the attached agreement form indicating your agreement to keep logs of all of your subjects.

Forward all future correspondence to the Research Review Office, St. Mary's Hospital Centre.

Thank you for your attention to this matter,


Julie St-Cyr, MDCM
Chair, Research Ethics Committee
St. Mary's Hospital Center

cc: Katya Loban, Research Coordinator
Dominique Rivest, *Chef de service - Trésorerie et Centre de recherche*
Wim Wolfs, Manager, Research Administration
Cindy Starnino, Director of academic affairs, teaching and research, CIUSSS-ODIM



INFORMED CONSENT FORM

PROJECT TITLE: Multi-stakeholder Partnerships to Promote Access to Primary Health Care for Vulnerable Populations: A Mixed Methods Study

PURPOSE OF THE STUDY

The purpose of this doctoral project is to understand how each of the two IMPACT local partnerships (in Quebec and Ontario) develop a common purpose, undertake specific tasks and share risks, responsibilities, resources, competencies and benefits. More specifically, the PhD student is interested in understanding how strategies/processes to promote and solidify partnerships, which are employed by the research teams, contribute to improving the overall functioning of these two local partnerships.

DATA COLLECTION

The data will be gathered through: a) non-participant observation of IMPACT meetings; b) in-depth individual interviews; and c) a questionnaire.

YOUR INVOLVEMENT

You are invited to provide your consent to having the PhD student observe and take notes during some of the meetings of your local partnership and the Canadian Executive team. You will be informed of the student's participation prior to each meeting. You are also invited to take part in an individual interview and, subsequently, to fill out a questionnaire (paper or electronic version). The one-on-one interview will take approximately 1 hour. The interview will be recorded, unless you specify otherwise. It will take you about 30 minutes to fill in the questionnaire.

POSSIBLE BENEFITS OF PARTICIPATION

There are no immediate benefits from participating in this study. In the medium term, the hope is that the data gathered and fed back to the IMPACT teams will result in their improved functioning. Overall, what the student learns from observing your exchanges, from the interviews and the questionnaire will help her gain a better understanding of how the strategies/processes to improve partnerships are applied in a primary health care context. This knowledge will help other partnerships in health care contexts be more effective.

POSSIBLE RISKS AND DISCOMFORTS OF PARTICIPATION

General themes from the data collected will be shared with you and your teams. This information that is fed back to the IMPACT teams has the potential to highlight activities and approaches that are perceived by LIP members to be working well and some that are not working well. To minimize the risk associated with identifying areas for change, the PhD student will:

Appendix G. IMPACT Consent Form - English

Project Title: Multi-stakeholder Partnerships to Promote Access to Primary Health Care for Vulnerable Populations: A Mixed Methods Study

August 2016

- clarify meaning by reviewing summaries of individual statements with each individual prior to sharing a synthesis of responses with the group;
- ensure that individual statements are non-identifiable (all names, position titles, and any other identifiable features will be removed);
 - o if it is not possible to ensure that statements are not identifiable, the student will request consent to share individual comments and responses prior to sharing with the group. If such consent is not provided, these statements will not be shared.
- use an appreciative inquiry and improvement lens throughout the project and as a frame for providing feedback to participants.

In addition to these risks, the participation will take some of your time.

VOLUNTARY PARTICIPATION/WITHDRAWAL

You are free to choose to participate or not participate in this study as a whole or only in some parts of this study. Refusal to participate will not affect your relationship with the IMPACT team or your immediate supervisors if they are also part of the IMPACT program. If you choose not to participate in the observation part of the study, your comments will not be recorded in writing and will not be used in any way in the study.

If you choose to participate, you can change your mind later and stop at any time, without giving a reason, simply by notifying the student. Information that you have provided up to the point of stopping your participation will be stored in the student's files unless you request otherwise.

CONFIDENTIALITY

The confidentiality of the information that you provide will be protected. All observation notes, recordings and transcripts will be kept in a locked file cabinet at the St. Mary's Research Center for a period of time (5 years) after which they will be destroyed. The knowledge gained from this project will be published or communicated in other ways such as presentations at conferences, but it will be impossible to identify you in any of these materials.

NAME OF STUDENT:

Ekaterina (Katya) Loban, Department of Family Medicine, McGill University

STUDENT'S SUPERVISORS:

Dr. Jeannie Haggerty, Professor, Department of Family Medicine, McGill University

Dr. Cathie Scott, Chief Knowledge and Policy Officer, Alberta Centre for Child, Family, and Community Research

MORE QUESTIONS?

If you have any questions, please contact:

Katya Loban

E-mail: ekaterina.loban@mail.mcgill.ca

Cell: 514-576-4671

Appendix G. IMPACT Consent Form - English

Project Title: Multi-stakeholder Partnerships to Promote Access to Primary Health Care for Vulnerable Populations: A Mixed Methods Study

August 2016

If you have any questions about your rights as a research participant or if you have a complaint about this project, please contact the Service Quality and Complaints Commissioner of the Montréal West Island IUHSSC Ombudsperson at 514-630-2225, extension 5277.

CONSENT STATEMENT

I understand the procedures, risks and benefits associated with my participation in this research study, and that the information collected during the study will be kept confidential.

I have had the opportunity to ask all my questions concerning the different aspects of the study, and I have received satisfactory answers.

I have had ample time to make my decision.

I will be given a signed and dated copy of this informed consent form and the original will be placed in a locked file cabinet at the St. Mary's Research Center.

I agree to participate in this study (including observations, interview and survey):

Your Signature

Name (Print)

Date



Approuvé par :
Comité d'éthique de la recherche
Centre hospitalier de St. Mary
Par : Thierry M. Laforce



FORMULAIRE DE CONSENTEMENT ÉCLAIRÉ

Titre du projet de recherche: Les partenariats multipartites pour la promotion d'accès aux soins de santé de première ligne pour les populations vulnérables: recherche par méthodes mixtes

BUT DE L'ÉTUDE

Le but de ce projet de recherche de doctorat est de comprendre comment chacun des deux partenariats locaux du programme de recherche IMPACT (au Québec et en Ontario) développent un but commun, entreprennent des tâches spécifiques et partagent les risques, les responsabilités, les ressources, les compétences et les avantages. Plus spécifiquement, l'étudiante est intéressée à comprendre comment les stratégies / processus pour promouvoir et consolider les partenariats, qui sont utilisés par les équipes de recherche, contribuent à améliorer le fonctionnement de ces deux partenariats locaux.

COLLECTE DE DONNÉES

Les données seront recueillies par le biais: a) d'observation non-participante des réunions du programme de recherche IMPACT; b) d'entrevues individuelles; et c) d'un questionnaire.

VOTRE CONTRIBUTION

Vous êtes invité à fournir votre consentement à une étudiante de doctorat pour observer et prendre des notes lors de certaines réunions de votre partenariat local et de l'équipe de direction canadienne. Vous serez informé de la participation de l'étudiante avant chaque réunion. Vous êtes également invités à prendre part à un entretien individuel et, par la suite, de remplir un questionnaire (format papier ou électronique). L'entrevue individuelle durera environ une heure. L'entrevue sera enregistrée, sauf indication contraire. Il vous faudra environ 30 minutes pour remplir le questionnaire.

