## Challenges of Capacity Building in Multisector Community Health Alliances


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Capacity building is often described as fundamental to the success of health alliances, yet there are few evaluations that provide alliances with clear guidance on the challenges related to capacity building. This article attempts to identify potential challenges of capacity building in multistakeholder health alliances. The study uses a multiple case study design to identify potential challenges and trade-offs associated with capacity building in four community health alliances in the United States. Multiple challenges were found to be common across the four alliances, including specifying appropriate governance structures and decision-making frameworks, aligning stakeholder interests with the vision of the alliance, balancing short-term objectives with long-term goals, and securing resources to sustain the effort without compromising it. These challenges often involved trade-offs and choices that alliances need to prepare for if they are to approach capacity building in a planful rather than a reactive manner.

***Keywords:*** *Aligning Forces for Quality; capacity building; community health alliances; qualitative research*

Health care "alliances" refer to partnerships, coalitions, consortia, and other forms of voluntary, multistakeholder arrangements created to pursue mutually agreed on goals related to improving health care delivery in the community (Mitchell & Shortell, 2000). To improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression, and heart disease, a number of communities are developing voluntary alliances among health care plans, providers (physicians and physician groups, hospitals), purchasers (employers) and consumers (patients), and other stakeholders. These alliances are intended to facilitate local or regional integration of efforts to address the complex

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problems of caring for the chronically ill and improve the quality of care received by those who experience chronic illness (Butterfoss, Goodman, & Wandersman, 1996; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001; Mitchell & Shortell, 2000). The prospect of accomplishing together what no one sector could do if acting alone has provided a compelling rationale for traditionally independent actors to engage in collaborative approaches to improve quality of care for the chronically ill.

Although the theoretical advantages of collaboration are considerable, recent experience has shown that many alliance efforts have found it difficult to demonstrate meaningful impact in the short term (Wagner et al., 2000; Wickizer et al., 1998). Many times, this is because they fail to develop a viable and durable basis for collective action. To realize their ambitious goals, in other words, many believe that alliances must develop the capacity to sustain activity and participation over a significant period of time (Aspen Institute, 1997; Green, 1989; Huxham, 1996; Lasker & Weiss, 2003; Lasker, Weiss, & Miller, 2001; Shortell et al., 2002). Thus, capacity building may be defined as the activities and structures that leverage existing resources in pursuit of some common objective(s), and which are sustainable over the long term.

Despite experts' view that capacity building is of critical importance to the success of health alliances, there are few empirical studies that provide alliances with realistic description of the challenges and trade-offs related to capacity building (Butterfoss et al., 1996; Butterfoss, Goodman, & Wandersman, 1993; Green, 1989; Shortell et al., 2002). Indeed, much of the literature on alliance capacity building is both highly prescriptive and based on very limited empirical evidence (often case studies of single alliances). Furthermore, most such prescriptions assume that a "one best model" exists for capacity building for all alliances, under all conditions. However, given the wide range of alliance types, goals, and membership composition, such assumptions are disingenuous and may establish unrealistic expectations for alliance leaders about how capacity is built and the trade-offs that may be necessary in practice (Chavis, 2001).

Our article attempts to strike a balance between two polar positions: (a) that all alliances are fundamentally similar and therefore subject to a singular approach to capacity building and (b) that all alliances are unique and so approaches to capacity building need to be idiosyncratic to each case. Using comparative, qualitative data from four alliances from the Aligning Forces for Quality (AF4Q) initiative and established theoretical constructs in the alliance literature, we attempt to identify the likely challenges and trade-offs that alliances may encounter as they work to develop strategies to sustain their efforts over the long term. Unlike previous writing on alliance capacity building, we do not provide prescriptive solutions. Our research is designed to use empirical analysis to lay the groundwork for alliances to make their own decisions about capacity-building approaches. Without such guidelines, alliances are forced to learn "on the job" as such issues arise, rather than anticipating and strategically preparing for these challenges. From a policy perspective, a balanced analysis of capacity-building challenges may inform debate about the sustainability of multisector health alliances and determine whether future policy should promote alliances as alternatives to more national approaches to improving health care quality.

## BACKGROUND

Capacity building is both a key requirement for alliance success and a major challenge for such organizations in achieving these goals (Altman et al., 1991; Janz et al., 1996; Seifer, 2006). Multisector health alliances face strong structural challenges to capacity

building. Because they operate on the basis of voluntary collaboration rather than hierarchical control, an alliance's authority to set agendas, allocate resources, and resolve conflict is tenuous, deriving more from consent than from equity ownership or contractual authority (Alexander, Comfort, Weiner, & Bogue, 2001; Huxham, 1996). This suggests that members of the alliance are only loosely bound to the organization and can leave without serious consequences to themselves should the alliance take an unacceptable position or threaten entrenched interests. Lack of barriers to exit is an omnipresent threat to alliance capacity building (Alexander et al., 2001; Zuckerman, Kaluzny, & Ricketts, 1995). Furthermore, alliances often consist of a broad spectrum of public, nonprofit, investor-owned, and community-based organizations. Cultural differences that arise from differences in time horizons, risk orientations, and decision-making styles make it difficult to design an alliance structure and set of operational rules that are acceptable to all parties (Alexander et al., 2001; Sink, 1996; Weiner, Alexander, & Zuckerman, 2000). Because the structural "glue" present in most formal organizations is lacking in most alliances, considerable efforts by alliances in the short term are focused on building trust and collaborative decision-making norms, rather than active movement toward the goals of the alliance (Gulati, Khann, & Nohria, 1994; Huxham, 1996).

