Received: 23 August 2022 | Revised: 26 March 2023 | Accepted: 14 April 2023

DOI: 10.1002/nvsm.1796

RESEARCH ARTICLE

WILEY

Maximizing value in healthcare partnerships: A case examining an inter-organizational relationship in the public and non-profit sectors

Joan Carlini [1] | Kim Lehman [2] | Maria Dharmesti [1] | Kathy Knox [3]

[1]Department of Marketing, Griffith University, Gold Coast Campus, Southport, Queensland, Australia

[2]Liverpool Business School, Liverpool John Moores University, Liverpool, UK

[3]Social Marketing @ Griffith, Griffith Business School, Department of Marketing, Griffith University, Nathan, Queensland, Australia

Correspondence
Joan Carlini, Department of Marketing, Griffith University, Gold Coast Campus, G42 Level 7, Parklands Drive, Southport, QLD 4222, Australia.
Email: j.carlini@griffith.edu.au

Funding information
Sustainability Small Grants Griffith Centre for Sustainable Enterprise

Abstract

Healthcare organizations around the world are striving to find the right balance between using their resources effectively and providing personalized care to patients. Health care is shifting from a reactive, towards a more person-centric approach to improve health outcomes. To achieve quality improvements and efficiencies, health care organizations are forming inter-organizational relationships. Despite the benefits, little is known about how organizations capture value from strategic partnership. In this context, this paper aims to examine the processes that occur as part of a public and non-profit sector relationship within health care that directly relate to how the partnering organization acts to capture value. Using a qualitative case study of an Australian public-sector health service partnership, the study employs a value mapping framework to distinguish between different types of value (captured, missed, destroyed, and opportunity), and presents an integrated model consisting of three process phases: (1) inter-organizational cooperation effort, (2) organizational effect, and (3) social value. The study highlights the potential for negative and unintended consequences and discusses implications for management.

KEYWORDS
health service, IOR, public-sector, social value, value creation

Practitioner Points

What is currently known about the subject matter to this

- The health care sector is undergoing significant changes and facing many challenges, leading service providers to look for ways to increase efficiency and improve quality.
- One approach to achieving this is through strategic partnerships, also known as inter-organizational relationships (IORs), where organizations can pool resources to create synergistic benefits and value creation.
- Although there is evidence to support the benefits of IORs, there is a lack of information on how value is created and destroyed.

What your paper adds

- This study broadens the understanding of value creation within an IOR in the public sector health care context.
- Demonstrates the applicability of Bocken's et al. (2013) value mapping tool in identifying value creation, including captured, missed, destroyed, and opportunity value, beyond its original use in the for-profit sector.
- Extends the use of the value mapping tool to assess the intended and unintended value creation from IORs.
- A process model is presented by integrating the results and extant literature to better understand how partnering with a non-profit organization captures value.

The implications of your study findings for practitioners

- From the presented process model developed highlights the different stages in a strategic partnership aimed at reducing organizational costs and increasing social value.
- Understanding these stages can help managers better navigate the complexities of implementing an inter-organizational relationship and ensure that the partnership delivers the intended value.
- The study also sheds light on the factors that contribute to the complexity of implementing an IOR, such as the dimensions of supply chain collaboration, and the importance of employee beliefs and attitudes in supporting organizational outcomes.
- The study's method and the model can be used by managers to make informed decisions about the design and implementation of IORs in their organizations, which can help them maximize the benefits and minimize the risks associated with such partnerships.

1 | INTRODUCTION

The health care sector is in the midst of transformational change (i.e., more patients, technology, information, patient-centered care, and new delivery models) and faces many challenges in keeping up with the dynamic nature of the sector (Nik Hashim et al., 2020). In rising to the challenge of managing increasing costs, service providers are looking to implement efficiencies for savings and quality benefits (Fleiszer et al., 2015). One way they are doing this is to transition from conventional models toward innovating with strategic relationships that can deliver financial benefits, quality improvements and efficiencies. Increasingly, health care organizations are developing strategic partnerships, also known as inter-organizational relationships (IOR) as the vehicle for sustainable change (Palumbo et al., 2020).

In the public health sector context, IOR offers organizations an opportunity to develop quality improvements to deliver economic (as cost savings), social and environmental value by integrating resources aimed at developing person-centric care as a key societal requirement (Ozeren et al., 2018). During times of squeezed budgets and resources which are emphasized post-pandemic, the focus on maximizing social value must be realized by existing resources (Gaudin et al., 2019). The advantage of IOR is heterogeneous organizations with differing motivations, interests, and practices (Zahoor & Al-Tabbaa, 2020) can partner to create synergic benefits and value creation (Caldwell et al., 2017). There is growing evidence to illustrate how organizations can work together, yet it is still unclear how cooperating can reconfigure resources (Castañer & Oliveira, 2020). Although most research on IORs focuses on direct interactions, Lumineau and Oliveira's (2018) literature review identified gaps in the field, including the need to understand the role of employee beliefs and attitudes in supporting organizational outcomes.

The purpose of this study is to broaden the theoretical scope of value creation within an IOR aimed at reducing organizational costs and increasing social value for stakeholders. The study draws on a newly formed strategic fee-for-service partnership between an Australian public-sector health care organization and an American Nurses Credentialing Center (ANCC). The strategic partnership committed the health care organization to align their nursing strategic goals and patient outcomes for credentialing by the Magnet® recognition program. The ANCC Magnet® program is a pathway to nursing excellence involving education and development for nurses during their careers resulting in more autonomy, and the best possible care for patients (Castaneda et al., 2022). Achieving Magnet® designation is considered to be a substantial achievement for a health care organization as it recognizes exceptional performance in nursing practice and empirical outcomes including a healthy work environment, and quality patient care (Regan et al., 2016). However, sustaining Magnet® designation is a challenge, with only 10% of Magnet® hospitals maintaining the designation for more than 12 years (Hayden et al., 2016), illustrating that sustaining value from the cooperation can be difficult.

While there is growing evidence on the benefits of this type of partnership from the nursing perspective (e.g., see, Menser et al., 2022; Moon et al., 2019; Regan et al., 2016), there is a dearth of information about how value is created and destroyed. Accordingly,

this study explores the perceptions of public sector health care workers with the aim of better understanding how partnering with a non-profit organization acts to capture value. To achieve this aim, we employ the Bocken et al. (2013) value mapping tool to enhance our understanding of value creation from the IOR from the public-sector organization perspective. In addition, to understand the factors that contribute to the complexity of implementing an IOR (Lepak et al., 2007), we apply supply chain collaboration dimensions proposed by Cao and Zhang (2010). Prior to this, the paper presents a literature review of IOR, the imperative for public-sector organizations to create social value, then, the practicality of the value mapping tool is discussed including its appropriateness for this context considering the tool's intended use was for-profit firms. Next, we outline our research design, consisting of a single case study. We present our results, then integrate the results and extant literature to develop a model, discussing each of the stages in relation to extant knowledge and implications for managers. Finally, we conclude with limitations and future research suggestions.

2 | THEORETICAL BACKGROUND

2.1 | Why and how of inter-organizational relationships

The goal of a strategic partnership is to create value for each organization by offering resources that the other has no access to. In this way, organizations can create economic and/or social value for its stakeholders. Drawing on the wider strategic management and organizational literature, typically, IOR focuses on the properties and overall pattern of relationships between and among organizations that are pursuing a mutual interest, or addressing and delivering a common purpose or social issue, while also remaining independent and autonomous (Kożuch & Sienkiewicz-Małyjurek, 2016; Sagawa, 2001; Seo, 2020). Inter-organizational cooperation is gaining momentum in the health care sector, with the bibliometric analysis by Palumbo et al. (2020) finding that a third of all IOR articles in health care have been published since 2010. However, the systematic review of IOR collaboration, coordination, and cooperation by Castañer and Oliveira (2020), reported that these are mainly descriptive accounts, and studies in the non-profit sector are rare and it remains underexamined.

However, there are notable exceptions. For example, Curnin and O'Hara (2019) examined non-profit and public-sector IOR within the context of the recent environmental disasters and recovery efforts in Australia, seeking to extend insights into the barriers and mechanisms used to facilitate inter-organization cooperation. Their study's findings characterized role clarity (expressed in the administrative arrangements), inter-organizational structures (clearly articulated organizational roles), and trusting relationships (between organizations) as necessary enablers (or the absence of acting as barriers) of inter-organizational cooperation in public and non-profit sectors in disaster recovery. Curnin and O'Hara's (2019) study exemplifies the careful management required for organizations to gain advantage through cooperation. Forming strategic partnerships can bring numerous benefits to organizations, including new knowledge, innovation, and improved efficiency (Parmigiani & Rivera-Santos, 2011). Value creation emerges from collaborative efforts, such as sharing information, working towards common goals, making decisions together, aligning incentives, and sharing resources (Cao & Zhang, 2010). These efforts can lead to collaborative advantages, including increased efficiency, flexibility, business synergy, quality, and innovation. Lawrence et al. (2002) also explore new practices within organizations, calling them proto-institutions, which are informal norms and practices that have not yet been formalized. These practices may not be formal but have the potential to become a permanent part of an organization's culture. The authors believe that IORs play a crucial role in internal innovation and that organizations can gain an advantage by embedding the creation of new knowledge, tasks, or activities that generate value.