BÉNÉFICES ET AVANTAGES

Il n'y a pas d'avantages immédiats de participer à cette étude. À moyen terme, nous espérons que les données recueillies et partagées avec les équipes d'IMPACT mèneront à une amélioration de leur fonctionnement. Dans l'ensemble, ce que l'étudiante apprendra en observant vos échanges, et à l'aide des entrevues et du questionnaire lui permettra de mieux comprendre la façon dont les stratégies / processus pour améliorer les partenariats sont appliqués dans un contexte de soins de santé de première ligne. Ces connaissances permettront à d'autres partenariats dans le domaine de la santé d'être plus efficace.

RISQUES ET INCONVÉNIENTS DE VOTRE PARTICIPATION

Les thèmes généraux qui ressortent des données seront partagés avec vous et vos équipes. Cette information pourrait mettre en évidence des activités et des approches qui fonctionnent bien ou non selon les membres du partenariat. Afin de minimiser les risques associés à l'identification des zones de changement, l'étudiante s'engage à:

- Clarifier ce que signifient des déclarations individuelles en examinant les résumés avec chaque individu avant de partager une synthèse des réponses avec le groupe;
- Veiller à ce que les déclarations individuelles sont non identifiables (tous les noms, les titres de poste et d'autres caractéristiques identifiables seront supprimés);
 - s'il est impossible de garantir que les déclarations ne sont pas identifiables, l'étudiante demandera le consentement pour partager ces commentaires et réponses individuelles avant de les partager avec le groupe. Si un tel consentement n'est pas fourni, ces déclarations ne seront pas partagées.
- Utiliser une approche appréciative et un objectif d'amélioration tout au long du projet et comme cadre pour fournir une rétroaction aux participants.

En plus de ces risques, la participation prendra une partie de votre temps.

PARTICIPATION VOLONTAIRE/RETRAIT

Vous êtes libre de choisir de participer ou non à cette étude dans son ensemble ou seulement dans certaines parties de cette étude. Le refus de participer n'affectera pas votre relation avec l'équipe IMPACT ou vos superviseurs immédiats si ils/elles font également partie du programme IMPACT. Si vous choisissez de ne pas participer à la partie d'observations de cette étude, vos commentaires ne seront pas consignés par écrit et ne seront pas utilisés.

Si vous choisissez de participer, vous pouvez vous retirer de l'étude à n'importe quel moment, sans avoir à donner de raisons, en avisant l'étudiante. Si vous décidez, à n'importe quel moment, de vous retirer de l'étude, l'information recueillie sur vous jusqu'à ce point sera gardée dans les dossiers de l'étudiante et pourrait être utilisée pour les analyses, à moins que vous demandiez autrement.

CONFIDENTIALITÉ

La confidentialité des informations fournies sera protégée. Toutes les notes d'observations, enregistrements et transcriptions seront conservés dans un classeur verrouillé au centre de recherche de St. Mary pour une période de temps (5 ans), après quoi elles seront détruites. Les connaissances acquises à partir de ce projet seront publiées ou communiquées par des moyens tels que des présentations lors de conférences, mais il sera impossible de vous identifier dans ces matériaux.

Titre du projet de recherche: Les partenariats multipartites pour la promotion d'accès aux soins de santé de première ligne pour les populations vulnérables: recherche par méthodes mixtes

août 2016

NOM DE L'ÉTUDIANTE:

Ekaterina (Katya) Loban, Département de médecine de famille, Université McGill

SUPERVISEURES DE L'ÉTUDIANTE:

Dre. Jeannie Haggerty, Professeure, Département de médecine de famille, Université McGill

Dre. Cathie Scott, Agente en chef de connaissances et politiques, Centre pour enfants, la famille, et la recherche communautaire de l'Alberta

PLUS DE QUESTIONS?

Si vous avez des questions, veuillez contactez:

Katya Loban

Courriel: ekaterina.loban@mail.mcgill.ca

Cellulaire: 514-576-4671

Si vous désirez parler avec une personne qui n'est pas membre de l'équipe de recherche au sujet de vos droits en tant que participant, ou si vous avez des plaintes à propos du projet, veuillez communiquer avec la commissaire aux plaintes et à la qualité des services du CIUSSS de l'Ouest-de-l'Île-de-Montréal au 514-630-2225, poste 5277.

Titre du projet de recherche: Les partenariats multipartites pour la promotion d'accès aux soins de santé de première ligne pour les populations vulnérables: recherche par méthodes mixtes

août 2016

ÉNONCÉ DU CONSENTEMENT

La nature de l'étude, les procédés à utiliser, les risques et les bénéfices que comportent ma participation à cette étude ainsi que le caractère confidentiel des informations qui seront recueillies au cours de l'étude m'ont été expliqués par un membre de l'équipe de recherche.

J'ai eu l'occasion de poser toutes les questions concernant les différents aspects de l'étude et j'ai reçu des réponses de façon satisfaisante.

Je reconnais avoir eu le temps voulu pour prendre ma décision.

Je recevrai une copie signée et datée de ce formulaire de consentement et l'original sera déposé dans une filière fermée à clé au Centre de recherche Hôpital St-Mary.

J'accepte de participer dans cette étude (incluant les observations, les entrevues et un sondage):

Votre signature

Nom (caractères d'imprimerie)

Date

Centre intégré
universitaire de santé
et de services sociaux
de l'Ouest-de-
l'Île-de-Montréal
Québec 
Centre hospitalier de St. Mary
St. Mary's Hospital Center

Approuvé par :
Comité d'éthique de la recherche
Centre hospitalier de St. Mary
Par : Thierry M. Laforce

Appendix I. Interview Guide

General:

As you are aware, each IMPACT site has established a local innovation partnership (LIP) – partenariat d'innovation local (PLI). These look slightly different in each of the 6 sites. The first couple of questions are just to get an initial picture or overview of 'what' it is and how you are involved.

1. How would you describe the way your LIP is organised (i.e., membership, structure (committees, working groups), resources, frequency of meetings and communication, leadership (e.g., distributed)).
 - a. When you say "your LIP" or "the LIP" what are you referring to?
2. How have you been involved with your LIP? Please describe.
 - a. How long have you been involved with your LIP?
 - b. Your role

Work sharing:

3. How would you describe key tasks and activities of your LIP?
 - a. How is the work divided among the different partners?
 - b. How would you describe the roles of members? How do they contribute?

Decision-making/problem solving:

4. Can you name 2-3 significant decisions that were made in the past year?
5. How are decisions made? How are decisions communicated? (prompts: committee process; voting/consensus; transparency)
6. How are challenges resolved/ conflict dealt with?
7. Can you name 2-3 significant problems encountered in the past year? How were they resolved? (if appropriate: What were the consequences of conflict or efforts to resolve problems (benefits, risks)?)

Complementarity of skills:

8. Describe how the LIP is building on the strengths and resources of its members.
 - a. What facilitates member contributions?
 - b. What limits member contributions (barriers)?
9. How is the partnership including the views and priorities of the people affected by the partnership's work?
10. Has there been any change over time in terms of how team members contribute?