In a similar vein, alliances consist of members with varying levels of resource and effort commitment to the alliance and varying degrees of overlap between their own institutional goals and activities and those of an alliance (Okubo & Weidman, 2000; Swain, Bennett, Etkind, & Ransom, 2001). All partner organizations walk a fine line between commitment to the alliance and its goals, on the one hand, and those of their home organizations, on the other (Gamm, 1998; Huxham, 1996; Sink, 1996; Zuckerman et al., 1995). If these commitments are not aligned, this duality can provide considerable stress on the ability of health alliances to develop capacity to accomplish their goals and sustain the alliance over the long term.

Formal studies of barriers to capacity building provide a useful starting point to identify challenges to developing sustainable programs. Hannah (2006), for example, discusses the tension between a program's desire to produce tangible outcomes ("product") and the need to develop processes that support capacity building ("processes"). Funding agencies that stress accountability create pressure to produce and measure short-term outcomes, possibly at the expense of processes that support and sustain longer term capacity (P. Brown, Butler, & Hamilton, 2001). This view is indirectly supported by research demonstrating that programs more focused on capacity-building activities obtained less external funding than those programs predominantly focused on measuring short-term results (Chaskin, Chipenda-Dansokho, & Richards, 1999). Similarly, research has found that the demands of implementing programs (as opposed to the planning stage) can undermine longer term capacity-building goals (Herbert, Vidan, Mills, James, & Gruenstein, 2001). Specifically, the operational and monitoring demands of implementing these programs can dominate staff time and effort, resulting in a loss of focus on longer term program goals.

## THEORETICAL FRAMEWORK

Building on the extant literature on capacity building, we propose that there are two primary domains of activity that form the building blocks for enhanced capacity in multisector alliances: infrastructure and governance, and stakeholder relations and participation (Foster-Fishman et al., 2001; Hawe, Noort, King, & Jordens, 1997; Zakocs & Guckenburg, 2007). *Infrastructure and governance* refers to the ability of the alliance to develop internal

support and decision-making systems that foster effective member participation, develop leadership, acquire resources, and avoid overburdening key members. *Stakeholder relations and participation* refers to the relationships between alliance stakeholders that facilitate or inhibit the ability of the alliance to set goals and undertake activities in pursuit of those goals. This domain also includes activities undertaken by the alliance and its leadership to establish these relationships *and* to be inclusive with regard to direct community input and participation in the alliance.

The primary objective of this study is to use systematic, empirical analysis to identify common capacity-building challenges and trade-offs within these two domains.

## METHOD

### Study Design

This study was part of a larger investigation, *Aligning Forces for Quality: The Regional Market Project*, a national program of the Robert Wood Johnson Foundation (RWJF) designed to help communities across the United States improve the quality of health care for patients with chronic conditions such as diabetes, asthma, depression, and heart disease. The premise of *Aligning Forces for Quality* (AF4Q) is that no single person, group or profession can improve the quality of care without the support of others. AF4Q seeks to drive quality improvement by aligning key stakeholders, including health care providers (physicians/physician groups, nurses, clinics), health care purchasers (employers and insurers), and health care consumers (patients) in what we call "alliances." Through this funding, the regional alliances are charged to improve health care by moving on three fronts: (a) help providers improve their own ability to deliver quality care (Quality Improvement); (b) help providers measure and publicly report their performance (Quality Measurement and Reporting); and (c) help patients and consumers understand their vital role in recognizing and demanding high-quality care (Consumer Engagement).

Like other collaborative community health organizations, those we studied possessed several features that distinguish them from traditional service delivery organizations, advocacy organizations, and special-interest groups. First, they are based on voluntary collaboration rather than hierarchical control. Second, they reflect multiple sectors of business, care delivery, insurance, and consumers. Third, they consist of partnering organizations with varying levels of resource and effort commitment to the alliance and varying degrees of overlap between their own institutional goals and activities and those of the alliance as a whole. Fourth, they were charged to take a comprehensive and coordinated approach to improving care for the chronically ill. Finally, they exist primarily to benefit the community, although they must also create value for the partnering organizations (Shortell et al., 2002).

To examine the challenges related to alliance capacity building, we adopted a multiple holistic case study design (Yin, 1994). We used theoretical rather than statistical criteria to generalize study findings to the body of knowledge relevant to these kinds of interorganizational arrangements. We selected four alliances (out of 14 total) based on their early entrant status into the AF4Q program and their relative level of experience and development. All alliances were required to participate as a condition of the grant. The four study sites vary in terms of their environmental contexts and histories of collaboration. For instance, two were from the Midwest, one was from the Pacific Northwest, and one was from the South. Three of the alliances had preexisting structures in place prior to the AF4Q

project, whereas one was formed largely in response to the project. Despite such market and developmental differences, in this study we emphasize common themes and dilemmas rather than differences across cases in an effort to identify robust, generalizable issues rather than those that were idiosyncratic to a particular site.

## Data

We conducted semistructured, face-to-face interviews at the four case study sites in 2007. On average, 17 key informants were interviewed at each site, with a range of 15 to 19. After initial selection by the investigators, potential informants were encouraged to participate in the study by the alliance leadership, which helped secure full participation from all informants identified for the study. These informants represented a broad cross section of stakeholders in each alliance, including hospital and insurance company chief executive officers, practicing physicians, representatives from professional associations and consumer organizations, government representatives, local employers, and retirees and consumers. They also included alliance governing body representatives as well as general members and staff of the alliance. Each interview lasted approximately 1 hour and was tape recorded in full by the investigators. The semistructured interviews were conducted using formal interview protocols that were divided into eight question "modules," each of which addressed a particular aspect of alliance organization, governance, or strategy. Topics included alliance history, governance and management, staffing, membership, vision and goals, and activities designed to achieve alliance objectives. A total of 68 individual interviews were transcribed word-for-word and prepared for computerized text search using ATLAS.ti software. A team of two researchers conducted the interviews at each site; however, each informant typically was interviewed by only one researcher.