Cross-sector forms of IOR typically emerge from a primary focus on the social, rather than business issues. It is these differences in motivations toward the relationship that can create challenges, such as power imbalances, which can be difficult to manage (Parmigiani & Rivera-Santos, 2011). Nonetheless, relationships across differing sectors are attractive, as they offer additional opportunities to integrate differing capabilities to create advantage (De Vries et al., 2016; Leung, 2013). Obstacles preventing value outcomes can arise from differences in strategic goals and management styles (Davis, 2016; Molander et al., 2018), which can lead to no positive outcomes, as seen in the research by Boockvar and Burack (2007) on the relationship between nursing homes and hospitals. Additionally, these partnerships can also lead to negative consequences, such as the destruction of value when resources are used improperly or unexpectedly (Palumbo et al., 2017; Plé & Cáceres, 2010).

While IORs present challenges, they also offer the opportunity to disrupt conventional business constraints that significantly affect business function (Jer et al., 2017). In developing new partners and collaborators, organizations can overcome institutional restrictions to create new forms of value that would otherwise be beyond their current capabilities (Page et al., 2015). Public-sector organizations partnering with complementary organizations to design and implement solutions are inter-organizational collaborations to create public value that are both viable and necessary due to the growing complexity of social problems (Kożuch & Sienkiewicz-Małyjurek, 2016; Leite & Bengtson, 2018; McDougle, 2014; Page et al., 2015). Such collaborations can be high risk and full resultant benefits are not guaranteed (Seo, 2020). Certainly, while there has been considerable growth in research and knowledge, much more needs to be known about how IORs operate in the health sector (Palumbo et al., 2017, 2020).

2.2 | The public-sector imperative to create social value

Originally, the social value concept provided management with the notion of public organizations contributing to the common good (Kullak et al., 2020). However, in a review article on governing public-private partnerships, Xiong et al. (2019) noted that IORs can be a

powerful tool for public-sector organizations to create social value. By establishing IORs, these organizations can reshape their operations and increase the value they capture. It is essential for social value to be the ultimate goal of any IOR involving a public-sector organization, as their role in society is to provide services for the common good. Cao and Zhang (2010) argue that IORs can generate collaborative advantage, which ultimately leads to the creation of social value for the community. There are ongoing discussions about the meaning of social value. Wood and Leighton (2010) have defined social value as the "wider non-financial effects of programs, organizations, and interventions, such as the well-being of individuals and communities, social capital, and the environment" (p. 7). Social value can also be seen as the benefits that an organization brings to society through the positive social outcomes that it generates, which go beyond what one organization alone or within its sector can achieve (Boenigk & Möhlmann, 2016; Caldwell et al., 2017; Lepak et al., 2007).

With public-sector organizations facing unprecedented cuts as the economy shrinks, costs increase, in combination with growing demands for better services (Nik Hashim et al., 2020). Given public sector organizations essentially aim to meet the need of publics rather than gain profits, strategic approaches in the public sector typically emphasize augmenting internal performance and efficiency (Elbanna et al., 2016). However, Splitter et al. (2021) and Leung (2013) suggest that the way resources are distributed and managed within organizations can have a significant impact on their overall performance, and, point out that individual employee actions at various levels within the organization can have a significant effect. Therefore, it is important for those developing strategies for public sector organizations to consider both the internal resources available and the internal employees involved in order to ensure success (Nik Hashim et al., 2020).

2.3 | Measuring value creation

Measuring the impact of social value can be difficult (Quélin et al., 2017). To truly understand it, we need to look at the process of creating value and how resources are integrated (Cao & Zhang, 2010; Vargo & Lusch, 2008). To achieve this, Bocken et al. (2013) created a multi-stakeholder method for mapping value. This tool helps companies understand their value proposition in relation to key stakeholders and improve it for sustainability by using a systematic approach to business modeling. It also helps companies understand their connections with other organizations and is known as their value network.

Recently, the value mapping tool has been utilized to comprehend how organizations can become more focused on sustainability and improve their value proposition by incorporating economic, societal, and environmental value for a wider range of stakeholders' interests (Freudenreich et al., 2020; Geissdoerfer et al., 2016). Typically, changes to business processes are ad hoc, and there are limited tools to facilitate the rethinking of the value proposition which can be achieved by decoupling value creation for the organization and society (Castañer & Oliveira, 2020), and provide distinction between the different types of value creation. For example, the tool uses multiple stakeholder views of value to determine how it can be captured, destroyed, missed, or new value opportunities may be created. *Value captured* is defined as the process of retaining some of the value from a change in practices or processes. *Value destroyed* is represented by negative social impacts, such as damage to the environment and social consequences of business activities. *Value missed* is defined as situations where stakeholders fail to capitalize on existing assets, resources and capabilities. *Value Opportunity* for new value creation relates to new forms of value for existing stakeholders or value for new stakeholders.

Applying Bocken's distinct forms of value (i.e., captured, destroyed, missed, and opportunity) to the context of a strategic partnership of a non-profit and public-sector organization is useful because as Cao and Zhang (2010) noted, there is more to creating value than simply bringing together two organizations. Identifying value creation by stakeholder group (e.g., employee, supplier, and community) offers a holistic approach to value creation and capture (Freudenreich et al., 2020; Leite & Bengtson, 2018). Furthermore, it recognizes that value takes on many forms and requires an alignment of interests among various stakeholder groups. As has been noted previously, IORs are not without risk, and, benefits are not guaranteed (Seo, 2020).

Furthermore, the recent literature review by Niesten and Stefan (2019) on the paradoxical tension between value co-creation and capture in IORs demonstrates that value co-creation and value capture are simultaneously interdependent and contradictory. For example, by applying paradox theory to assess the existing literature on IORs, the study's findings identify factors such as plurality (e.g., cultural and geographic distance, cross-industry, and incongruent goals), scarcity (e.g., IORs between small/young and large firms, lack of knowledge and experience in R&D or local market), and change (e.g., changes in technology and scope of IOR, evolving preferences), as well as compound factors (e.g., settings of hyper-competition, globalization and technological innovation) increase tensions. In contrast, factors leading to positive change were governance mechanisms (e.g., contracts, trust, and equity sharing), organizational capabilities (e.g., previous experience with IORs, partner-specific capabilities), appropriation strategies (e.g., having a boundary organization, intended and unintended knowledge leaks for delayed capture, varying levels of interdependence, commitment to cooperation). These findings demonstrate that a delicate balance is required between managing the factors leading to successful value creation and value capture, without neglecting factors that might lead to negative outcomes. Thus, research exploring the collaborative forms and processes undertaken by public-sector organizations in these circumstances will help establish the "baseline of best practice" emerging in the health sector. Importantly, such studies will also provide guidance to researchers and practitioners in the sector going forward.

3 | METHOD

3.1 | Qualitative approach

To address this research opportunity, a qualitative approach was used to construct a focused study to examine the interaction and value

creation process using a case study of an IOR in the form of a public-sector and a non-profit organization. A case study approach is particularly appropriate here, as there is a lack of available previous data on the specific research area (Yin, 2018). In addition, the case study approach allowed for insight to be gathered from participants generated through interaction in the workplace (Eisenhardt & Graebner, 2007).

3.2 | Industry context

The context was a large-scale Australian public health service offering a diverse range of secondary and tertiary services such as midwifery, emergency care, oncology, mental health, dentistry, children's critical care, aged care, pathology testing, and vaccination across 20 facilities in a regional city with a population of over 600,000. The study's focus was a single case study due to its relative importance as a large-scale health service (including hospitals, allied health, children services and community health centers). The Health Service sought to partner with the non-profit organization American Nurses Credentialing Centre (ANCC) to implement the Magnet® quality enhancement program (for specific information see, ANCC, 2022; Hayden et al., 2016) across all divisions of the Health Service (herein, the case organization is referred to as *Health Service*). Magnet® is an international program developed by the ANCC providing recognition in nursing care. A Magnet® organization is recognized as providing superior quality in nursing and midwifery care (ANCC, 2022). Research has shown that organizations that establish IOR with the ANCC result in captured value creation. For example, previous IORs demonstrate excellence in leadership and professional practices, and benefits include enabling nurses to work autonomously and collaboratively with other medical professionals (Moon et al., 2019; Regan et al., 2016).