Appendix I. Interview Guide

Benefits/value added:

11. What are the perceived benefits of participating in the activities of the LIP/IMPACT programme in general?

- a. How do you benefit (professionally/personally)?
- b. How does your organisation benefit (policy/practice/service delivery)?

12. How do you perceive that others are benefitting from their participation?

13. What sorts of benefits do you perceive that are above and beyond what might have been expected as a result of working in this partnership, as opposed to working independently? If yes, could you provide a few examples? If no, are there any limitations that you can think of?

Outcomes:

14. What is the LIP trying to achieve?

15. Does it seem as if everyone understands and supports these goals (i.e., Is everyone headed in the same direction)?

16. How would you describe the LIP's progress towards these goals to date?

Experience:

17. How would you describe your overall experience of being part of this LIP?

18. What has been the most positive aspect of your involvement?

19. What has been the most negative aspect of your involvement?

20. Do you look forward to the meetings of the LIP? Why or why not?

Energy:

21. What words would you use to describe the general atmosphere of the LIP (e.g., level of energy surrounding the LIP)?

Synergy-promoting strategies (enablers and barriers to partnership):

22. Describe the processes and approaches that have been used to facilitate the work of the LIP.

23. What's working well? How do you know (are there any indicators of success)?

24. From your perspective, what might be improved? And how? What would make your LIP more effective?

Closing:

25. Is there anything else that you would like to mention?

**Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy,
including illustrative quotations**

Categories of factors likely to influence partnership synergy	Factors fostering or hindering partnership synergy	Primary Care Connection Partnership (PCCP)	Community Health Resources Partnership (CHRP)
Structure		- Formalized groups of stakeholders involving in each case: a) a research team – composed of academic investigators (including Principal Investigators and co-investigators) and research coordinators (including partnership coordinators); b) a local partnership core team – comprising the research team, clinicians, decision makers, health care managers and community partners (e.g., representatives of non-profit organizations working with vulnerable populations, patient-partners).	
Partner Characteristics	Composition (Lasker et al. model: heterogeneity)	- Membership fluctuated over the years, with relatively stable organizational representation but significant turnover in individuals. In 2018 there were 13 members. Total number of stakeholders since the beginning of the project: 30 to 40 stakeholders.	- Membership fluctuated over the years, with less individual flow-through than in the PPCP. In 2018 there were 23 members. Total number of stakeholders since the beginning of the project: 30 to 40 stakeholders.
	Nature and level of stakeholder engagement (Lasker <i>et al.</i> model: level of involvement)	- Group of partners referred to as a “<i>steering committee</i>” (011, PCCP) and “<i>IMPACT* project</i>” (016, PCCP). - Participatory approach to inquiry and problem-solving. All stakeholders participated actively in the co-construction of the various aspects of the project, the non-researchers – on an ad hoc voluntary basis. The researchers’ stakes were perceived to be higher. - Patient partner representation only at the initial project stage, subsequently minimal community input: “<i>What we are really lacking are patient representatives. This is a hole we have not filled since we had the</i>	- Group of partners referred to as an “<i>advisory group</i>” (013, CHRP) and the project - as “<i>the IMPACT study</i>” (015, CHRP): Well, the meetings it’s more [...] around discussions, about what they want to do with the project, rather than the actual operational pieces of that. Another part of the team, I believe, has been doing that piece. So it’s primarily been more like advisory kind of input. (017, CHRP). - Structured way of soliciting input from stakeholders. Meetings were perceived to be confined to gathering information, with an eventual shift to problem-solving:

Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy, including illustrative quotations

		<i>patient representative who was not quite what we were looking for as for the criterion of vulnerability.” (011, PCCP).</i>	[...] I think, that it changed over time. So certainly at the outset I think it was more information gathering, you know, what’s out there, what works, what have you guys tried, who’s doing what, that sort of thing, that was at the start. Then I would say there was that phase we’ve got an idea now but we need some further resources because our grant is not going to cover all this stuff. (015, CHRP). - High level of engagement of patient representatives, but not at the initial project stage.
Partnership Characteristics	Leadership	- Both partnerships are largely driven by the research teams. - Presence of boundary-spanning formal (academic investigators) and informal (partnership coordinators) leaders knowledgeable about the context and skilled at capitalizing upon the various strengths and perspectives of stakeholders, creating the atmosphere of trust and encouraging different opinions to be voiced: “[...] <i>they [research team members] consult us a lot, I think because of our knowledge of the environment.</i>” (013, PCCP); “[...] <i>there is a very open kind of environment there and frankly and you can tell that the research team really wants to hear what people have to say and so they act [...] and they ask pointed questions.</i>” (015, CHRP).	
		- Leadership distributed among academic and nonacademic stakeholders.	- Leadership distributed within the research team.
	Administration and management	- Face-to-face meetings every two to 8 weeks.	- Face-to-face meeting frequency: from every 6 weeks to two/three times a year. Frequency is determined by the availability of new information. Experienced one delay between meetings of 1.5 years due to delays in ethics protocols approvals.
		- Despite the availability of meeting agenda, enough room provided for deep discussions on issues of concern. - Targeted, ongoing communication regarding project activities.	- Effective organization and logistical support for meetings:

Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy, including illustrative quotations

		- Substantial field presence by the research team.	Well, they do an excellent job of time-keeping. So I feel that they are very well organized for these meetings. I feel there is not a wasted minute in those meetings. They seem to just be very effective and very planned and organized. So I'm learning from seeing how a well organized meeting unfolds. (016, CHRP). - Periodic newsletter regarding project activities, with a broader community reach, that some participants admitted to not reading due to busy schedules.
	Decision-making (Lasker <i>et al.</i> model: governance)	- Participants reported that the decision-making process was transparent and inclusive: <i>"Decisions, I think the fact that you go to a vote [...] to decide how to make a change, I think that's good. They take all opinions into account before making a major decision."</i> (016, PCCP). The decisions ... before being made, there is a study, consultation, a consultation process that is undertaken, and that's really commendable. This is done through email exchange. They ask three questions, four questions, following our last meeting, where we had not necessarily identified the solution to resolve our problem. They ask questions, we analyze the answers when we meet again. At that point you have to decide. They submit the hypotheses to us, a proposal, a decision, we discuss it and we decide. So that it is done in a group, it is during meetings that it is done. (013, PCCP).	- Nonacademic participants reported a lack of clarity as to how decisions were made: <i>"I'm not sure how [...] the leaders ... how they decide who's going to do what."</i> (018, CHRP). - Other nonacademic participants argued that decisions are largely undertaken by the research team: <i>"Well, really there's no decisions that are made during the committee meetings per se. I think it's more information gathering for the people who are leading the study. Umm and then decisions are made, I guess, within the project team."</i> (017, CHRP).

**Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy,
including illustrative quotations**

Relationships among partners	General atmosphere	- The general atmosphere was described as “good” (011, PCCP) and “open” (013, PCCP): The exchanges are very open. That is to say, when we [...] put forth a proposal or a possible solution, it is always well received ... not necessarily always accepted, but well received. Lots of openness. That, I find that interesting. (013, PCCP).	- The general atmosphere of the partnership was described as “positive” (018, 011, CHRP), “dynamic” (017, CHRP), “respectful” (019, CHRP), “open” and “friendly” (015, CHRP), “collaborative”, “energizing” and “engaging” (013, CHRP): “Everybody seems to be happy to be involved.” (018, CHRP).
	Trust	- Participants stressed the importance of having signed letters of understanding with institutions at the start of the project. Despite the fact that membership fluctuated, these letters underscored the credibility of the project and facilitated trust-building with new members: [...] although the people around the table have changed, the organizations were involved from the start. [...] What has made it easier was that we had the commitment of people pretty high up in the organization from the start. In addition, we succeeded at establishing a climate of trust. (011, PCCP).	- Participants highlighted the importance of face-to-face meetings from the standpoint of trust-building: [...] it’s positive and everybody seems to think that they have a ... they make a difference, yeah. And so they’re in there and people are actually taking notes when they speak, the patients aren’t used to having people take notes about what they say. Well, this happens at this meeting, and people actually pay attention. (018, CHRP).
	Conflict	- Some participants stated that they did not observe any conflict: “I would say that we did not have any major conflicts in the steering committee.” (011, PCCP). - Other participants described strategies used to overcome differences: “I think there is a lot of discussion [...] we have the freedom to give our opinion, to discuss. I think it is very appropriate.” (016, PCCP).	- Participants felt that they could contribute openly, including voicing concerns and disagreement: “[...] it’s a good trusting environment. People are happy to speak up and say what they need to say.” (018, CHRP). - Other participants reported observing no challenges: “I never saw anything as a major challenge.” (019, CHRP).

Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy, including illustrative quotations

		<i>“I did not sense any conflict, but if there were moments where there was misunderstanding regarding certain aspects, [...] it was [managed] through conversation.” (020, PCCP).</i> - Some participants referred specifically to overcoming difficulties related to policy changes that affected the partnership: <i>“It’s not conflicts, but it’s the pitfalls that are difficult to overcome.” (013, PCCP).</i>	
Resources	Financial resources	- Both projects funded under the envelope of the larger IMPACT program. - The program provided funds for the coordinating research infrastructure. The research team spearheaded the program and provided ongoing support to the partnership. - The interventions were not covered under the IMPACT program funding. Each partnership was required to mobilize adequate local resources to respond to regional access needs and implement an intervention tailored to local context. - CHRP management activities carried out by the research team located in a research institute, and in the case of PCCP - a research center. - Face-to-face meetings organized either at the research center/institute, nearby locations, one of partner universities, or a participating community organization.	
			- In the early stages of the project, acquired additional funding in order to conduct a randomized controlled trial to test the effectiveness of the navigator model.
	Nonfinancial resources	- Unpaid time of partnership members; - Information exchanged; - Skills and expertise; - Connections to a broader web of organizational and community stakeholders.	
External Context	Community characteristics/ history of prior collaboration	- History of pre-existing relationships and collaboration between research teams of two universities, no past collaboration	- History of pre-existing relationships and collaboration within the research team and with some decision makers and

Appendix J. Cross-case synthesis highlighting factors fostering/hindering partnership synergy, including illustrative quotations

		history between the two health authorities, relationships with community had to be forged: [...] it was pretty special, because, all the people around the table didn't know each other and had never worked together. Worse even we could see that they were not ready to work together, they had never spoken to each other. (011, PCCP).	patient representatives, relationships with other stakeholders had to be forged.
	Policy context	- Major reform leading to a number of policy changes. The legislation behind the reform was introduced by the Liberal government of the time and included the following Bills: <i>An Act to modify the organization and governance of the health and social services network</i>; and <i>An Act to promote access to family medicine and specialized medicine services and to amend various legislative provisions relating to assisted procreation</i>. Bill 10 served to re-organize the health and social services establishments under a new governance structure; while Bill 20 served to improve access to primary care through a system of quotas of registered patients: <i>"The change is quite major [...]it's a transition, it's difficult, and we're right in the middle of it."</i> (013, PCCP). - The intervention had to be adapted several times to respond to the evolving environmental opportunities and threats.	- At the time of the CHRP project activities, the province was undergoing significant changes in its health care system, with services being integrated sub-regionally based on geographical utilization patterns. These changes were taking place within the framework of tight budgets, contract negotiations and increasing demands on the system.

* IMPACT - Innovative Models Promoting Access-to-Care Transformation.

Appendix K. Comparison of Questionnaires.

Comparison of the Multi-Stakeholder Partnership Questionnaire (MSPQ) with (a) the PSAT and (b) the Partner Questionnaire.

MSP Study Questionnaire	PSAT / Partner Questionnaire	Changes Implemented
Communication (new subscale in MSPQ)		
<i>Preamble: Please think about communication and information sharing in your partnership.</i>		
How do you learn about what is happening in the partnership? Check all that apply ☐ Updates during in-person meetings ☐ Minutes of previous meetings ☐ Electronic updates between meetings (e.g., newsletter) ☐ Verbal unstructured information sharing by partners ☐ External conferences and events ☐ Other, please specify _____	PSAT / Partner Questionnaire: Not elicited	New question, based on qualitative findings that highlighted the importance of communication to the functioning of partnerships
How <u>useful</u> is the information that you receive? ☐ Not very useful ☐ A little useful ☐ Moderately useful ☐ Useful ☐ Very useful ☐ I do not recall receiving any information	Not elicited	New question, based on qualitative findings
Do you receive <u>enough</u> information regarding partnership's activities? ☐ No, but I do not need more information ☐ No, and I would have liked more information ☐ Yes, mostly I am adequately informed ☐ Yes, I am always informed	Not elicited	New question, based on qualitative findings
Decision-making		

Appendix K. Comparison of Questionnaires.