## Analysis Plan

The 68 hour-long interviews produced approximately 1,222 double-spaced pages of transcripts. As a research tool, ATLAS.ti helped us manage this quantity of data and examine the meanings and methods of capacity-building from the perspective of the interview participants. Analysis proceeded in four steps. First, we used the existing literature to develop a conceptual map of the capacity-building construct and a corresponding list of search terms related to this conceptual map. In the second step, we used the resulting groups of capacity building–related terms to conduct text searches with ATLAS on all 68 interview transcripts. The text searches used a Boolean "OR" logic, such that any references to a search term by any interview participant would be captured and collated into a report. Five project investigators reviewed these reports independently to examine what informants said about capacity building, with one team member formally coding the results for each report. This process yielded a consolidated scheme of emergent categories that could be organized around domains related to challenges of alliance capacity building (Lofland & Lofland, 1995). In the third step, the team used the consolidated scheme in a further round of coding and generated a subsequent set of reports that linked all coded text associated with a given category. Each team member then examined these reports, identified key challenges for each capacity-building factor, and wrote a short memo that more fully described these themes (Lofland & Lofland, 1995). Team members discussed the memos, expanded or consolidated challenges, and repeated the process for each capacity-building category. In the fourth and final step, we used the memos to compare and contrast challenges and trade-offs based on the two capacity-building domains. The aim of these

Table 1. Domains, Search Terms, and Challenges Associated With Capacity Building

| Capacity-Building Domain | Search Terms | Challenge |
|---|---|---|
| Infrastructure and governance | Accountability<br>Consensus building<br>Focus<br>Goals<br>Governance/authority<br>Identifying needs<br>Leadership<br>Resources<br>Staffing<br>Vision | 1. Establishing the right organizational or governance structure<br>2. Appropriately balancing power and participation<br>3. Decision-making inclusiveness versus decision-making efficiency<br>4. Making collateral leadership work<br>5. Defining staff versus member roles<br>6. Developing resource capacity |
| Stakeholder relations and participation | Conflict<br>Cost-benefits of involvement<br>Credibility/standing in the community<br>Interorganizational relationships<br>Participation<br>Trust | 1. Building on culture and historical relationships<br>2. Reconciling short and long-term objectives<br>3. Soliciting participation<br>4. Sustaining participation |

comparisons was to identify commonalities in capacity-building factors among sample sites. Table 1 references the two capacity-building domains and related search terms and codes identified from the extant literature. The capacity-building challenges listed in the third column emerged from the analysis of key informant transcripts using these search terms.

We present the key findings of this analysis below. The most salient challenges associated with both of the domains—infrastructure and governance, and alliance–partner relations—are discussed. We conclude with several recommendations for both existing and emerging alliances.

## INFRASTRUCTURE AND GOVERNANCE

### Establishing the Right Organizational and Governance Structure

Our data suggest that one of the first capacity-building challenges for an emerging alliance is the decision to develop a new, independent governance structure versus using an existing, more established structure. In the former case, a new structure gives the alliance an identity that is potentially independent from any historical or established organizational relations in the market and offers the potential for creating a vehicle for initiatives that is not burdened by existing "baggage." In the latter case, it builds on a foundation developed by an existing organization that may provide leverage for the alliance and its activities. The decision of the appropriate organizational arrangements may have implications for how that alliance is generally perceived by the public or by key stakeholder groups and its ability to generate participation and resources. For example, if the alliance is tied to an organization acting as fiscal agent for the grant, this may or may not work to

the advantage of the alliance if that organization is perceived to be committed to a particular position or philosophy with regard to, say, public reporting or quality improvement. Similarly, perceptions that the alliance is tied to an existing organization may cause certain stakeholders to perceive the alliance as less than impartial in its dealing with new members of multistakeholder groups. These perceptions may have significant consequences for sustainable effort, especially for those alliances that depend on continued or renewed commitment from stakeholders or funders. In the final analysis,

> There's recognition that there needs to be a strong governance model to make sure that everyone was represented and not any one particular group is too heavily represented. We spent a lot of time trying to determine what the right balance was for governance in the various subcommittees under the executive committee and under the board of directors and how all of those rolled up.

## Appropriately Balancing Power and Participation

The four alliances took two distinct power sharing strategies. Two alliances embraced a norm of equality among members and valued leadership neutrality. They selected individuals with few vested interests or prespecified agendas to hold leadership positions. By contrast, the two alliances that used an equity approach to leadership tied leadership directly to the level of resources contributed to the alliance or to the perceived centrality of the organization to the community. Previous research suggests that neutral leadership fosters equal voice and representation among all members of the alliance, regardless of resources, power, and size, and reduces perceived threats by ensuring no one actor or perspective dominates (Alexander et al., 2001). Neutral leadership is expected to ensure that leadership will not favor particular constituencies over the interest of the collective enterprise. Although holding considerable appeal, our results also indicate that so-called neutral or equality leadership may exclude committed, visionary individuals from leadership positions based simply on organizational or sectoral affiliation. In addition, the desire for neutrality may at times lead to democratic paralysis or unwillingness for leadership to make difficult but necessary decisions to move the alliance forward. For instance, one respondent noted that a norm of consensus decision making had delayed progress on a key alliance initiative:

> See we're heading towards a very important Board meeting next week, key issues on our performance reporting system, and we don't have consensus. The doctors are over here and the purchasers are over here on some issues, as you might expect and so the make up of the Board is going to be very important next week.