3.3 | Data collection and analysis

In line with our research aim, we recruited participants using a purposeful sampling strategy seeking out key people who were likely to have in-depth knowledge and provide rich data. (Kumar et al., 1993), including, executives, senior managers, Magnet implementors, and Magnet ambassadors (see Table 1 for role definitions). Staff were contacted by the Magnet implementers by email with information about the project and asked to return the consent form to the research team if they wished to participate in an interview. As suggested by Kumar et al. (1993), to improve variability and validity, a range of participants from differing levels (e.g., service directors, managers, Magnet implementation program leaders, and Magnet program implementation staff), role types (e.g., clinical and non-clinical), and profession (e.g., nurses, allied health, administrators, cleaners, and maintenance) were included. Of the 16 staff interviewed, 10 were clinical staff directly involved in treating patients, and six were non-clinical staff that did not treat patients. Each participant's position and level within the organization is provided in Table 1. Limited information about participants is provided to preserve anonymity.

TABLE 1 Participant position and level within the health service organization.

Participant	Position	Role type	Level
P1	Nurse	Clinical	Front line
P2	Admin	Non-clinical	Manager
P3	Nurse	Clinical	Front line
P4	Allied Health	Clinical	Health professional
P5	Nurse	Clinical	Front line
P6	Allied Health	Clinical	Health professional
P7	Administration	Non-clinical	Front line
P8	Nurse	Clinical	Manager
P9	Nurse	Clinical	Front line
P10	Allied Health	Clinical	Health professional
P11	Nurse	Clinical	Executive manager
P12	Nurse	Clinical	Manager
P13	Allied Health	Non-clinical	Senior manager
P14	Nurse	Non-clinical	Mid-level manager
P15	Nurse	Non-clinical	Mid-level manager
P16	Allied Health	Non-clinical	Health professional

Position/role	Definition
Clinical	Involved in treating patients.
Non-clinical	Not directly involved in the treatment of patients.
Nurse	Health care profession focused on the care of individuals.
Non-nurse	Health care professions (not including nurses) such as allied health, administrators, cleaners, and maintenance.
Allied health	Professionals such as dental hygienists, dietitians, occupational therapists, social workers, and so forth, that work as part of a healthcare team.
Administration	Concerned with business operations.
Ward assistant	Help healthcare staff with non-medical duties.
Magnet ambassador	Frontline staff tasked with Magnet implementation duties.
Magnet implementers	A small group tasked with providing Magnet ambassadors with support to actualize best practice.

The interviews were semi-structured (Kvale & Brinkmann, 2009), and were guided by an interview schedule developed from the research aims and the review of extant literature. As such, the interviews focussed on perceptions, understanding, activities and attitudes to the strategic partnership and Magnet® program implementation. The questioning enquiry followed Patton's (2002) categorized questions approach, including, (a) experiential and behavioral questions about what a person does or has done, (b) opinion and values questions were designed to understand what people think about the phenomena, and other prompts, and affect questions were used to elicit the emotional responses of people to their experiences and thoughts, (c) knowledge questions sought to determine what facts the respondents understood, and finally, (d) demographics identified the

characteristics of participants. Interviews lasted up to 60 min and were audio recorded for later transcription and analysis. Field notes were taken during each interview and were discussed in the debriefing after each interview and later in research team meetings.

The de-identified transcripts were analysed using an inductive and deductive analysis approach adapted from Fereday and Muir-Cochrane (2006), represented in Table 2. Initially, inductive coding of the data occurred, breaking it down into smaller units, then plotted to the value mapping tool (Appendix A). Codes were later grouped into themes. The themes were subsequently confirmed through research team meetings. The themes were next deductively grouped using the theoretical framework of Bocken's et al. (2013) value mapping tool into value categories. After the initial categorization, the research team tested the reliability of the code by developing a table with the raw information and coding definitions. The template including category, themes, definitions and sample data were compared and contrasted between researchers (Spencer et al., 2013), until alignment was achieved. A matrix of themes associated definitions and sample evidence is set out in Table 3.

Once finalized, the types of value were further analysed to identify the types relevant to the various stakeholder groups. This analysis also confirmed the following as stakeholders: (1) Magnet implementers within the Health Service (a small team tasked with integrating the relationship); (2) nurse employees; (3) non-nurse employees; (4) consumers/patients; and (5) the non-profit partner (ANCC) (see Appendices A–C). Data collection and analysis ultimately concluded when it became apparent that conducting and analysing additional interviews primarily contributed additional support for existing themes, rather than new insights or variations to existing themes as a form of theoretical saturation (Glaser, 1965). In addition to interviewing, we regularly checked with the Magnet implementation manager during the research process to confirm we had understood the conversations correctly, and ensure data were coded appropriately. We also collected documents from the Magnet implementation manager in order to better understand the nature of the cooperation (to inform Section 4.1). These documents included, the ANCC Professional Practice Guide, Pre-intention program guide, and the Health Service's Professional Practice Model.

TABLE 2 Tabular representation of the research analysis stages (adapted from Fereday & Muir-Cochrane, 2006).

	Steps in thematic analysis	Application of the steps in the research
Step 1	Identified coding template—value mapping tool	Description of Bocken's et al. (2013) types of value and definitions
Step 2	Identification of data set	Interview data from the case organization. Documents were used to inform the inter-organizational cooperation efforts (see Section 4.1)
Step 3	Analysis of the data: Inductive analysis	Inductive analysis, coding of the data, breaking it down into smaller units and assigning labels
Step 4	Deductive mapping using theory and testing the reliability of the code	Deductively, data plotted directly on the value mapping tool (see Appendix A). Codes were grouped into themes. A matrix was developed to determine the applicability of the raw information to the code (Table 3)
Step 5	Connected the codes and identified themes: discuss each significance within the context of the template (mapping tool)	Further explore codes to discover themes. Consider possible contributions to the theoretical framework (Appendix C) and broader literature (Figure 1)

4 | RESULTS

The results are presented first on the inter-organizational cooperation effort, next according to the ranges of values categories —*Value captured*, *Value missed*, *Value destroyed*, *Value opportunity*—along with examples of how these are manifested within the partner organizations (see also Table 2, and Appendices A–C). The data analysis revealed that within these value categories. A number of themes were evident. The following sections outline each of the value categories and their resultant themes.

4.1 | Inter-organizational cooperation efforts

In order to examine the nature of the cooperation and combination of resources, we applied Cao and Zhang (2010) collaboration efforts dimensions, which are discussed below and summarized in Table 4.

Information sharing. The non-profit partner provided the partner organization with books and tools to guide the development of nursing excellence. Only the health service's boundary spanning group (referred to as the Magnet implementors here) met with the non-profit organization to share performance data. The health service also enrolled in a program including monthly meetings to discuss expectations and receive practical advice.

Goal congruence. The non-profit organization is well known for its pursuit of nursing excellence. The Magnet® recognition program has 78 stipulated goals to achieve nursing excellence. To achieve Magnet® designation only nursing excellence is required, however, the public-sector organization chose to pursue a whole of organization excellence and included non-nursing professions (e.g., allied health, maintenance, etc.) in the program.

Resources sharing. The non-profit provided access to expert knowledge and tools to implement in the public-sector organization. The public-sector organization paid a fee to access the Magnet® program and provides performance data to the ANCC.

TABLE 3 Thematic matrix, definitions, and evidence.

Category and theme	Definition	Sample data
Value captured		
Professional practice	Combination of collaboration, communication, and professional development.	Skill Champions, everybody has skills and different attributes that they can bring. People put their hand up and say, "Yeah, I could be the Champion of that skill" and are acknowledged for their expertise. P1
Patient-centered orientation	Health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers.	It's involving the patient in that decision around so what for the patient or if it could be something as simple as reducing pressure injuries or reducing fall rates so you do not necessarily need to ask a patient would you like us to look at this because you know that is something intuitively that we would obviously do. P12
Value missed		
Process orientation	An approach that moves to make improvements but may be limited to functions instead of outcomes.	With normal quality improvement ideally that's what we want to see but quite often you do not, so people do not often have what the end goal is in mind… "Oh yes we have improved documentation in this area." That's very much a process measure that rather than an outcome measure. P2
High complexity	State of the work environment that is complicated or hard to understand.	Magnet can be quite difficult to understand. We tried a number of different avenues. We do hold ambassador workshops and initially we ran every month at both here and at Robina. P8
Reduce waste	The inefficiency in process, operations, or management where resources are not optimized resulting in misused materials, energy, or time.	Our ward was involved with a trial that looked towards saving money, by reducing waste. The trial was a massive flop. P3 Most participants did not discuss waste reduction. (observation)
Value destroyed		
Lack of support and resources	The supply of money, materials, staff, and other assets that can be drawn on in order to run effectively.	I am doing this project at the moment that is almost finished, that is taking almost a year to get it done. I've noticed there was a lack of communication between X-ray and our ward, and I wanted to make a page—just a document that says what we need to do to prepare our patients for certain procedures. P3
Change fatigue	High levels of change in the workplace result in negative staff reactions.	Yeah, another program that is supposed to make us feel better about where we are working, but that sounds just like what we did 5 years ago but it wasn't called Magnet in it. It was called like Change for Good. P10
Lack of engagement	Staff that are not on board or invested in the organization's efforts.	Each division has a lead. It was just me, and I was struggling to get people on board, and I got someone from CN (Clinical Nurse) helping me. P9
Value opportunity		
Staff empowerment	The degree of autonomy and self-determination in employees in the workplace, enhance their current ability.	"Do you want a new uniform? What do you want it look like? Here are some examples." And then everybody gets in together and has some fun. Then something can actually then be progressed and actually goes right. P6
Continuous improvement	Ongoing effort to improve products, services, or processes.	What it is, is about recognising nursing's contribution in the organization and to improving the care or just improving all the different processes and things. It's recognising and valuing their input into how we actually create change. P12
Reputational benefit	Perceptions others hold of an organization. It is the image that is projected to the public and is based on their past and predicted future actions.	Magnet organizations have better patient outcomes and staff are more satisfied… the reputation side of things is not as important in terms of monetary gain. It definitely is important in terms of trust within the community. P12

Collaborative communication. Bidirectional formal and informal communication between the non-profit coaches and the Magnet implementation team. Most communications occurred via email and site visits to the ANCC by the health service Magnet implementation manager.