<i>Preamble: Please think about how decisions are made and challenges are resolved in your partnership.</i>																
What are the <u>top two</u> ways in which decisions are made in the partnership? ☐ Consensus: discussion and then everyone agrees to support the decision ☐ Majority rule: voting/show of hands ☐ Executive: chair/leader decides ☐ Expert: decision delegated to a small subgroup ☐ Default: action/inaction forces a conclusion	Partner Questionnaire: What is the main way decisions are made in the partnership? PLEASE CIRCLE ONE ANSWER ONLY. <table><tr><td>Consensus (discussion and then everyone agrees)</td><td>5</td></tr><tr><td>Voting/show of hands</td><td>4</td></tr><tr><td>Official subcommittees decide</td><td>3</td></tr><tr><td>Chair/leader decides</td><td>2</td></tr><tr><td>Made by a few partners outside the partnership meetings</td><td>1</td></tr><tr><td>Don't know</td><td>0</td></tr><tr><td colspan="2">If other, please say what it is</td></tr></table>	Consensus (discussion and then everyone agrees)	5	Voting/show of hands	4	Official subcommittees decide	3	Chair/leader decides	2	Made by a few partners outside the partnership meetings	1	Don't know	0	If other, please say what it is		Response options modified, based on qualitative findings regarding how decisions were made during partnership face-to-face meetings
Consensus (discussion and then everyone agrees)	5															
Voting/show of hands	4															
Official subcommittees decide	3															
Chair/leader decides	2															
Made by a few partners outside the partnership meetings	1															
Don't know	0															
If other, please say what it is																
How <u>comfortable</u> are you with the way decisions are made in the partnership? ☐ Not very comfortable ☐ A little comfortable ☐ Moderately comfortable ☐ Comfortable ☐ Very comfortable	PSAT: How <u>comfortable</u> are you with the way decisions are made in the partnership? ☐ Extremely comfortable ☐ Very comfortable ☐ Somewhat comfortable ☐ A little comfortable ☐ Not at all comfortable	Response options modified, based on cognitive testing, changed the valence of response options from negative (1) to positive (5), in order to reduce the commonly observed positive bias in responding														
How often do you feel that you are <u>included</u> in the decision-making process? ☐ None of the time ☐ Almost none of the time ☐ Some of the time ☐ Most of the time ☐ All of the time	PSAT: How often do you feel that you have been <u>left out</u> of the decision making process? ☐ All of the time ☐ Most of the time ☐ Some of the time ☐ Almost none of the time ☐ None of the time	Modified question to use an appreciative stance, changed the valence of response options														
<u>How well</u> does the partnership address problems? ☐ Not well at all ☐ Not so well ☐ Moderately well ☐ Very well ☐ Extremely well	PSAT and Partner Questionnaire: Problem-solving questions were part of the two synergy scales.	New question, based on qualitative findings, moved to the decision-making section in order to reflect the critical thinking process involved in problem solving and decision-making														
Leadership																

Appendix K. Comparison of Questionnaires.

<i>Preamble: Please think about all the people who provide either formal or informal leadership in your partnership.</i>	PSAT: <i>Preamble: Please think about all of the people who provide either formal or informal leadership in this partnership.</i>	
How would you rate your partnership's leadership in each of the following areas: - Taking responsibility for the partnership - Communicating the vision of the partnership - Working to develop a common language within the partnership - Building on the perspectives, resources and skills of partners - Helping the partnership to look at things differently - Fostering respect, trust, inclusiveness and openness in the partnership - Creating an environment where differences of opinion can be voiced - Inspiring or motivating people involved in the partnership - Empowering people involved in the partnership - Resolving conflict among partners - Recruiting diverse people and organizations into the partnership All response options: Poor, Fair, Good, Very Good, Excellent	Please rate the <u>total effectiveness</u> of your partnership's leadership in each of the following areas: a. Taking responsibility for the partnership b. Inspiring or motivating people involved in the partnership c. Empowering people involved in the partnership d. Communicating the vision of the partnership e. Working to develop a common language within the partnership f. Fostering respect, trust, inclusiveness, and openness in the partnership g. Creating an environment where differences of opinion can be voiced h. Resolving conflict among partners i. Combining the perspectives, resources, and skills of partners j. Helping the partnership be creative and look at things differently k. Recruiting diverse people and organizations into the partnership All response options: Excellent, Very good, Good, Fair, Poor, Don't know	Modified the introductory question eliminating reference to "total effectiveness" due to various conceptualizations of effectiveness; modified the order of component questions; changed the valence of response options; removed "don't know" to force a response; changed into a matrix to reduce the amount of space used
Administration/Management		
<i>Preamble: Within the framework of IMPACT the administrative and management activities in your partnership have mostly been undertaken by the research teams.</i>	PSAT: <i>Preamble: We would like you to think about the administrative and management activities in your partnership.</i>	
How would you rate the administration/management's performance in each of the following areas: - Coordinating communication among partners - Coordinating communication with people and organizations <u>outside</u> the partnership	Please rate the effectiveness of your partnership in carrying out each of the following activities: a. Coordinating communication among partners b. Coordinating communication with people and organizations <u>outside</u> the partnership	Modified the introductory question eliminating reference to "effectiveness" due to its various conceptualizations; modified the order of component questions; changed the valence of response options; removed

Appendix K. Comparison of Questionnaires.

- Informing partners on how their input is being integrated - Organizing the overall work of the partnership - Performing secretarial duties - Preparing materials that inform partners and help them make timely decisions - Providing orientation to new partners as they join the partnership - Minimizing barriers to participation in meetings and activities (e.g., meetings at convenient places and times, providing transportation, etc.) - Facilitating meetings - Accurately reflecting discussions and decisions in the minutes of meetings or other documentation - Evaluating the progress and impact of the partnership All response options: Poor, Fair, Good, Very Good, Excellent	c. Organizing partnership activities, including meetings and projects d. Applying for and managing grants and funds e. Preparing materials that inform partners and help them make timely decisions f. Performing secretarial duties g. Providing orientation to new partners as they join the partnership h. Evaluating the progress and impact of the partnership i. Minimizing the barriers to participation in the partnership's meetings and activities (e.g., by holding them at convenient places and times, and by providing transportation and childcare) All response options: Excellent, Very good, Good, Fair, Poor, Don't know	“don't know” to force a response; changed into a matrix to reduce the amount of space used; removed “Applying for and managing grants and funds” as it was not relevant to the partnerships being studied; added “Accurately reflecting discussions and decisions in the minutes of meetings or other documentation” from the Partner Questionnaire; added “Informing partners on how their input is being integrated” as qualitative data highlighted the importance of feedback loops
Non-financial resources		
<i>Preamble: A partnership needs non-financial resources in order to work effectively and achieve its goals.</i>	PSAT: <i>Preamble: A partnership needs non-financial resources in order to work effectively and achieve its goals.</i>	
<u>To what extent</u> does your partnership have the <u>skills and expertise</u> to work well (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, etc.)? ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	For each of the following types of resources, to what extent does your partnership have what it needs to work effectively? a. Skills and expertise (e.g., leadership, administration, evaluation, law, public policy, cultural competency, training, community organizing): [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs [] Don't know	Re-wrote as separate questions; modified the response options; removed “don't know” to force a response

Appendix K. Comparison of Questionnaires.

<u>To what extent does your partnership have the <u>data and information</u> to work well (e.g., statistical data, information about community perceptions, values, resources and politics)?</u> ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	b. Data and information (e.g., statistical data, information about community perceptions, values, resources and politics)? [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs [] Don't know	
<u>To what extent does your partnership have the <u>connections to target populations</u> to work well?</u> ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	c. Connections to target populations [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs [] Don't know	
<u>To what extent does your partnership have the <u>connections to political decision-makers, government agencies, other organizations/groups</u> to work well?</u> ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	d. Connections to political decision-makers, government agencies, other organizations/groups [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs [] Don't know	
<u>To what extent does your partnership have <u>legitimacy and credibility</u> to work well?</u> ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	e. Legitimacy and credibility [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs [] Don't know	
<u>To what extent does your partnership have the <u>convening power</u> (influence and ability to bring people together for meetings and activities) to work well?</u> ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs	f. Influence and ability to bring people together for meetings and activities [] All of what it needs [] Most of what it needs [] Some of what it needs [] Almost none of what it needs [] None of what it needs	

Appendix K. Comparison of Questionnaires.