An equity-based leadership approach assumes that the views of all alliance members are respected in alliance decisions but that influence will be tied to financial or political support of the alliance, or importance of the organization in achieving the goals of the alliance. An example is the strong representation of payers in one alliance, which required that this group hold a majority position on the steering committee of the alliance. Such explicit consideration of powerful stakeholders makes it obvious that these groups are critical to decision making in reaching alliance goals of disseminating quality information and changing provider and consumer behavior. Equity-based power sharing may provide more efficient decision making and more focused direction for the alliance. Like other approaches to leadership, however, an equity leadership approach presupposes that a strong foundation of trust and honesty exists between alliance leaders and

members of the alliance. Partners of lesser power will quickly feel disenfranchised or threatened unless they feel their views are respected and they can be assured that the alliance leaders will not abuse their position or show preference for the views of certain alliance partners.

Some put the challenge of finding the optimal distribution of power and influence bluntly: "You have to give adequate roles to those writing the biggest checks." Others provide a more subtle description of creating gradations of membership with major funders given greater standing in governance, whereas others use an approach with a prescribed majority on the controlling body for certain groups:

> We spend a lot of time on that governance model. There was a recognition that there needed to be a strong governance model to make sure that everyone was represented and not any one particular group is too heavily represented. For example, the purchasers do have a majority on the board but only by one seat.

### Decision-Making Inclusiveness Versus Decision-Making Efficiency

Another governance and accountability challenge identified in our analysis is the trade-off between decision-making efficiency and inclusiveness in participation. The essence of this dilemma comes in the inherent challenge of managing a multistakeholder group and the inordinate amount of time typically needed to discuss and make decisions regarding alliance strategy or operational practices. Often alliances are faced with a choice of establishing a smaller "executive committee" to make key policy decisions versus taking a more consensus-based approach of involving the entire alliance membership in virtually all decisions. The risk of adopting a small, exclusive decision-making group is that it may create the perception that the alliance is more oriented to some stakeholder groups than others, which other research has suggested may negatively affect member satisfaction (Alexander et al., 2001; Metzger, Alexander, & Weiner, 2005; Weiner, Alexander, & Shortell, 2002) and perceptions of participation costs and benefits (Metzger et al., 2005; Shortell et al., 2002). Alternatively, a more consensus-based approach necessitates much greater commitment of time and process-oriented activities. This in turn may lead to delays in alliance development and possibly burnout in alliance leadership and staff. As one respondent stated,

> Every one of our committees represents the multistakeholders of the alliance and most of the time that's a good thing. Occasionally when you get so many divergent points of views in the room, it's hard to agree on things. That's what we are all about trying to build agreement among those things but sometimes it makes the work tough, it makes it harder going.

In a related vein, alliance governance must often contend with the trade-off between including organizations or individuals for political reasons versus substantive reasons. For example, some organizations may be considered for membership in the alliance steering committee or board because these organizations are powerful players within the community, or have the ability to contribute or raise funds for the alliance despite having no real substantive bearing on the alliance goals or strategies. The risk in taking a more politically oriented view in alliance membership is that the substantive input and expertise necessary to make a lasting contribution to alliance capacity may be sacrificed. Alternatively, ignoring key organizational players in alliance membership may deprive the alliance of both political and resource support as it moves forward toward its goals.

## Making Collateral Leadership Work

A key challenge of alliance leadership in capacity building is to ensure that the leadership functions in the alliance do not reside in one individual or one organization but are systematically and strategically distributed in a manner to ensure the effective recognition of specific areas of expertise and to avoid both burnout and control by a single individual or stakeholder (Alexander et al., 2001; Shortell et al., 2002). The risk in pursuing such a collateral leadership model is that the efforts of the alliance soon become fragmented and uncoordinated (Bazzoli et al., 2003; Hasnain-Wynia et al., 2003). Thus, a key challenge in capacity building is for alliances to engage leaders from a broad and representative group of committed individuals and, at the same time, direct the alliance in an effective fashion toward its ultimate objectives. The results of our study support such findings and show that significant problems can result when the formal leadership and collateral leadership are out of balance. For example, if formal leaders exercise little or no influence over alliance strategies, advocates for particular approaches to the alliance goals may unduly influence the alliance. As stated by one respondent:

> The leadership here is always going to be a challenge because everyone wants to lead and that is a good thing and a bad thing. If we are all leading in the same direction that is fabulous.

Conversely, if the alliance enjoys strong formal leadership but little collateral leadership, the alliance may lose the broad-based participation needed to address systemic health care issues over the long term (Alexander et al., 2001; Shortell et al., 2002). In a similar vein, a leadership challenge for alliances is to ensure that there is both effective internal and external leadership (Butterfoss et al., 1993, 1996; Wandersman, Florin, Friedmann, & Meier, 1987). For example, our respondents indicated that it is critical for alliances to develop ties with key political leaders or important influentials within the market even if these individuals are not formally represented in the alliance. These external leaders can provide support for the alliance and its goals among policy-making bodies and help spread the word about the alliance and its activities. Despite the importance of such external leaders, our data also indicate that a challenge in many alliances is to both identify and cultivate such leadership, an often daunting challenge given the time and effort involved. In the final analysis, alliances that depend on voluntary participation typically rely on a small coterie of people to move the alliance forward. Potential turnover among a small set of key individuals can create challenges for alliance capacity building. Specifically, the loss of key individuals may create a leadership vacuum that may paralyze the alliance for significant periods of time, resulting in a loss of momentum, gaps in task coordination, and entropy of alliance cohesion.