Joint knowledge creation. The non-profit can use the performance data to improve existing and future IORs. The public-sector organization actively participates in conferences, forums, updates, and networks with the non-profit organization and other Magnet® designated hospitals.

TABLE 4 Inter-organizational cooperation efforts.

Organization	Information sharing	Goal congruence	Resource sharing	Collaborative communication	Joint knowledge creation
Non-profit	Non-profits provide partner organizations with guidance and tools to assist in achieving nursing excellence.	Pursuit of nursing excellence. 78 stipulated goals to achieve in nursing excellence.	Provides capabilities sharing and expertise to interpret implementation in the local context.	Bidirectional formal and informal communication. Provides a coaching role to achieve goals.	Health Service performance data is used to improve existing and future inter-organizational relationships.
Health Service	Health Service organization (Magnet implementors) supply partners with ongoing performance data (such as staff satisfaction, customer satisfaction, and staff retention).	Pursuit of whole-of-organization excellence. Including non-nursing professions; allied health, maintenance, pharmacy, and so forth. Required to submit evidence of 78 goals to partner.	Health Service paid a fee and performance is evaluated on achieving nursing excellence goals by site visits, reviewing evidence, performance data and application.	Bidirectional formal and informal communication.	Active participation in conferences, forums, updates, and networks with non-profit organizations.

4.2 | Value captured

Value Captured is defined as the process of retaining some of the value from a change in practices or processes. Within this category are the themes *professional practice* and *patient-centered orientation*.

4.2.1 | Professional practice

Following the implementation of the Magnet® program, participants described information sharing experiences, increased opportunities for training, and in turn led to more efficient, better-informed, evidence-based practice. For example, Participant 11, a clinical nurse manager stated, "*the Magnet program elevates professionalism and gives evidence-based practice, by encouraging post-grad study*." Given the Magnet® program was initially designed specifically for nurses, in this case organization, non-nursing health care staff (e.g., allied health) were implementing the Magnet® program as a base to build a best practice model suited to the needs of their division. Communities of practice were organically evolving at the Health Service, for example:

> We sifted all that out (guidelines for best practice) from a nursing point of view and then we looked at what of that is relevant for allied health, because allied health is different culturally. … we've developed a community of practice with Magnet and allied health. (P13, non-clinical allied health)

To improve the ward's professional knowledge and practice, "*a 'skills champion' was assigned*," said a clinical nurse (P1, clinical nurse). They noted that implementing the Magnet® credentialing program across the Health Service allowed diverse staff to self-nominate and identify other staff skilled in professional practice standards, thus facilitating greater knowledge and professionalism. "*There are things in our ward that are quite specialized, and people put their hands up and said Yeah, I would love to be the champion of that skill*" the nurse added.

4.2.2 | Patient-centered orientation

For both clinical and non-clinical staff, the whole-of-organization's effort in the Magnet® program generated the perceived value in uniting staff for a common purpose and engaging in collaborative communication. The collaborative advantage of achieving patient-centered care was realized through this approach whereby nursing and non-nursing staff work together to achieve common goals.

The whole-of-organization effort was perceived as valuable by both clinical and non-clinical staff. It helped to unite staff for a common purpose and engage in collaborative communication. The program's organizational advantage was realized through staff work together to achieve common goals, resulting in a patient-centered approach.

> … our patients are the people that we need to be focused on and then if we are all on the same page, if everybody feels confident in what they are doing, our patients are going to have the best outcomes … (P9, clinical nurse)

Participant 10, an allied health worker, noted that implementing and attaining the Magnet® status would help to ensure that patients received more seamless care throughout their "*patient journey*." The Magnet® program is specifically designed to provide a framework for nursing practices. In this organization, the program was being implemented throughout the organization, thus the collaborative function assisted in boundary spanning across divisions. Interestingly, non-nurse staff reported benefiting from inclusiveness and building expertise.

> One of the main things is that patients are always (central)—so we talked a lot about our patient's journey through the hospital, … if Magnet reaches the standards that we are supposed to be, then we are going to create a (patient) journey that is much more seamless… (P10, clinical allied health)

4.3 | Value missed

According to Bocken et al. (2013) *value missed* "represents situations where individual stakeholders squander or fail to capitalize on existing assets, resources and capabilities, are operating below industry best practice, or fail to receive the benefits they seek" (p. 9).

Within the data analysed here, some participants highlighted that opportunities for improvements were missed due to the Health Service staff's focus on *process orientation*, the *high complexity* of the Magnet® program implementation, and the inability to optimize resources to ***reduce waste.***

4.3.1 | Process orientation

Several participants commented that the Magnet® program was not well embedded in the Health Service which had led to a "box ticking" administrative culture. Staff perceived that emphasis was placed on following the credentialing standards and processes rather than achieving quality outcomes.

> There was a little bit of tick-boxing going on and you're kind of doing nothing. … I thought it would be great to be involved in something that actually changes that culture … (P4, clinical allied health)

The nurse comments reflected that in focusing on processes the patients can become irrelevant and the health service is not achieving its planned outcomes, as explained, "*But what we're finding through capturing some of the stories, is that we're very process orientated, not so much outcomes-orientated*" (P11, clinical nurse).

4.3.2 | High complexity

A lack of understanding of the Magnet® program was perceived as having contributed to misunderstandings. Interviewees commented that health care is complex and continually changing and that the implementation of the Magnet® program added to the difficulty in staying up-to-date with practices and policies. Consequently, staff may not understand how to apply Magnet® standards to their current role, thus leading to a source of value missed: "*Most staff don't even know what Magnet is and they might see the (Magnet notice) board, but they don't know what it is …*" (P4, clinical allied health).

Without sufficient awareness and understanding to apply Magnet® standards to their role much of the potential value is not realized. The complexity of the standards and multiplicity of requirements result in missed value for the organization. "*I actually find them (Magnet standards) a little, I find them very confusing and there are sources of evidence that are needed to be attached to each standard*" (P8, clinical nurse).

4.3.3 | Reduce waste

Participants did not commonly discuss a reduction in waste during the study. The researchers found this to be unusual, as the Magnet® program goals align with environmental stewardship. The only successful waste reduction that was reported was in an initiative to reduce blood wastage by establishing a blood allocation system. This initiative involved installing swipe card-accessible fridges in operating theatres to ensure that products were stored correctly and returned intact if unused.

> She (the person in charge of blood products) used a range of different data to be able to identify how they can try and reduce blood wastage in the organization. … She has received national recognition essentially for what she's done. (P12, clinical nurse)

During another interview, when the participant was probed about waste reduction initiatives, the nurse spoke about a failed trial aimed at reducing discarded equipment for infusion-type medications. "*Our ward was involved with a trial that looked towards saving money, by reducing waste. The trial was a massive flop*" (P3, clinical nurse).

4.4 | Value destroyed

The *Value destroyed* category can be represented by negative social impacts, including environmental and social consequences of business activities. Analysis of the data revealed the themes of *lack of support and resources*, *change fatigue*, and *lack of engagement*.

4.4.1 | Lack of support and resources

A lack of support and resources available to implement the Magnet® program arose as a reason for instances of "destroyed value." Participant 1, a clinical nurse, expressed a perceived lack of support for Magnet® ambassadors on the ward by nursing staff which resulted in reduced motivation: "*I was losing a bit of motivation because nobody really wanted to do anything.*" The Magnet® implementation team were described as "*… busy, and difficult to get hold of.*" In another example, a clinical nurse and an allied health staff member commented about how a lack of time resulted in Magnet® tasks not getting done: "*It's [Magnet®] a great idea, except that it does take time, and it has*

been really busy at the moment" (P3, clinical nurse). *A clinical allied health worker agreed:* "*Magnet® takes time and effort. …I often feel like I don't contribute enough*" (P6, clinical allied health).