☐ All of what it needs	☐ Don't know	
Financial and other resources		
<i>Preamble: A partnership also needs financial and other capital resources in order to work effectively and achieve its goals.</i>	PSAT: <i>Preamble: A partnership also needs financial and other capital resources in order to work effectively and achieve its goals.</i>	
<u>To what extent</u> does your partnership have <u>financial support</u> that it needs to work well? ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	For each of the following types of resources, to what extent does your partnership have what it needs to work effectively? a. Money ☐ All of what it needs ☐ Most of what it needs ☐ Some of what it needs ☐ Almost none of what it needs ☐ None of what it needs ☐ Don't know	Re-wrote as separate questions; modified the response options; removed "don't know" to force a response
<u>To what extent</u> does your partnership have the <u>space</u> that it needs to work well? ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	b. Space ☐ All of what it needs ☐ Most of what it needs ☐ Some of what it needs ☐ Almost none of what it needs ☐ None of what it needs ☐ Don't know	
<u>To what extent</u> does your partnership have the <u>equipment and goods</u> that it needs to work well? ☐ None of what it needs ☐ Little of what it needs ☐ Some of what it needs ☐ Most of what it needs ☐ All of what it needs	c. Equipment and goods ☐ All of what it needs ☐ Most of what it needs ☐ Some of what it needs ☐ Almost none of what it needs ☐ None of what it needs ☐ Don't know	
Resource utilization (Efficiency in PSAT and Partner Questionnaire)		
<i>Preamble: Please think about the degree to which various partnership resources are optimized.</i>		

Appendix K. Comparison of Questionnaires.

Please choose the statement that best describes how well your partnership uses its <u>non-financial resources</u> (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods, etc.). ☐ The partnership makes <u>poor</u> use of its non-financial resources ☐ The partnership makes <u>fair</u> use of its non-financial resources ☐ The partnership makes <u>good</u> use of its non-financial resources ☐ The partnership makes <u>very good</u> use of its non-financial resources ☐ The partnership makes <u>excellent</u> use of its non-financial resources ☐ I do not know how the partnership uses its non-financial resources	PSAT: Please choose the statement that best describes how well your partnership uses the partners' <u>in-kind resources</u> (e.g., skills, expertise, information, data, connections, influence, space, equipment, goods). ☐ The partnership makes <u>excellent</u> use of partners' in-kind resources. ☐ The partnership makes <u>very good</u> use of partners' in-kind resources. ☐ The partnership makes <u>good</u> use of partners' in-kind resources. ☐ The partnership makes <u>fair</u> use of partners' in-kind resources. ☐ The partnership makes <u>poor</u> use of partners' in-kind resources.	Changed from “in-kind resources” to “non-financial resources” as “in-kind” would not be understood by all partners; changed the valence of response options; added “don’t know” as a response option for all questions, as some partners in the partnerships under investigations were not involved in decisions regarding resources; added “not applicable” as a response option in question regarding financial resources as some partnerships did not have financial resources
Please choose the statement that best describes how well your partnership uses the <u>partners’ time</u>. ☐ The partnership makes <u>poor</u> use of partners’ time ☐ The partnership makes <u>fair</u> use of partners’ time ☐ The partnership makes <u>good</u> use of partners’ time ☐ The partnership makes <u>very good</u> use of partners’ time ☐ The partnership makes <u>excellent</u> use of partners’ time ☐ I do not know how the partnership uses partners’ time	Please choose the statement that best described how well your partnership uses the partners’ <u>time</u>. ☐ The partnership makes <u>excellent</u> use of partners’ time. ☐ The partnership makes <u>very good</u> use of partners’ time. ☐ The partnership makes <u>good</u> use of partners’ time. ☐ The partnership makes <u>fair</u> use of partners’ time. ☐ The partnership makes <u>poor</u> use of partners’ time.	
Please choose the statement that best describes how well your partnership uses its <u>financial resources</u>, including those of any partner. ☐ The partnership makes <u>poor</u> use of its financial resources ☐ The partnership makes <u>fair</u> use of its financial resources	Please choose the statement that best describes how well your partnership uses the partners’ <u>financial resources</u>. ☐ The partnership makes <u>excellent</u> use of partners’ financial resources. ☐ The partnership makes <u>very good</u> use of partners’ financial resources. ☐ The partnership makes <u>good</u> use of partners’ financial resources.	

Appendix K. Comparison of Questionnaires.

☐ The partnership makes <u>good</u> use of its financial resources ☐ The partnership makes <u>very good</u> use of its financial resources ☐ The partnership makes <u>excellent</u> use of its financial resources ☐ I do not know how the partnership uses its financial resources ☐ Not applicable, there are no financial resources	☐ The partnership makes <u>fair</u> use of partners' financial resources. ☐ The partnership makes <u>poor</u> use of partners' financial resources.	
External environment (new subscale in MSPQ)		
<i>Preamble: Please think about all the external influences that your partnership has experienced (e.g., changes in the funding landscape, policy changes) that have had an impact on the partnership or achievement of its goals.</i>		
<u>To what extent</u> has the partnership been affected by <u>external factors</u>, beyond the control of the partnership? ☐ Not at all ☐ A little ☐ Moderately ☐ A lot ☐ A great deal	PSAT / Partner Questionnaire: No separate external environment scale	New question, based on qualitative findings that highlighted the important impact of the external environment on the work of the partnerships
<u>How well</u> has the partnership <u>adapted</u> to these external influences? ☐ Not well at all ☐ Not so well ☐ Moderately well ☐ Very well ☐ Extremely well		New question, based on qualitative findings
Partnership's Value (Synergy in PSAT)		
<i>Preamble: Please think about the people and organizations that are participants in your partnership.</i>	PSAT: <i>Preamble: Please think about the people and organizations that are participants in your partnership.</i>	

Appendix K. Comparison of Questionnaires.

<u>By working together, how well are these partners able to identify new and creative ways to solve problems?</u> ☐ Not well at all ☐ Not so well ☐ Moderately well ☐ Very well ☐ Extremely well	<u>By working together, how well are these partners able to identify new and creative ways to solve problems?</u> [] Extremely well [] Very well [] Somewhat well [] Not so well [] Not well at all	Outcome measure. Item from the Weiss synergy scale: changed valence of response options, changed “somewhat” to “moderately”
<u>By working together, how well are these partners able to include the views and priorities of the people affected by the partnership’s work?</u> ☐ Not well at all ☐ Not so well ☐ Moderately well ☐ Very well ☐ Extremely well	<u>By working together, how well are these partners able to include the views and priorities of the people affected by the partnership’s work?</u> [] Extremely well [] Very well [] Somewhat well [] Not so well [] Not well at all	Outcome measure. Item from the Weiss synergy scale: changed valence of response options, changed “somewhat” to “moderately”
<i>Preamble: Now, thinking about how often things happen.</i>		
<u>When working together, how often do you feel that the partnership is making good progress towards its goals?</u> ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always	Partner Questionnaire: When working together, how often does your partnership experience the following? The partnership is making ongoing progress towards its goals - Always - Often - Sometimes - Rarely - Never - Don’t know	Process measure. Item from the Jones synergy scale: modified question, changed from matrix question into a separate question, changed response option valence, removed “don’t know” response option
<u>When working together, how often do you feel that added value is achieved as a result of working in this partnership?</u> ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always	Extra outcomes are achieved as a result of working in partnership - Always - Often - Sometimes - Rarely - Never - Don’t know	Process measure. Item from the Jones synergy scale: modified question, changed from matrix question into a separate question, changed response option valence, removed “don’t know” response option

Appendix K. Comparison of Questionnaires.