## Defining Staff Versus Member Roles

A challenge often faced by alliances is to appropriately balance the contributions of alliance staff and general alliance membership (Bazzoli et al., 2003). Our data suggest that staff support for alliance activities is critical for coordinating the complex array of tasks necessary to achieve alliance goals. However, the risk in relying on staff for such activities is that it deprives alliance members of "ownership" of these activities and often renders their participation superficial at some level. To develop long-term capacity then, alliances need to develop an appropriate balance between staff support for alliance activities and membership involvement in and ownership of alliance activities.

This may reflect a critical decision as to whether the alliance should be a facilitating organization or the actual "doer" of work. As put by one respondent:

> We just need to make sure we draw the lines. You know, we define ourselves as a facilitating group. And we've become more of a working group. I've periodically tried to help us be sure we have lines.

The decision between facilitating and doing the work has important implications for the level, types, and coordination of staffing. "Facilitating" alliances tended to use volunteers, and respondents from these organizations indicated that the alliance had less flexibility in the types of initiatives pursued and their approaches to implementing initiatives because of their dependence on volunteers. These alliances expressed concerns about the ability of volunteers to commit the time to existing and growing workloads when the alliance was only one part of their professional lives. In contrast, "working" alliances employed more staff and expressed more flexibility in their choice of and approaches to new initiatives.

There was a consistent belief across alliances that they would be adding new initiatives and work to support those new initiatives would require some "working" staff to accomplish these objectives. This further called into question what activities could realistically be handled by nonpaid participants. An alliance's position on this issue and its decisions regarding an appropriate staffing model appeared to be largely dependent on its stage of development:

> It (staffing level) was fine when it started, it's a weakness now, they've got to have somebody. They need a little staff, not a big staff, but they need [some staff], and part of this is because they've been successful, they're on to something, they're building some momentum.

## Developing Resource Capacity

A common challenge noted across alliances was balancing resource availability with the intensity and reach of capacity-building activities. A consistent concern for alliances is lack of financial and staffing resources, especially with regard to subject matter experts in the areas emphasized by the AF4Q project. Such resource shortfalls were seen to have consequences for the scope and depth of activities undertaken by the alliance. Alliance leaders noted that because AF4Q highlights interventions that are relatively new concepts for their respective communities, it can be difficult to identify staff with knowledge and skills in these areas. For example, alliances were struggling to understand what types of mechanisms, and therefore what types of staff, would be effective at engaging consumers to manage their health conditions. Some alliances felt that it was a matter of education and that health educators fit the role best. For others, communication was critical and marketing skills were needed. Still others felt that physicians should play the central role in engaging consumers.

There were notable differences across sites in terms of their dependence on certain types of stakeholders/resources, often driven by the employer base and provider make-up of the surrounding community. These differences presented significant challenges for alliances in terms of mobilizing resources for new and existing initiatives. For example, one alliance's early financing efforts were dependent on the commitment of a single local industry. Relative to other alliances, this financing enabled this site to pursue alternative approaches to initiating projects. It hired external consultants in the early stages to maintain

focus on one key initiative, a decision that many respondents praised for the consultants' ability to bring process expertise to these initiatives and the progress that emerged early in the life of the project. In contrast, other alliances lacked a large employer base to draw from and focused on hospitals and health systems to fund early efforts. To date, these alliances have depended more on volunteers with minimal use of external consultants, to which several respondents attributed a very cautious and deliberate decision-making process regarding new projects.

A related concern for alliances was overdependence on a few sources of funding. Most alliances noted the importance of drawing from a diverse stakeholder base and felt that doing so would minimize the burden placed on any one organization as well as reduce vulnerability to changing levels of commitment from a particular organization or set of organizations. This vulnerability is exhibited by stakeholders struggling to balance a sense of moral obligation to commit resources to the alliance with their ability to meet their own financial bottom lines. More specifically, there were concerns that key stakeholders may be reluctant to give money "for yet another initiative." Respondents noted that the same organizations are often asked to contribute money and time to these types of projects, resulting in diminished capacity or willingness to contribute additional resources.

Another resource challenge for alliances was cultivating nonfinancial resources that are essential to sustained effort. Although financial resources dominated the concerns of most alliance leaders, most respondents acknowledged the importance of nonfinancial resources in overcoming financial limitations or in addressing areas that could not be addressed with dollars alone. Respondents often pointed to the emotional and intellectual investment of individual stakeholders, oftentimes referring to the passion that was instrumental in moving alliance activities forward and sustaining interest in alliance activities. At the same time, respondents also expressed concern for how long this passion could be sustained when most stakeholders are engaging in these activities as their second, third, or fourth job:

> You have to connect the people who want to do good, really directly with the people who need the work. It's, and I think that this is, I think the project has a lot of promise there, but there's a fatigue and also a wariness that exists in a community like this where one more do-gooding effort, what they want is one more do-gooding effort that has some measurable result.