The cost of the cooperation was perceived negatively by staff. Several participants commented on the relationship fee as an opportunity cost which resulted in reduced clinical services and reduced patient care, as explained; "*[During an executive speech] he then keyed in, the cost [of inter-organizational relationship] is 2 million dollars to do it, but I have put this in the budget*" (P7, non-clinical administration). Staff questioned the appropriateness of the allocation of resources to the inter-organizational relationship, instead of direct spending on patients, such as this comment by Participant 14: "*So, when they close a ward, and they close ten beds and they don't talk to the staff, then staff respond with, is this Magnet®?*"

4.4.2 | Change fatigue

Over the past 5 years, the Health Service has undergone much change. Many participants deliberated about considerable change that had been thrust upon them, such as *moving hospitals*, *acquiring a new hospital*, and *advancing from a secondary service hospital to a tertiary referral hospital service*. Participant 10 had experienced much change and used cynicism when discussing Magnet®:

> [Magnet is] another program that is supposed to make us feel better about where we're working, but that sounds just like what we did five years ago, but it wasn't called Magnet. (P10, clinical allied health)

Participants expressed frustration about the slowness of change from the time when the partnership was announced by management: "*There are definitely things that haven't happened, and we are reasonable people, … and I think that's what our frustration is…*" (P1, clinical nurse).

4.4.3 | Lack of engagement

The lack of engagement with the Magnet® program by management was visible to frontline employees. Perceived leadership attitudes compounded staff reluctance to engage with Magnet®:

> Some managers think it's a load of shit. So, they are not even fully supportive of it [Magnet]. Some managers have never even been to the actual Magnet program meeting to even understand what it is. (P4, clinical allied health)

The ongoing change initiatives had led to employees' resentment of the Magnet® implementation process. Participant 16 highlights that low staff participation and engagement had impeded the change process. She felt that this could be caused by a lack of trust and that she would need to work individually with staff to involve them.

> I came into a directorate that wasn't very well engaged with the process. I guess the first thing I needed to do was gain people's trust and get their interest and convince them that this was a worthwhile endeavor. (P16, non-clinical allied health)

4.5 | Value opportunity

As was stated above, *Value Opportunities* can involve the development of new values with enhanced, and mutual, benefits to stakeholders, with mutual benefits. Based on our analysis, value opportunity is represented here by the themes; *staff empowerment*, *continuous improvement*, and *improved reputation*.

4.5.1 | Staff empowerment

Magnet® helped to empower employees with participant 6, a clinical allied health worker stating: "*I feel empowered to do that [speak up] because the Magnet is here*." Similarly, another participant used the Magnet® values to encourage an environment that supported staff to express their opinions: "*I try to create those environments where from an education point of view the staff are feeling like their thoughts and wishes are heard …*" (P3, clinical nurse).

Participants noted that the all-of-health service implementation of Magnet® was imperative to improving the patient journey. The patient journey is the foundation of good care, and nursing and non-nursing staff should be empowered to collaborate. For example, a clinical nurse shared their experience of collaborating with staff members in the social work department. "*… if we got nursing and allied health on the same page (common purpose), we'd get a better momentum of cultural change (toward patient-centered care)…*" (P13, non-clinical allied health).

4.5.2 | Continuous improvement

Achieving Magnet® accreditation requires a high standard of learning and evidence-based outcomes. The process of evidencing staff training and development highlights new opportunities for continuous learning and improvement:

> We did look recently at our [nursing] postgrad certificates and appraise what the girls are doing … We're encouraging that (upgrading qualifications), myself included … (P5, clinical nurse)

In this theme, many participants deliberated about possible improvements to the patient journey that could increase efficiency and care

and at the same time, reduce cost: "*… we're looking at the cost-effectiveness of a (patient) appointment, the use of staffing when we don't necessarily have to, so it does have a little trail-off effect*" (P9, clinical nurse).

4.5.3 | Reputational benefits

Participants noted that hospitals that achieve Magnet® accreditation are prestigious and held in high esteem generally by health care staff. Thus, Magnet® accreditation results in a strong overall perception and can attract a highquality talent pool.

> … (if you make your health organization) excellent, … then you are going to attract better staff and you are going to hold your staff and the staff are going to have something to work towards… (Participant 7, non-clinical administrator)

The health service's reputation was a consideration important in terms of patient outcomes, staff satisfaction, and community trust. Although public-sector organizations are not aimed at gaining extra profit from consumer loyalty (i.e., for-profit organizations), staff recognized other benefits of having a strong reputation.

> Magnet organizations have better patient outcomes and staff are more satisfied… It definitely is important in terms of trust within the community. Also then, being able to recruit and retain people too. (Participant 12, clinical nurse)

5 | DISCUSSION

Overall, this paper set out to examine the perceptions of public sector health care workers to understand how partnering with a non-profit partner can capture value. Based on our findings and the literature on inter-organizational relationships and value mapping, we present a model that illustrates how the social value from IORs in the public-sector can be achieved and identifies attributes that act as antecedents to social value in this case study. As demonstrated in the model (see Figure 1), the inter-organizational effort is based on a contract fee-for-service strategic partnerships involving organizations from non-profit and public sectors. The public-sector organization is motivated to join the strategic partnership to achieve the recognition of excellence in nursing standards by assimilating new and existing knowledge (Parmigiani & Rivera-Santos, 2011). Our model consists of three process phases: (1) inter-organizational cooperation effort, (2) organizational effect, and (3) social value.

5.1 | Inter-organizational cooperation effort

The model's initial stage aligns with the trend among many healthcare organizations forming IORs to take advantage of enhancements in quality, efficiency, and overall societal benefit, instead of continuing with traditional healthcare models (Moon et al., 2019; Palumbo et al., 2017, 2020). Creating societal benefits for communities is the primary objective of any public-sector healthcare organization. In order to innovate within these organizations, it is essential to establish appropriate inter-organizational cooperation, however, this can be a difficult task to accomplish (Kożuch & Sienkiewicz-Małyjurek, 2016).

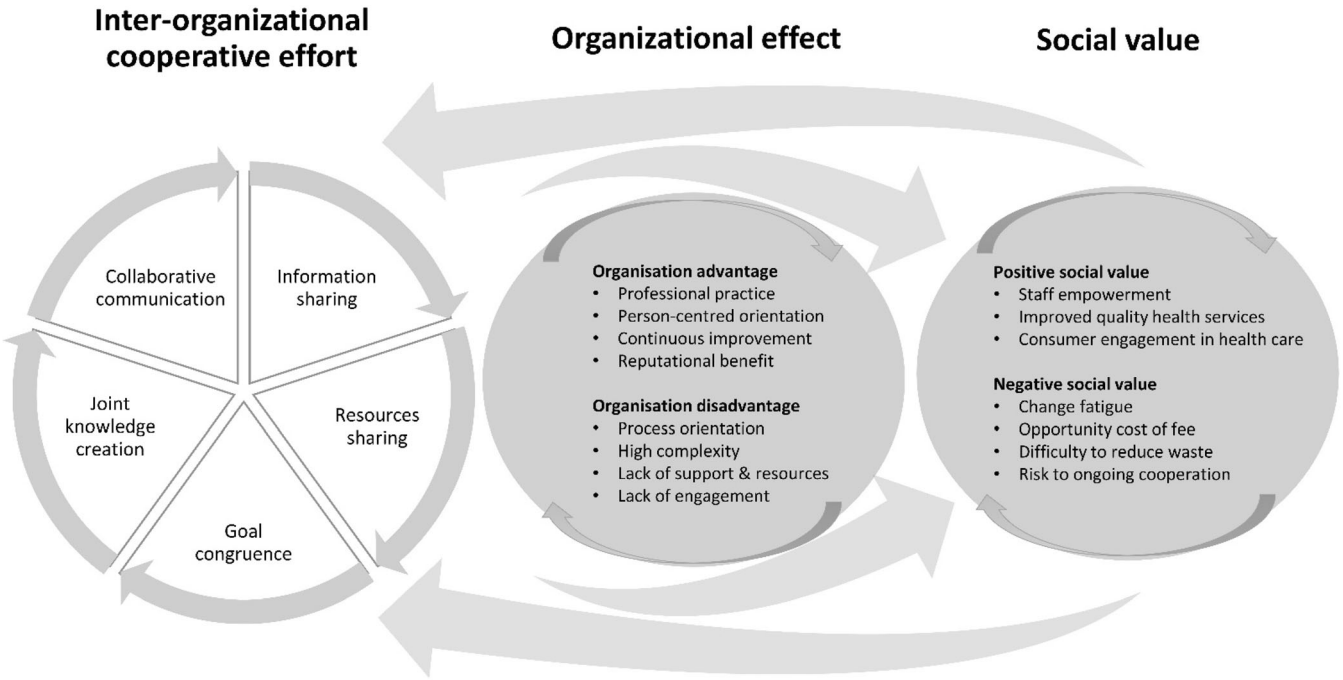


FIGURE 1 Model for achieving social value from inter-organizational relationship in a public-sector health care organization.