<u>When working together, how often do you feel that the skills and unique perspectives of the partners <u>complement</u> each other?</u> ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always	The skills and unique perspectives of the partners complement each other - Always - Often - Sometimes - Rarely - Never - Don't know	Process measure. Item from the Jones synergy scale: changed from matrix question into a separate question, changed response option valence, removed "don't know" response option
<u>When working together, how often do you feel that <u>all partners are benefiting</u> from the activities of the partnership?</u> ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always	All partners are benefiting from the activities of the partnership - Always - Often - Sometimes - Rarely - Never - Don't know	Process measure. Item from the Jones synergy scale: changed from matrix question into a separate question, changed response option valence, removed "don't know" response option
<u>When working together, how often does the partnership experience <u>feelings of energy, excitement and passion</u>?</u> ☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Always	Feelings of energy, excitement and passion - Always - Often - Sometimes - Rarely - Never - Don't know	Process measure. Item from the Jones synergy scale: changed from matrix question into a separate question, changed response option valence, removed "don't know" response option
Benefits		
<i>Preamble: Please think about the benefits of participating in this partnership for the organization that you are representing.</i>		
For each of the following benefits, please indicate whether <u>the organization that you are representing</u> has benefitted from: - Enhanced ability to address an important issue - Development of new skills - Heightened public profile of the organization - Increased understanding of partners of my organization's expertise and services	PSAT: For each of the following benefits, please indicate whether you have or have not received the benefit as a result of participating in the partnership: a. Enhanced ability to address an important issue ☐ Yes ☐ No b. Development of new skills ☐ Yes ☐ No	Modified the introductory question changing emphasis from "you" to "organization"; changed the order of component questions; changed from stand alone questions into a matrix to reduce the amount of space used; changed the number of response option from Yes/No to No, not at all; No, not really; Yes, a little;

Appendix K. Comparison of Questionnaires.

- Acquisition of useful knowledge about services, programs or people represented in the partnership - Enhanced ability to affect public policy - Development of valuable relationships - Enhanced ability to meet the needs of my organization's constituency or clients - Ability to have a greater impact than we could have on our own - Ability to make a contribution to the community - Acquisition of additional financial support All response options: No, not at all; No, not really; Yes, a little; Yes, definitely	c. Heightened public profile [] Yes [] No d. Increased utilization of my expertise or services [] Yes [] No e. Acquisition of useful knowledge about services, programs, or people in the community [] Yes [] No f. Enhanced ability to affect public policy [] Yes [] No g. Development of valuable relationships [] Yes [] No h. Enhanced ability to meet the needs of my constituency or clients [] Yes [] No i. Ability to have a greater impact that I could have on my own [] Yes [] No j. Ability to make a contribution to the community [] Yes [] No k. Acquisition of additional financial support [] Yes [] No	Yes, definitely, in order to capture a more nuanced picture. Modified wording in questions c, d, e, h and i.
Drawbacks of participation		
<i>Preamble: Please think about the drawbacks of participating in this partnership for the organization that you are representing.</i>		
For each of the following drawbacks, please indicate whether the organization that you are representing has experienced the following: - Diversion of time and resources away from other priorities or obligations	PSAT: For each of the following drawback, please indicate whether or not you have or have not experienced the drawback as a result of participating in this partnership.	Modified the introductory question changing emphasis from "you" to "organization"; changed from stand alone questions into a matrix to reduce the amount of space used;

Appendix K. Comparison of Questionnaires.

- Insufficient influence in partnership activities - Negative publicity due to association with other partners or the partnership - Insufficient credit given to my organization for contributing to the accomplishments of the partnership - Conflict between the demands of this partnership and other projects within my organization All response options: No, not at all; No, not really; Yes, a little; Yes, definitely	a. Diversion of time and resources away from other priorities or obligations ☐ Yes ☐ No b. Insufficient influence in partnership activities ☐ Yes ☐ No c. Viewed negatively due to association with other partners or the partnership ☐ Yes ☐ No d. Frustration or aggravation ☐ Yes ☐ No e. Insufficient credit given to me for contributing to the accomplishments of the partnership ☐ Yes ☐ No f. Conflict between my job and the partnership's work ☐ Yes ☐ No	changed the number of response option from Yes/No to No, not at all; No, not really; Yes, a little; Yes, definitely, in order to capture a more nuanced picture. Modified wording in questions c, e, f; removed d.
Comparing benefits and drawbacks		
On the whole, how do the benefits of participating in this partnership compare to the drawbacks? ☐ Benefits greatly exceed the drawbacks ☐ Benefits exceed the drawbacks ☐ Benefits and drawbacks are about equal ☐ Drawbacks exceed the benefits ☐ Drawbacks greatly exceed the benefits	PSAT: So far, how have the benefits of participating in this partnership compared to the drawbacks? ☐ Benefits greatly exceed the drawbacks ☐ Benefits exceed the drawbacks ☐ Benefits and drawbacks are about equal ☐ Drawbacks exceed the benefits ☐ Drawbacks greatly exceed the benefits	Slightly modified the question, emphasizing the experience as a whole
Other comments		
Overall, how well has the goal of developing a meaningful partnership been achieved? ☐ Not well at all ☐ Not so well ☐ Moderately well ☐ Very well ☐ Extremely well		New question, to capture the aggregate assessment

Appendix L. Comparison of Ranking of Partnerships

Table 1. Synergy processes (partnership-level mean scores (SD) and median scores (IQR)), and rankings of partnerships based on partnership synergy processes scores and qualitative assessment by content reviewers (N=5)

Partnership	Partnership Synergy Processes (means and SD)	Partnership Synergy Processes (medians and IQR)	Rank by mean ^a score, Highest (1), lowest (5)	Rank by content reviewers, Highest (1), lowest (5)
Service Linkage	3.31 (0.75)	3.60 (1.30)	5	4
Community Health Resources	3.76 (0.53)	3.60 (0.95)	3	3
Diabetes Self-management	3.54 (0.61)	3.80 (1.00)	4	5
Primary Care Connection	3.78 (0.75)	4.00 (1.00)	2	2
Community Outreach	4.20 (0.37)	4.20 (0.60)	1	1
^a Mean values were used where there was insufficient differentiation between partnerships based on medians.				

