Covering Kids and Families Evaluation

CKF Activities: A Collaborative Effort

Sheila Hoag and Beth Stevens
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EXECUTIVE SUMMARY

CKF grantees work with a variety of partners to achieve CKF goals and objectives. Most partnerships have been fruitful, although some grantees have noted problems within their coalitions. Key findings from an analysis of interviews with CKF grantees and of a survey of CKF coalition members include:

- **CKF grantees named state and local government agencies as the most helpful collaborators in increasing enrollment.** Grantees choose partners who can best aid them in achieving CKF goals. Government agencies set policies for Medicaid and SCHIP eligibility, enrollment, and retention, and grantees expressed clear preferences for these partners: 76 percent named them the most helpful partners in terms of increasing enrollment for Medicaid and SCHIP. The dominant selection of government agencies holds true for all types of organizations hosting the grant.

- **Collaborators provide varied support to grantees.** Forty percent of CKF grantees indicated that their work is supported by non-CKF grants or in-kind contributions "to a large extent." Grantees reported that coalition members offer their time and expertise to grantees, as well as providing access to target groups, state leaders, and to the media and public as a whole.

- **CKF grantees expect their collaborating organizations to continue the work of CKF even if the grantees cease to exist when RWJF funding ends.** Thirty-one percent of grantees expect that CKF activities, such as outreach and simplification of procedures, will be integrated into the ongoing operation of some coalition members. Another 30 percent expect coalition members to take on these activities, while a quarter of grantees expect that the organization hosting the CKF grant will continue the work.

The collaborative model used by the Covering Kids and Families program has had clear positive effects. Grantee expectations about their collaborators' role in continuing CKF activities holds promise for the value of collaboration in improving access to health insurance in the long term.

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
Tel: (609) 799-3535
Fax: (609) 799-0005

The Urban Institute
2100 M Street, NW
Washington, DC 20037
Tel: (202) 833-7200
Fax: (202) 223-1149

Health Management Associates
120 N. Washington, Suite 705
Lansing, MI 48933
Tel: (517) 482-9236
Fax: (517) 482-0920

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INTRODUCTION

Collaboration is the lifeblood of the Covering Kids and Families (CKF) program. CKF grants require grantees to work in partnership with community groups, forming coalitions that help enroll and sustain the enrollment of eligible children and adults into state Medicaid and SCHIP programs, as well as work on policy changes that support expanded enrollment and retention in those programs. This memo explores the types of organizations that CKF grantees partner with, the kinds of support that partners offer grantees, and whether and how these community partners factor into grantee plans to sustain their efforts after the CKF program ends.

CONTEXT

The CKF initiative of the Robert Wood Johnson Foundation (RWJF) uses a collaborative model—the coalition—to achieve its goals. Funders use such a model for a variety of reasons. First, public and private funders employ these models for health initiatives to capitalize on the strengths and capabilities of cooperative partners (Lasker et al. 2001; Wandersman et al. 1997). Also, funders believe that complex health care problems cannot be solved by an individual or organization working alone (Lasker et al. 2001; Gray 1989; Richardson and Allegrante 2000; Zuckerman et al. 1995). This belief is supported by evidence that communities are facing health care problems with complex socioeconomic and environmental components, many of which have not responded in the past to remedies attempted by solo organizations (Lasker et al. 2001; Aspen Institute 1997; Butterfoss et al. 1996). Next, although not well-evidenced in the literature, it is believed that partnership models can achieve bigger impacts than individual organizations (Kreuter et al. 2000; Lasker et al. 2001; Fawcett et al. 1997). Lastly, collaborations can provide sustenance for health initiatives by bringing together collaborators' dedication, financial support, and institutional memory to protect and preserve programs into the future.

Although collaborations or coalitions can be powerful vehicles of progress and change, they sometimes can hinder grantees' work. Problems documented in the literature include challenges in recruiting members, running the coalition effectively, and sustaining collaborative efforts over time; coalitions are also time- and resource-intensive (Lasker and Weiss 2003; Weiner and Alexander 1998; Cheadle et al. 1997; Fawcett et al. 1997; Mitchell and Shortell 2000; Lasker et al. 2001). In fact, it has been estimated that up to half of health partnerships formed do not survive the first year (Kreuter and Lezin 1998; Kreuter et al. 2000; Lasker et al. 2001). There is also the concern that "forced" collaborations—those required by funders—might be partnerships on paper only , so that the "partners" have little influence on what these partnerships do (Lasker et al. 2001; Lewin Group 2000).

In this memo, we look closely at collaborations in the CKF program by focusing on the CKF grantees' "key" collaborators, those community partners that CKF grantees reported were the most helpful in their efforts to increase enrollment of children and families in Medicaid and SCHIP programs. How has the CKF program used collaborations to improve access to care? As a precursor to answering this question, we traced who these partners are and what support they offer to grantees. We also report grantees' expectations, as of late 2003, as to how they anticipate sustaining their work after CKF ends and examine the role community partners may play in their plans for sustainability.

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METHODS

This memo draws information from three sources: (1) telephone interviews with grantees in 36 states dating from autumn 2003 (representing 107 coalitions); (2) information from site visits conducted in 10 additional states in the spring of 2003; and (3) a mail survey of selected state and local coalition members in spring 2003, known as the Coalition Self Assessment Survey (CSAS). When combined, the 46 states with CKF grants are included.