When embarking on an IOR, it is crucial to understand the nature of the cooperative effort. An effective IOR requires coordination and cooperation among the partner organizations to achieve common goals and improve overall efficiency and effectiveness (Lepak et al., 2007). In applying Cao and Zhang's (2010) inter-organizational cooperative effort, we noted five factors in use: information sharing, goal congruence, resource sharing, collaborative communication, and joint knowledge creation. In contrast, Curnin and O'Hara's (2019) examination of a non-profit and public sector IOR found that inter-organization cooperation was characterized by administrative role clarity, inter-organizational structures, and trusting relationships. This difference may be explained by the ANCC's long history of cooperative partnerships for Magnet® designation including clear policies and practices for both parties.

5.2 | Organizational effect

The second phase of the model represents the crucial synthesis of resources by employees within the organization. Cao and Zhang (2010) suggest that this phase can lead to cost savings, enhanced capacity and flexibility, better decision-making, and resource synergy. Our research found the IOR led to several organizational advantages in the form of professional practice, person-centered orientation, continuous improvement, and reputational benefits.

However, our study also identified several challenges negatively impacting the sustainability of the IOR. These challenges include process orientation, lack of support and resources, lack of engagement, and high complexity. In an earlier study, Hayden et al. (2016) reported that only 10% of hospitals were able to maintain Magnet® designation for more than 12 years, with potential barriers to sustaining the IOR including leadership turnover and change, lack of advocacy, lack of funding, and weakening of nurse autonomy. While our results are consistent with this regarding the insufficiency of support, resources, and engagement, we concluded the variation in results could be attributed to factors such as the organization's (Hayden's case study) longstanding Magnet® designation, and the prevalence of for-profit healthcare organizations in the United States. Furthermore, we identified a high level of complexity as another obstacle, which may be attributed to the fact that the practices arising from the IOR have not yet been fully institutionalized (Lawrence et al., 2002).

Therefore, our study suggests that individual organizations embedding value creation in the IOR need to use differing mechanisms and strategies to manage and resolve tensions of value co-creation and capture, even when the non-profit partner (e.g., ANCC) of the IOR is consistent. As previous research has emphasized (Caldwell et al., 2017; Cao & Zhang, 2010; Irún et al., 2020), working with partners can often lead to an unexpected workload, and as a result, it can be easy to underestimate the amount of resources and support that will be needed to sustain the relationship. By addressing these challenges, organizations can maximize the benefits of the IOR and achieve sustainable value creation.

5.3 | Social value

The third phase again highlights the importance of leadership and strategic planning for partnering. Our results showed the implementation of IOR's can have positive social value, which is consistent with broader IOR research (Castaneda et al., 2022). Unlike other research, this study extends the understanding of the relationship to explicate how the IOR between the ANCC and public-sector health services can produce social value. Specifically, we found that the IOR led to increased staff empowerment, improved health services, and enhanced consumer engagement in healthcare. Unfortunately, when developing social value there can be unintended negative impacts that may be realized due to the complexities of partnering. Our findings are similar to that of Oliveira and Lumineau's (2019) review of the negative aspects of IORs identifying various adverse consequences that can arise from partnerships. In particular, our findings evidenced negative social value represented by change fatigue, the opportunity cost of the fee, difficulty to reduce waste, and the risk to ongoing cooperation. In 2006, Bryson et al. observed that partnerships are more likely to arise in turbulent environments where there is a crisis or an increasing level of complexity. They also pointed out that a downside of this phenomenon is that it can become challenging to monitor any negative outcomes or value destruction that may occur as a result of these partnerships.

To minimize the destruction and loss of social value in IORs, it is essential to conduct regular evaluations and make necessary adjustments to internal processes and practices. This will ensure the effectiveness of the partnership and potentially reduce negative consequences. The literature has noted that partnerships can lead to a range of unexpected factors that create missed opportunities or wasted value (Niesten & Stefan, 2019). One effective way to reduce wasted resources and improve sustainability is through continuous appraisals. Geissdoerfer et al. (2016) suggest evaluations are necessary to assess the partnership's effectiveness, allocation of resources, and stakeholder satisfaction. Continuous monitoring, evaluation, and adjustment can help to ensure that the partnership is creating value rather than destroying or missing it.

5.4 | Managerial implications

The focal point of this study was the collaborative forms and processes undertaken by a public-sector organization within a value framework. By examining the Health Service organization, we were able to determine the micro-level elements. In line with Palumbo et al. (2017), we also found creating organizational advantage was necessary to realizing the organization's patient-centered care goals. At the micro-level we found evidence that the organization's patient-centered orientation had the additional benefit of improved horizontal integration within the Health Service organization, that is, between different directorates (e.g., allied health, nursing, pharmacy, maintenance, and administration).

Another implication for managers is understanding value creation as an ongoing process as an outcome of an IOR (see Figure 1). As

mentioned previously, social value is difficult to measure (Quélin et al., 2017), therefore, organizations can use a value framework as we did in this study, or interactively use a design thinking technique similar to the method shown in Geissdoerfer et al. (2016) to illustrate and assess the process of value creation and possible value destruction (Plé & Cáceres, 2010). It is evident that a significant source of value captured was due to the employees' activities and incorporating value creation practices such as professional practice and patient-centered orientation (see Appendices A–C). However, a major source of missed and destroyed value included change fatigue, difficulty to reduce waste, the opportunity cost for patient care and, the risk to the ongoing partnership.

These findings are likely to be of interest to health care organizations considering strategic partnerships with the ANCC to achieve Magnet® designation, the ANCC's future management of the program, and as a funding source. More broadly, the findings are of interest to public-sector organizations seeking to innovate through IORs and non-profits offering fee-for-service programs. The value creation outcome of the partnership is an important consequence for the non-profit organization as they may rely on fees for services as a funding source (Jung et al., 2022; Noel & Luckett, 2014). The outcomes of such agreements can impact the confidence (Farwell et al., 2019), and motivation to engage (Patel & Weberling McKeever, 2014) for non-profit organizations' stakeholders (Rupp et al., 2014).

6 | CONCLUSION, LIMITATIONS AND FUTURE RESEARCH

In conclusion, this research demonstrates the utility of a value framework to determine the location and types of value created in an IOR. In this case, a public-sector health organization's value imperatives were not focused on for-profit metrics, but rather, on providing social value by improving knowledge, skills, and empowerment that can lead to better health outcomes for the community. Given the nature of the public-sector, where the ever-increasing demand for services is driving an emphasis on efficiency (Xiong et al., 2019), encouraging new and collaborative ways to enhance performance and create value is critical.

This article makes important contributions to the field of organizational research. Firstly, it demonstrates the applicability of Bocken's et al. (2013) value mapping tool in identifying value creation, including captured, missed, destroyed, and opportunity value, beyond its original use in the for-profit sector. Second, it extends the use of the value mapping tool to assess the intended and unintended value creation from IORs. This provides a valuable tool for non-profit and public-sector organizations to manage value creation and avoid inadvertent missed or destroyed value. The study also has practical implications for public-sector healthcare, showing that strategic use of IORs can support the reorientation of internal practices and processes to meet growing challenges. The cooperation between public-sector and non-profit organizations is an effective way to reconfigure resources and produce social value, which is particularly important in our post-COVID-19 and resource-constrained world.

The scope of this research is first limited by the method. A cross-sectional design included in-depth qualitative interviews with employees about their behaviors and attitudes. Given value creation is not static, a longitudinal or action research design could enable the evaluation of long-term consequences. The data were not observed and therefore, relied on participant representations and perceptions through self-report in one organization only. Extending this research may include a focus on the non-profit partner organization, and other potential stakeholders (such as consumers, suppliers, potential employees, and media). Second, this study's narrow focus on one health care organization may be considered problematic. As such, findings are not representative of the entire health care sector and conclusions should be drawn with caution.

ACKNOWLEDGMENTS

We are grateful for the support of Samantha Clayton and the Health Service staff, who generously contributed their time to this project. A small grant was received from: Sustainability Small Grants Griffith Centre for Sustainable Enterprise (GCSE). Open access publishing facilitated by Griffith University, as part of the Wiley - Griffith University agreement via the Council of Australian University Librarians.

DATA AVAILABILITY STATEMENT

Research data are not shared.