## STAKEHOLDER RELATIONS AND PARTICIPATION

### Building on Culture and Historical Relationships

Another important challenge in alliance capacity building is establishing an appropriate culture for multistakeholder, collaborative efforts. Often, this consists of building a foundation of trust and respect among members that have traditionally not interacted with each other, or have interacted while pursuing their organizations' divergent interests (Gulati et al., 1994; Hageman, Zuckerman, Weiner, Alexander, & Bogue, 1998; Nelson, Rashid, Galvin, Essien, & Levine, 1999). In our study, many of the stronger cultures appeared to be established well before the establishment of the alliance. Participants in these alliances tended to have previous experience working with each other around collaborative, community-oriented endeavors. This was generally seen as a positive factor in facilitating the activities of the alliances, primarily if members trusted each other based on those prior activities. As one alliance member indicated,

> There's a really strong culture of respect here. And so when we get together she would say alright we'll need to figure that out. Let's discuss it and then we would debate the pros and cons of different approaches and come up with the best recommendation we can come up with even though sometimes I just want to go on record and I think OK duly noted, and then you kind of commit and move forward.

The existence of personal relationships among alliance leaders that spanned many years was seen as a facilitating factor in recruiting alliance participants and in reaching early consensus about vision and goals for the alliance. However, the existence of historical relationships was not always positive. One respondent noted that past shared experience in collaborative efforts created expectations about "biases" that participants might bring to the new effort, and that these biases could impede progress in the early stages. Similarly, another respondent believed that new leadership at key organizations opened up opportunities for the development of new relationships, unencumbered by past positions that might have been taken by previous leaders. Thus, alliance leaders may find themselves confronting a trade-off between leveraging existing relationships and cultivating new ones when pursuing alliance objectives.

### Reconciling Short- and Long-Term Objectives

Previous research has found that significant dependence on stakeholders for financial and in-kind contributions means that alliances must demonstrate value to stakeholders, especially in the short term (C. Brown, 1984; P. Brown et al., 2001; Chaskin et al., 1999; Hord, 1986). Similarly, our data showed alliance leaders recognized the need for a long-term perspective to observe the results of their efforts, yet found themselves in the precarious situation of devoting resources to activities that did not optimally contribute to these long-term objectives. This concern was summarized well by an employer representative:

> And until we can demonstrate a very strong ROI that our money has been—that the company's money has been spent and we're going to see an ROI in our health claims dollars as well as maybe soft dollars on the productivity side, it's a hard sell when you try to get it through the finance committee when you're looking at the budget . . . the ROI is going to have to be demonstrated and it's going to have to be transparent in order for a program to be able to be successful and approved and bought in by those that may be funding it.

A related yet different capacity-building challenge common to the alliances in our study was the importance of striking a balance between instilling a broadly shared vision for the alliance and consensus among members on long-term goals on the one hand and action on specific initiatives on the other. Whereas vision is critically important to multistakeholder alliances such as those involved in AF4Q, such broad-based vision must be balanced by establishing and staying focused on specific, relevant initiatives to realize these broad goals. The particular challenges involved in achieving this balance are related to maintaining the discipline to commit to a long-term strategy and letting that strategy dictate the alliance's focus, rather than letting short-term goals, irrelevant activities, or enticing funding opportunities distract and take the alliance off course. As one respondent stated,

> there are tons of opportunities to expand, and our greatest challenge is probably keeping a lot of those "Wouldn't it be great if you . . . ," "Wouldn't it be great if you . . ." at bay and not becoming sort of the organization for everybody's idea and pet project.

In essence then, the capacity-building challenge is to establish both a broad and even abstract vision for the purpose of anchoring the alliance in a common set of goals while ensuring that there are specific, concrete initiatives that would further the alliance toward these broad goals.

Complicating matters for the alliances in our study was the challenge of striking a balance between alliance resource needs, the priorities that a diverse stakeholder constituency assigns to different goals, and the methods used to achieve these goals. For example, there was general agreement among stakeholders that quality can and should be improved; however, employers, insurers, and practitioners sometimes differed on whether decisions regarding new projects should only be concerned with quality improvement, or if cost savings or decreasing cost trends should be explicitly considered. Beyond cost and quality considerations, there was debate regarding the best way to achieve these objectives. These debates were not only costly in terms of time, but the outcomes had significant implications for subsequent resource allocations. Such differences speak directly to the challenge of motivating a diverse stakeholder constituency to sustain interest and involvement in the alliance over the long term. As one respondent stated,

> It's an interesting one to try and figure out, what do we need to produce as the alliance versus what do our stakeholders have to do to carry the ball forward? Because there are certain things where we can say, you know, health benefit designs should include xyz. We don't go in and negotiate those benefit packages, we don't shape the benefit packages at the health plan level, we don't go in and sit at the negotiating table, so part of what we have been in discussion with the board about is that the alliance has a role, that they (stakeholders) each have a role in terms of carrying this forward to really start to shape the community direction.

## Soliciting Participation

Identifying the multiple interests of key participants is one thing, actively soliciting their participation on that basis is another. Alliance leaders emphasized the importance associated with active recruitment strategies and tactics to build, sustain, and replenish their organizations:

> It's one of the things though that it's easy to let slip to a lower priority because you're working on everything else, so we need to keep reminding ourselves to give it that kind of attention.

The essence of recruitment is reaching respected organizations with common aims and connecting with the key influentials within these organizations. Ideally, this means CEOs where feasible, or "if not the CEO, then a clear channel to the CEO." Others noted that the type of person on the board is indicative of commitment and is perceived as such by other board members who are keenly aware of status differences in representation, especially between competing organizations.

By the same token, who constitutes the influentials varies across communities. For example, faith-based or elected official leadership may be prominent in some communities but seen as unimportant in others. Private and public purchasers of health services were typically seen as among the most critical participants and the most difficult to recruit (and retain, as noted below). In some communities, without key representation from these stakeholders, the alliance would not be viable, either because they provide core funding

or because their visible commitment is crucial to bring other stakeholders to the table. Other respondents acknowledged that inclusion of critical influentials, such as purchasers, on the alliance board or steering committee has considerable symbolic value. However, it may be even more important to have them or representatives of their organizations on key committees and workgroups to galvanize their engagement and create a sense of ownership of the alliance's work.