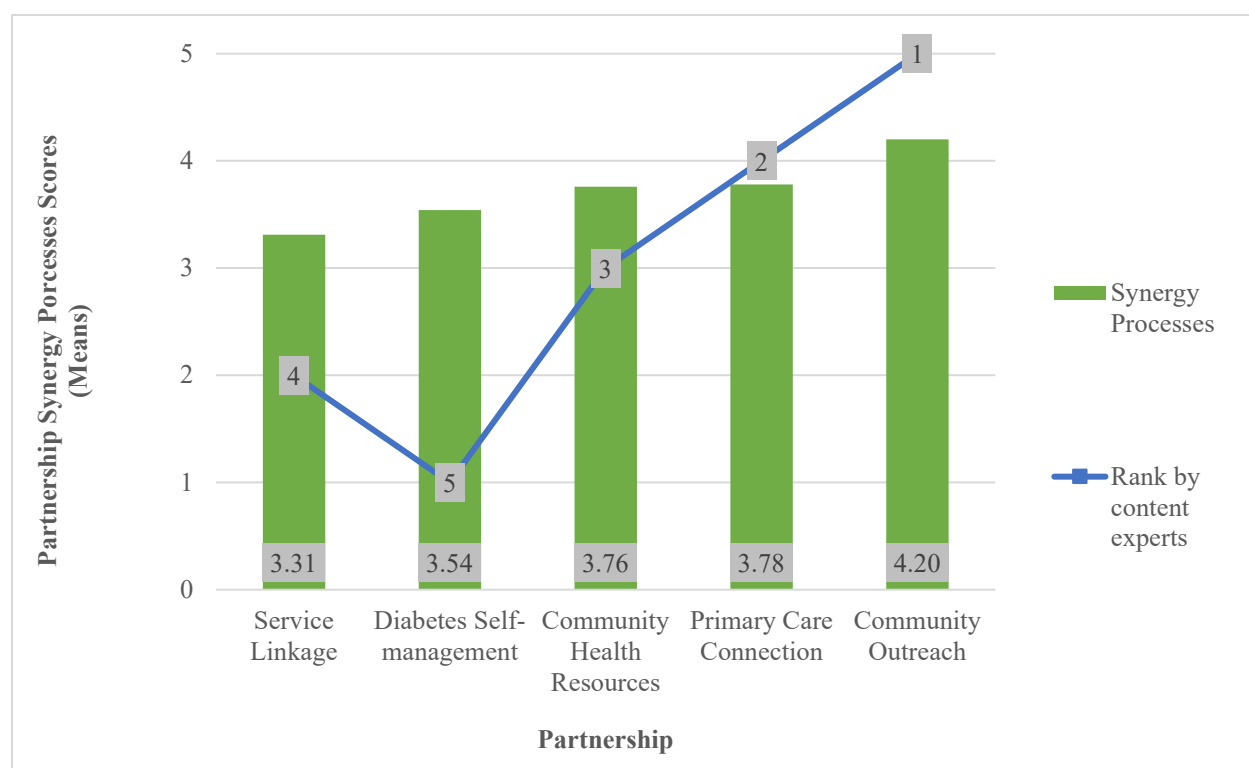


Figure 1: Partnership synergy processes (partnership-level mean scores) and rankings of partnerships based on qualitative assessment by content reviewers (highest = 1 to lowest = 5) (N=5)

Appendix M. Mapping of qualitative categories onto PSAT scales

Qualitative Categories	Existing PSAT (2002 version) scales	New scales and items	Item content
1) Non-financial (intangible) assets	Non-financial resources (6 items)	New descriptive questions about organizational expertise brought to the partnership table	Assessment of the degree to which the following resources were present: skills and expertise; data and information; connections to target populations; connections to political decision-makers, government agencies, other organizations/groups; legitimacy and credibility; convening power
2) Financial (tangible) assets	Financial and other capital resources (3 items)		Assessment of the degree to which the following resources were present: financial support; space; equipment and goods
3) Resource integration	Efficiency (3 items), renamed Resource Utilization	New descriptive questions about the nature of stakeholder engagement	Assessment of how well the partnership used partner's time, other non-financial resources, and financial resources
4) Leadership	Leadership (11 items)		Assessment of the partnership's leadership in the following areas: - Taking responsibility for the partnership; - Communicating the vision of the partnership; - Working to develop a common language within the partnership; - Building on the perspectives, resources and skills of partners; - Helping the partnership to look at things differently; - Fostering respect, trust, inclusiveness and openness in the partnership; - Creating an environment where differences of opinion can be voiced; - Inspiring or motivating people involved in the partnership; - Empowering people involved in the partnership; - Resolving conflict among partners; - Recruiting diverse people and organizations into the partnership
5) Administration and management	Administration and management (9 items)		Assessment of the administration/management's performance in each of the following areas: - Coordinating communication among partners; - Coordinating communication with people and organizations outside the partnership; - Informing partners on how their input is being integrated; - Organizing the overall work of the partnership; - Performing secretarial duties; - Preparing materials that inform partners and help them make timely decisions; - Providing orientation to new partners as they join the partnership; - Minimizing barriers to participation in meetings and activities (e.g., meetings at convenient places and times, providing transportation, etc.); - Facilitating meetings; - Accurately reflecting discussions and decisions in the minutes of meetings or other documentation; - Evaluating the progress and impact of the partnership

Appendix M. Mapping of qualitative categories onto PSAT scales

Qualitative Categories	Existing PSAT (2002 version) scales	New scales and items	Item content
6) Communication		New scale for Communication (3 items)	How the participants learn about what is happening in the partnership; how useful the information is; do the participants receive enough information
7) Decision-making	Decision-making (3 items)		The top ways in which decisions are made; how comfortable participants are with the way decisions are made; how often participants feel included in the decision-making process; how well the partnership addresses problems.
8) Contextual adaptation		New scale for External environment (2 items)	Assessment of the extent to which the partnership has been affected by external factors, beyond the control of the partnership; how well the partnership has adapted to these external influences
9) Reported benefits	Benefits of participation (11 items) Drawbacks of participation (6 items)		Whether the organization that each stakeholder is representing has benefitted from: - Enhanced ability to address an important issue; - Development of new skills; - Heightened public profile of the organization; - Increased understanding of partners of my organization's expertise and services; - Acquisition of useful knowledge about services, programs or people represented in the partnership; - Enhanced ability to affect public policy; - Development of valuable relationships; - Enhanced ability to meet the needs of my organization's constituency or clients; - Ability to have a greater impact than we could have on our own; - Ability to make a contribution to the community; - Acquisition of additional financial support Whether the organization that each stakeholder is representing has experienced the following: - Diversion of time and resources away from other priorities or obligations; - Insufficient influence in partnership activities; - Negative publicity due to association with other partners or the partnership; - Insufficient credit given to my organization for contributing to the accomplishments of the partnership; - Conflict between the demands of this partnership and other projects within my organization
10) Partnership synergy	Weiss <i>et al.</i> scale [49] – 2 items retained	Jones synergy scale (Jones & Barry, 2011b) – 5 items retained	How well the partners are able to: identify new and creative ways to solve problems; include the views and priorities of the people affected by the partnership's work. How often the participants feel that the partnership is making good progress towards its goals; added value is achieved as a result of working in this partnership; the skills and unique perspectives of the partners complement each other; all partners are benefiting from the activities of the partnership; how often does the partnership experience feelings of energy, excitement and passion