ORCID

Joan Carlini https://orcid.org/0000-0002-0446-9215
Kathy Knox https://orcid.org/0000-0001-9665-8867

REFERENCES

ANCC. (2022). *ANCC magnet recognition program®*. https://www.nursingworld.org/organizational-programs/magnet/

Bocken, N., Short, S., Rana, P., & Evans, S. (2013). A value mapping tool for sustainable business modelling. *Corporate Governance*. https://doi.org/10.1108/IJPPM-03-2013-0042

Boenigk, S., & Möhlmann, M. (2016). A public sector marketing model to measure the social and environmental values of public strategies: An empirical study on a green public service. *Journal of Nonprofit & Public Sector Marketing*, *28*(2), 85–104.

Boockvar, K. S., & Burack, O. R. (2007). Organizational relationships between nursing homes and hospitals and quality of care during hospital–nursing home patient transfers. *Journal of the American Geriatrics Society*, *55*(7), 1078–1084.

Caldwell, N. D., Roehrich, J. K., & George, G. (2017). Social value creation and relational coordination in public-private collaborations. *Journal of Management Studies*, *54*(6), 906–928.

Cao, M., & Zhang, Q. (2010). Supply chain collaborative advantage: A firm's perspective. *International Journal of Production Economics*, *128*(1), 358–367.

Castaneda, L. C., Spoerl, S. S., & Chang Martinez, C. (2022). Achieving 6th magnet designation via virtual visit during the COVID-19 pandemic. *Nursing & Health Sciences Research Journal*, *5*(1), 67–71.

Castañer, X., & Oliveira, N. (2020). Collaboration, coordination, and cooperation among organizations: Establishing the distinctive meanings of

these terms through a systematic literature review. *Journal of Management*, *46*(6), 965–1001. https://doi.org/10.1177/0149206320901565

Curnin, S., & O'Hara, D. (2019). Nonprofit and public sector interorganizational collaboration in disaster recovery: Lessons from the field. *Nonprofit Management and Leadership*, *30*(2), 277–297. https://doi.org/10.1002/nml.21389

Davis, J. P. (2016). The group dynamics of interorganizational relationships: Collaborating with multiple partners in innovation ecosystems. *Administrative Science Quarterly*, *61*(4), 621–661. https://doi.org/10.1177/0001839216649350

De Vries, H., Bekkers, V., & Tummers, L. (2016). Innovation in the public sector: A systematic review and future research agenda. *Public Administration*, *94*(1), 146–166. https://doi.org/10.1111/padm.12209

Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: Opportunities and challenges. *Academy of Management Journal*, *50*(1), 25–32.

Elbanna, S., Andrews, R., & Pollanen, R. (2016). Strategic planning and implementation success in public service organizations: Evidence from Canada. *Public Management Review*, *18*(7), 1017–1042.

Farwell, M. M., Shier, M. L., & Handy, F. (2019). Explaining trust in Canadian charities: The influence of public perceptions of accountability, transparency, familiarity and institutional trust. *International Journal of Voluntary and Nonprofit Organizations*, *30*(4), 768–782.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development. *International Journal of Qualitative Methods*, *5*(1), 80–92.

Fleiszer, A., Semenic, S., Ritchie, J., Richer, M., & Denis, J. (2015). The sustainability of healthcare innovations: A concept analysis. *Journal of Advanced Nursing*, *71*(7), 1484–1498.

Freudenreich, B., Lüdeke-Freund, F., & Schaltegger, S. (2020). A stakeholder theory perspective on business models: Value creation for sustainability. *Journal of Business Ethics*, *166*(1), 3–18.

Gaudin, S., Smith, P. C., Soucat, A., & Yazbeck, A. S. (2019). Common goods for health: Economic rationale and tools for prioritization. *Health Systems & Reform*, *5*(4), 280–292. https://doi.org/10.1080/23288604.2019.1656028

Geissdoerfer, M., Bocken, N. M., & Hultink, E. J. (2016). Design thinking to enhance the sustainable business modelling process – A workshop based on a value mapping process. *Journal of Cleaner Production*, *135*, 1218–1232.

Glaser, B. (1965). The constant comparative method of qualitative analysis. *Social Problems*, *12*(4), 436–445. https://doi.org/10.2307/798843

Hayden, M., Wolf, G., & Zedreck-Gonzalez, J. (2016). Beyond magnet® designation: Perspectives from nurse managers on factors of sustainability and high-performance programming. *JONA: The Journal of Nursing Administration*, *46*(10), 530–534.

Irún, B., Monferrer, D., & Moliner, M. Á. (2020). Network market orientation as a relational governance mechanism to public-private partnerships. *Journal of Business Research*, *121*, 268–282. https://doi.org/10.1016/j.jbusres.2020.08.044

Jer, R., Kim, D., & Bello, D. (2017). Relationship-based product innovations: Evidence from the global supply chain. *Journal of Business Research*, *80*, 127–140. https://doi.org/10.1016/j.jbusres.2017.07.008

Jung, J., Kim, M., & Suh, J. (2022). The scope of "marketing" research in the nonprofit sector: Lessons from the last 20 years literature. *Journal of Philanthropy and Marketing*, e1745.

Kożuch, B., & Sienkiewicz-Małyjurek, K. (2016). Factors of effective interorganizational collaboration: A framework for public management. *Transylvanian Review of Administrative Sciences*, *2016*, 97–115. http://rtsa.ro/tras/index.php/tras/article/view/474/463

Kullak, F. S., Baker, J. J., & Woratschek, H. (2020). Enhancing value creation in social purpose organizations: Business models that leverage networks. *Journal of Business Research*, *125*, 630–642. https://doi.org/10.1016/j.jbusres.2020.01.069

Kumar, N., Stern, L. W., & Anderson, J. C. (1993). Conducting interorganizational research using key informants. *Academy of Management Journal*, *36*(6), 1633–1651. https://doi.org/10.2307/256824

Kvale, S., & Brinkmann, S. (2009). *Interviews: Learning the craft of qualitative research interviewing* (2nd ed.). Sage.

Lawrence, T. B., Hardy, C., & Phillips, N. (2002). Institutional effects of interorganizational collaboration: The emergence of proto-institutions. *Academy of Management Journal*, *45*(1), 281–290.

Leite, E., & Bengtson, A. (2018). A business network view on value creation and capture in public-private cooperation. *Industrial Marketing Management*, *73*, 181–192. https://doi.org/10.1016/j.indmarman.2018.02.010

Lepak, D., Smith, K., & Taylor, M. (2007). Value creation and value capture: A multilevel perspective. *Academy of Management Review*, *32*(1), 180–194.

Leung, Z. C. (2013). Boundary spanning in interorganizational collaboration. *Administration in Social Work*, *37*(5), 447–457.

Lumineau, F., & Oliveira, N. (2018). A pluralistic perspective to overcome major blind spots in research on interorganizational relationships. *Academy of Management Annals*, *12*(1), 440–465.

McDougle, L. (2014). Understanding public awareness of nonprofit organizations: Exploring the awareness–confidence relationship. *International Journal of Nonprofit and Voluntary Sector Marketing*, *19*(3), 187–199.

Menser, T., Hamadi, H. Y., Boamah, S. A., Dorsey, K., Zhao, M., & Spaulding, A. (2022). The role of community-level characteristics in comparing United States hospital performance by magnet designation: A propensity score matched study. *Journal of Advanced Nursing*, 1–10. https://doi.org/10.1111/jan.15446

Molander, S., Fellesson, M., & Friman, M. (2018). Market orientation in public service—A comparison between buyers and providers. *Journal of Nonprofit & Public Sector Marketing*, *30*(1), 74–94.

Moon, S. E., Van Dam, P. J., & Kitsos, A. (2019). *Measuring transformational leadership in establishing nursing care excellence*. Healthcare.

Niesten, E., & Stefan, I. (2019). Embracing the paradox of interorganizational value co-creation–value capture: A literature review towards paradox resolution. *International Journal of Management Reviews: IJMR*, *21*(2), 231–255. https://doi.org/10.1111/ijmr.12196

Nik Hashim, N., Hock Ann, Y., Ansary, A., & Xavier, J. (2020). Contingent effects of decision-making and customer centricity on public-sector innovation success. *Journal of Nonprofit & Public Sector Marketing*, *34*(1), 36–70.

Noel, N. M., & Luckett, M. (2014). The benefits, satisfaction, and perceived value of small business membership in a chamber of commerce. *International Journal of Nonprofit and Voluntary Sector Marketing*, *19*(1), 27–39. https://doi.org/10.1002/nvsm.1485

Oliveira, N., & Lumineau, F. (2019). The dark side of interorganizational relationships: An integrative review and research agenda. *Journal of Management*, *45*(1), 231–261. https://doi.org/10.1177/0149206318804027

Ozeren, E., Saatcioglu, O. Y., & Aydin, E. (2018). Creating social value through orchestration processes in innovation networks. *Journal of Organizational Change Management*, *31*, 1206–1224.

Page, S., Stone, M., Bryson, J., & Crosby, B. (2015). Public value creation by cross-sector collaborations: A framework and challenges of assessment. *Public Administration*, *93*(3), 715–732. https://doi.org/10.1111/padm.12161

Palumbo, R., Cosimato, S., & Tommasetti, A. (2017). Dream or reality? A recipe for sustainable and innovative health care ecosystems. *The TQM Journal*, *29*, 847–862.