Participation is a key element for effective alliance functioning (Butterfoss et al., 1993; Chinman et al., 1996; Zakocs & Guckenburg, 2007), which in turn is dependent on recruitment and recognition of why some individuals or organizations may be reluctant to participate. Our data indicate that the reluctance may be general in nature, such as having to meet some financial obligation for membership. Others may fear increased demands on their time or in-kind contributions that mount rapidly and excessively. For other candidates, particularly senior executives, distractions and competing priorities from their home organization may prevent or undermine their intent to be engaged. On the other hand, some organizations—particularly trade associations—may not want to participate in a forum where compromise is expected and necessary, preferring to maintain a sufficient distance to critique independently the work of the alliance.

Lack of expected gains, especially in the short term, is another reason why organizations or individuals may choose not to become involved (Alter & Hage, 1993; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Schmidt & Kochan, 1977). Several study respondents highlighted the difficulty of creating such short-term gains by stressing that this work cannot be seen as simply "vanilla win–win" types of actions if it is to be meaningful. Furthermore, our results also suggest that the "evaluation" of short-term gains is nuanced and may vary for different stakeholders. Some organizations may not wish to be part of an enterprise that has explicit aims that may be at variance with their own, or may require altering their goals or modus operandi in ways they chose not to do. For example, grant expectations of public reporting at the individual physician level were seen as inappropriate by some organizations and a strategy they did not want to endorse by their participation. Others fear that the work of the alliance may compete or appear to compete for the roles they see for themselves in the community.

> Every constituency is skeptical in their way, but I think the health plans are skeptical that this isn't going to help them in any way. I think they'd rather get credit for activities that they want to do individually and I think there's some of that in health systems too.

These impediments to participation naturally spill over into concerns about sustaining participation.

## Sustaining Participation

There was considerable anxiety expressed by respondents regarding the ability of the alliances to retain the active participation of key members over time, especially given the perceived difficulty in making significant changes in health care systems. Most of this concern centered on retaining purchaser participation. Purchasers were seen as wanting change to occur quickly, being impatient with "process," and "not fully understanding" the issues. In contrast, physicians were seen as wanting to move in a more measured, "scientific" manner. Some respondents feared that purchasers would abandon the alliance if the pace of change did not meet their expectations. There was general recognition that although "painting a vision" for the alliance was essential, so was showing some progress

on achieving specific goals in order to retain members and reinforce member enthusiasm. One conclusion is that exploiting the potential benefits of multistakeholder involvement only becomes possible when the alliance has matured to the point where competing perspectives are channeled into constructive work and a sense of progress toward common aims emerges.

A capacity-building challenge in this regard is how to weather the time-consuming initial stages of alliance formation and "sorting out" of divergent interests, without putting the enterprise at risk of dissolving. Alliance leaders note that participants initially display a lot of watching, holding of their cards close to their vests until relationships form and they get a clearer sense of who is involved, where they stand on issues, and whether they are likely to be seriously engaged. They acknowledge the "fragility" of new alliances and the time required to cultivate authentic buy-in that is revealed, not by attendance at meetings or even paying dues, but willingness to actually substantively engage in efforts or decisions that support the alliance goals (e.g., sharing proprietary data, publicly endorse an alliance initiative). One such start-up challenge for many multistakeholder health care groups stems from the uneven level of understanding or knowledge of the issues and strategies necessary to address complex health care issues. This means that to sustain long-term commitment and concerted action toward achieving the goals of alliances, there must be considerable investment up front to "bring everyone up to the same speed." This may prove to be a diversion or distraction from alliance activities but it should be considered a necessary "cost of doing business" in order to establish a knowledge base common to all stakeholders involved. As stated by one respondent,

> So I think it's a challenge to work with the individual organizations who are in various stages of progress on what they're doing to improve quality and reduce cost.

Alliances we studied frequently use board retreats, outside speakers, and simply repeating basic messages to establish this common foundation of understanding and knowledge. However, the costs of these efforts are frequently frustrating to those who are more knowledgeable and wish the alliance would move more rapidly toward its stated goals. For example, one respondent noted that his efforts to establish a better understanding of incentives resulted in some exasperation from the leadership:

> But people seem to feel like I needed to have more clarity, so I'm going back to the [committee]. Several times the leadership has said, you know, "We've said what we said; how many different ways do we need to say it? Stop coming back to us with this issue."

In the most extreme case, this may lead to disillusionment and disengagement on the part of key stakeholder members of the alliance.

## STUDY LIMITATIONS

The results of the study should be interpreted in light of several limitations. First, the number of alliances included in the study limits the external validity of the study's findings. It is possible that other alliances face unique contexts or have different goals that present different challenges and trade-offs than those we identified here. However, we believe that the in-depth, qualitative analysis of four different alliances extends previous research on capacity building that often focuses exclusively on single case studies. Furthermore, the

alliances included in our study came from different geographic areas of the United States and varied on a number of contextual and organizational characteristics such as size, length of time working together, resources, and funding model. Together, we believe that these alliances and the issues they are confronting represent the challenges most health care alliances may face when trying to build capacity. Nevertheless, future research could build on the findings of this study by analyzing larger samples of alliances.