Palumbo, R., Manesh, M. F., Pellegrini, M. M., & Flamini, G. (2020). Exploiting inter-organizational relationships in health care: A bibliometric analysis and literature review. *Administrative Sciences*, *10*(3), 57.

Parmigiani, A., & Rivera-Santos, M. (2011). Clearing a path through the forest: A meta-review of interorganizational relationships. *Journal of Management*, *37*(4), 1108–1136.

Patel, S. J., & Weberling McKeever, B. (2014). Health nonprofits online: The use of frames and stewardship strategies to increase stakeholder involvement. *International Journal of Nonprofit and Voluntary Sector Marketing*, *19*(4), 224–238. https://doi.org/10.1002/nvsm.1507

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (Vol. 5, 3rd ed.). Sage.

Plé, L., & Cáceres, R. C. (2010). Not always co-creation: Introducing interactional co-destruction of value in service-dominant logic. *Journal of Services Marketing*, *24*, 430–437.

Quélin, B. V., Kivleniece, I., & Lazzarini, S. (2017). Public-private collaboration, hybridity and social value: Towards new theoretical perspectives. *Journal of Management Studies*, *54*(6), 763–792. https://doi.org/10.1111/joms.12274

Regan, S., Laschinger, H., & Wong, C. (2016). The influence of empowerment, authentic leadership, and professional practice environments on nurses' perceived interprofessional collaboration. *Journal of Nursing Management*, *24*(1), E54–E61.

Rupp, C., Kern, S., & Helmig, B. (2014). Segmenting nonprofit stakeholders to enable successful relationship marketing: A review. *International Journal of Nonprofit and Voluntary Sector Marketing*, *19*(2), 76–91. https://doi.org/10.1002/nvsm.1492

Sagawa, S. (2001). New value partnerships: The lessons of Denny's/save the children partnership for building high-yielding cross-sector alliances. *International Journal of Nonprofit and Voluntary Sector Marketing*, *6*(3), 199–214.

Seo, R. (2020). Interorganizational learning for R&D consortium performance: A social capital perspective. *Journal of Knowledge Management*, *24*(2), 395–414. https://doi.org/10.1108/JKM-06-2019-0265

Spencer, K., Foster, P., Whittamore, K. H., Goldberg, S. E., & Harwood, R. H. (2013). Delivering dementia care differently—Evaluating the differences and similarities between a specialist medical and mental health unit and standard acute care wards: A qualitative study of family carers' perceptions of quality of care. *BMJ Open*, *3*(12), e004198.

Splitter, V., Jarzabkowski, P., & Seidl, D. (2021). Middle managers' struggle over their subject position in open strategy processes. *Journal of Management Studies*. https://doi.org/10.1111/joms.12776

Vargo, S. L., & Lusch, R. F. (2008). Service-dominant logic: continuing the evolution. *Journal of the Academy of marketing Science*, *36*, 1–10.

Wood, C., & Leighton, D. (2010). Measuring social value: The gap between policy and practice. *Undercurrent*, (2), 7–9. https://doi.org/10.3316/informit.608274328337959

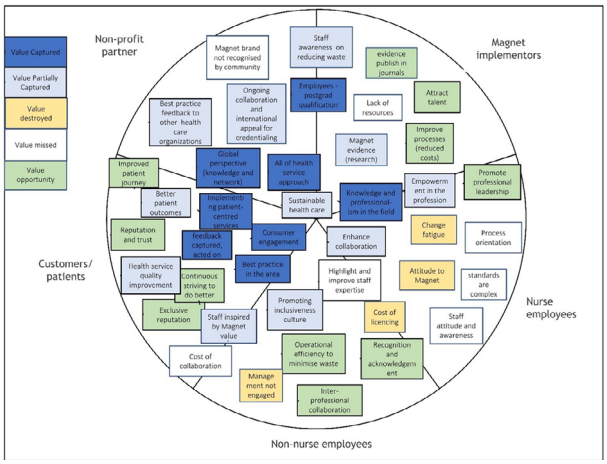
Xiong, W., Chen, B., Wang, H., & Zhu, D. (2019). Governing public–private partnerships: A systematic review of case study literature. *Australian Journal of Public Administration*, *78*(1), 95–112.

Yin, R. K. (2018). *Case study research and applications: Design and methods* (6th ed.). SAGE Publications.

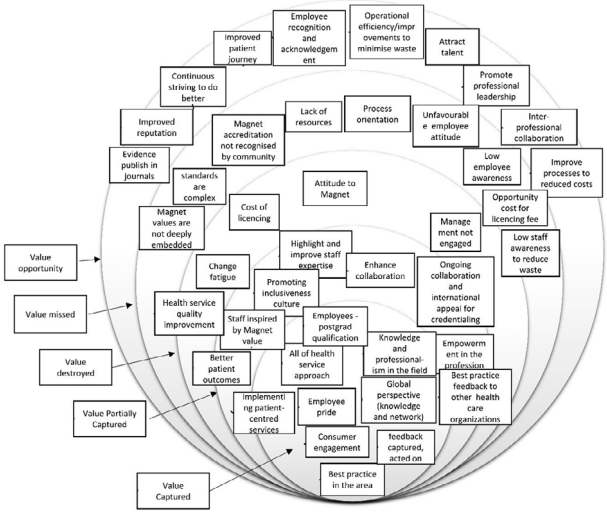
Zahoor, N., & Al-Tabbaa, O. (2020). Inter-organizational collaboration and SMEs' innovation: A systematic review and future research directions. *Scandinavian Journal of Management*, *36*(2), 101109. https://doi.org/10.1016/j.scaman.2020.101109

How to cite this article: Carlini, J., Lehman, K., Dharmesti, M., & Knox, K. (2023). Maximizing value in healthcare partnerships: A case examining an inter-organizational relationship in the public and non-profit sectors. *Journal of Philanthropy and Marketing*, e1796. https://doi.org/10.1002/nvsm.1796

APPENDIX A: POPULATED VALUE TEMPLATE FOR PUBLIC AND NON-PROFIT SECTOR HEALTHCARE PARTNERSHIP BY STAKEHOLDER GROUP



APPENDIX B: POPULATED VALUE TEMPLATE FOR PUBLIC AND NON-PROFIT SECTOR HEALTHCARE PARTNERSHIP BY VALUE



APPENDIX C: ILLUSTRATIVE EVIDENCE LINKING SOURCES OF VALUE TO AFFECTED STAKEHOLDERS

Stakeholder	Value captured	Value partially captured	Value missed	Value destroyed	Value opportunity
Health Service Magnet implementers	In-depth knowledge of program implementation.	The implementers are continually learning about service quality improvements from the partner. Some knowledge does not transfer well to the Australian context.	Many of the Health Service staff were not fully aware of the relationship and purpose. A lack of resources meant that it can be difficult to support staff in the collaboration.	A lack of understanding and awareness of the relationship by staff makes achieving the implementer's tasks difficult (e.g., staff may not return satisfaction surveys).	The relationship enables effective day-to-day operations and the continuous improvement of service.
Nurse employees	Nurses gained understanding and professional expertise from the relationship by using best practice techniques.	Nurses experience a relatively more collaborative environment, but their full potential is not realized.	Magnet standards for reporting are complex, and therefore difficult to meet the 78 goals.	Nurses experience change fatigue due to the ongoing change required for the relationship and program implementation.	The relationship program encourages nurses to gain professional leadership and empowerment.
Non-nurse employees	Non-nurses benefited from knowledge and professionalism specifically developed for their area of expertise (e.g., allied health).	The relationship program is designed for nurse credentialing, but, nonnurse staff benefited from inclusiveness and professionalism.	There is a lack of resources for non-nurse professionals.	Resistance to change is a challenge. Some non-nurse employees display negative attitudes to the relationship program.	Empowerment and interprofessional collaboration between health care workers (i.e., clinical, nonclinical, administrative, and allied health).
Consumers and community	The relationship enables patient-centered care, consumer engagement in health care, and feedback (e.g., satisfaction survey).	Improvements to service quality fosters patient-centered care leading to improved patient health outcomes.	There is lack of consumer and community awareness about the relationship and the program.	Staff perceived the relationship as an opportunity cost due to the fee (meaning reduced funds available for clinical services).	Improve service quality resulting in better health outcomes. Improve community awareness of the relationship benefits.
Non-profit (ANCC)	Additional insight into implementation (Australian context). First time relationship is not limited to nursing (i.e., whole of the organization) approach.	Insights gained from the ongoing relations and collaboration with Health Service.	Non-profit cannot easily ascertain the Health Service improvements (resultant social value) due to intangibility.	No value destroyed was identified.	Improve and refine the relationship program from data gathered from the Health Service.