A similar limitation relates to measurement variation across the alliances. A limited number of alliances could increase the level of variance we observed across the different sites. Put differently, an "outlier" alliance is more likely to stand out and affect our results when the number of alliances is limited. We believe that such outliers were unlikely to have been included in our sample of alliances, or to have affected our results significantly for a number of reasons. First, we used a semistructured interview protocol to ensure consistency in informant questions across the different alliances. Second, because we interviewed a large number of informants within each site, conclusions about an alliance were derived from multiple respondents, which reduced the likelihood that an alliance would be inaccurately classified in our framework. Finally, our analytic focus was on identifying similarities, not differences, across alliances. To the extent that the alliances in the study exhibited extreme variation on a measure or dimension of capacity building (i.e., each alliance was unique), our analytic approach would not have identified it as a significant barrier to capacity building. Even so, such differences may be important for alliance capacity building and represent an opportunity for future research.

## IMPLICATIONS FOR PRACTICE

This study was predicated on the premise that an awareness of the trade-offs and challenges of capacity building in multistakeholder alliances could help alliance leaders anticipate and prepare for these challenges rather than reacting to them as they occur. We believe that an ability to anticipate critical decisions is important for coalescing diverse participation and sustaining progress on alliance goals and objectives. In a similar vein, our findings reveal that a number of solutions and "right ways" of organizing the alliance may stem from these diverse challenges. Instead of offering a one-size-fits-all archetype, we submit that the trade-offs identified in the study provide a framework or a set of alternatives from which practitioners can draw on when addressing challenges unique to their own organizations.

From a practical standpoint, capacity is essential because the duration of the collaborative relationships in health care alliances is likely to be associated with positive performance, particularly with alliances that must contend with complex issues requiring a long period of time to address (e.g., quality improvement in chronic illness). However, it is important to emphasize that capacity should not be conflated with performance. This is tautological and not only confounds two related concepts but leads to the logical trap of performance driving longevity, rather than vice versa. For example, the efficacy of selected interventions, mix of partners, and soundness of operational management may all directly affect alliance performance while contributing to capacity only indirectly. Capacity, on the other hand, may at times have little to do with performance. An alliance may perform quite well in pursuit of its stated objectives, but fail to survive because it prioritized the wrong goals (a case of doing things right, but neglecting to do the right things).

This article has described the potential challenges and trade-offs related to two key elements of capacity building: infrastructure and governance, and stakeholder relations.

The identification of capacity-building challenges in these areas may help alliances of leaders and managers develop realistic expectations about key decisions as they weigh options and pursue their "value proposition." Importantly, the results of the analysis of the four AF4Q alliances suggest that although capacity-building challenges clearly include the development of a sustainable business model and securing monetary resources, capacity building is not limited to those areas. Effective management of stakeholder interests and appropriate balancing of staff versus member roles, among others, were also highlighted as key elements of capacity. This finding is important because it suggests that an overly narrow focus on developing a business model may not be enough to provide the alliance with sufficient longevity.

A second significant finding of our study is that the challenges and trade-offs of capacity building are likely to be highly interdependent. Problems in one area may create problems in another, or conversely, strength in one area may provide a foundation for developing another. For example, little institutional "ownership" of the alliance or its activities may contribute to infrastructure problems such as lack of stable funding. Similarly, a compelling vision coupled with mutually reinforcing activities related to that vision may contribute to the ability of an alliance to mount a successful outcomes-based marketing campaign to generate greater stakeholder interest and participation in the alliance. Indeed, successfully (or unsuccessfully) addressed challenges may have implications for capacity building in other domains (e.g., choice of governance structure may have direct implications for the extent and type of participation in the alliance).

Third, although we studied health care alliances at relatively early stages of their development, our findings suggest that capacity building is an ongoing process that involves a pattern of learning, reevaluation, and readjustment over time (Doz & Hamel, 1998). Other research, in fact, suggests that alliances move through stages of development (a life cycle), with each stage having important implications for the operations of the alliance, the relationships among those involved, and the type of infrastructure required (D'Aunno & Zuckerman, 1987; Forrest & Martin, 1992). Although all alliances will not move in lock-step fashion through a predetermined developmental sequence, those responsible for capacity building must recognize that an alliance's purpose, needs, structure, composition, and capabilities may evolve (or need to evolve) over time. As alliances grow in size and complexity, for example, their decision-making and communication processes may require more formal structure in order to ensure coordination and accountability. Likewise, an alliance may require both new leadership and new membership as the alliance's initiatives change focus or mature.

Finally, we also recognize that environmental and market forces will significantly influence both the nature of alliances and appropriate strategies for capacity building. Several trends encourage and facilitate multisector collaboration to improve community health status. These trends include an increased focus on community benefit, changing financial policies and programs that tie payment to quality outcomes and payment based on providers' risk profiles, growing emphasis on managing care (not merely cost) for the chronically ill, and better understanding of the multiple determinants of health and health care quality. On the other hand, several other countervailing trends in the organization, financing, and delivery of health care services may serve as disincentives and barriers to capacity building in health care alliances. The commodification of American medicine and the rise of multistate health plans may make it "implausible for providers to think about the health of particular geographic communities or to cross-subsidize unprofitable services that benefit indigent patients or disadvantaged neighborhoods" (Schlesinger & Gray, 1998). Finally, the "carving out" of specific diseases around which to manage

service delivery, the development of highly specialized organizations separate from other components of the care system, and the creation of independent professional organizations may serve to further fragment the system. In light of both market-specific forces and unique historical and cultural circumstances, it will be incumbent on alliances to avoid universal prescriptions for capacity building and to develop a theory of action, and periodically reassess the alliance and its activities to ensure that it is directed toward creating lasting value for the participating stakeholders and target population served. However, with all this said, we submit that capacity building is contingent on successfully balancing the challenges and trade-offs noted in this article.

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