For the telephone interviews, we interviewed three CKF grantees from each of 36 states.[1] In each instance, the state grantee was interviewed, along with two local grantees.[2] Out of 142 grantees in the 36 states in September 2003, 107 grantees or 75 percent were interviewed by telephone.[3]

The interview instrument was designed to garner CKF project directors' views on a variety of issues, including the project's environment, primary activities, and the rationale for those activities, as well as its most effective activities and any barriers grantees encountered conducting activities. Interviews took 60 minutes or less and were conducted between October and December 2003. Of the 50 questions included in the instrument, 21 were closed-ended (42 percent) and 29 were open-ended (58 percent).

Data from these interviews were supplemented, where possible, with information from the 2003 site visits to state and local CKF grantees in 10 additional states. We also used results from the CSAS mail survey in those states to supplement our analysis of community support for CKF grants.[4]

Data Limitations. Grantee responses are their subjective opinions, and we do not have data to verify their perceptions. Limitations of the CSAS data include a low response rate (43.9 percent), and representation of a small group of coalition members (30 coalitions in 10 states) (Lavin et al. 2004).[5]

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[1]Appendix A lists the states included in the interviews and site visits.

[2]There was only one local grantee to interview in Washington, DC.

[3]When a state had more than two local grantees, local grantees were selected based on five criteria: (1) location (one urban and one rural grantee chosen when possible); (2) grant amount (with those awarded higher grants preferred over those receiving smaller awards); (3) the grantee's organization type, in order to get a range of types (which include community-based organizations or advocacy groups, education-related groups such as a school or a state department of education, government agencies, and health-related groups such as health plans and health care providers, or "other" groups); (4) target populations, in order to get a range of types (which include hard-to-reach age groups, Latinos, migrants, other language groups, and Native Americans); and (5) types of interventions undertaken (including business-based, government-based, one-on-one, provider-based, school-based, and procedural change strategies aimed at administrative simplification).

[4]The CSAS, developed for the SmokeLess States Initiative by Shoshanna Sofaer, Dr. P.H., and Erin Kenney, Ph.D., was modified to fit CKF and sent to 539 members of 10 state CKF coalitions and 539 members of 20 local CKF coalitions in those same states in spring 2003 (Lavin et al. 2004).

[5]The CSAS survey response rate overall was 43.9 percent, with a range from 23.3 percent to 87.5 percent across coalitions (Lavin et al. 2004).

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Terminology. A number of organization types are discussed in this memo. They include:

- **Coalitions:** Includes arrangements of organizations, groups, and individuals intended to generate cooperative action toward explicit goals. Also known as "collaborations."
- **Government agencies:** Encompasses state government agencies, such as Medicaid, human services, social services, education, or health agencies, and local government agencies, such as city or county health districts, or social or health services agencies.
- **Community-based service organizations (CBOs) and advocacy organizations:** Includes organizations focused on children, families, health, access to care, and ethnic communities. Also includes local representatives of national advocacy groups (such as a state chapter of the Children's Defense Fund).
- **Schools:** Includes universities, schools, and school districts.
- **Foundations:** Includes foundations focused on medicine and health as well as community-focused foundations.
- **Health care providers or provider associations:** Includes health care providers such as hospitals, family practice providers, school-based or other health clinics, as well as provider associations, including hospital, primary care, and health center affiliated associations.
- **Other:** Includes quasi-public-private partnerships between government and private agencies, religious groups, other nonprofit groups, other CKF grantees in the state, businesses, and two health maintenance organizations.

FINDINGS

CKF grantees partner with diverse organizations. Most grantees report that government agencies are the most helpful collaborators for increasing Medicaid and SCHIP enrollment.

We asked grantees to tell us about their "key" collaborators, defined as those one or two organizations that have been the *most helpful* in the grantee's efforts to increase enrollment of children and families in Medicaid and SCHIP programs.[6] Three-quarters of grantees named state or local government agencies as their key collaborators (Table 1). For grantees, government agencies are logical partners, given their control over the rules and procedures that

[6]Ninety-five percent of respondents named two collaborators, with 87 percent of those naming collaborators from two different types of organizations (such as naming a government agency as one key collaborator and a community-based organization as a second key collaborator) and 13 percent naming collaborators from the same type of organization (such as naming two different health care providers as key collaborators).

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TABLE 1

KEY COLLABORATORS: ORGANIZATION TYPES

Organization Type	All Grantee Responses (n = 107) (Percent)	State Grantee Responses (n = 36) (Percent)	Local Grantee Responses (n = 71) (Percent)
State or local government agencies	76	81	73
Community-based service or advocacy organizations	42	53	37
Health care providers or provider associations	36	39	35
Schools	19	3	28
Foundations	6	8	4
Other types of organizations	16	14	17

Source: CKF telephone interview data, fall 2003.

Note: Column percentages total more than 100 percent because grantees could name two different key collaborators. Five grantees (one state and four local grantees) only named one organization as a "key" collaborator. Collaborators named in the "other" category include private businesses, faith-based alliances, a Medicaid HMO, quasi-governmental organizations, and in two instances, other local grantees in the state.

govern eligibility and enrollment in Medicaid or SCHIP. Another 42 percent of grantees named community-based organizations most helpful, while 36 percent named health care providers or provider associations most helpful.

Most of the time, state and local grantees made similar collaborator choices (Table 1). One interesting exception to this overall pattern is the popularity of schools as collaborators with *local* grantees; 28 percent of local grantees named schools as key collaborators, compared to only 3 percent of state grantees. Since similar percentages of state and local grantees identified school-based activities as very effective in pursuing their goals (data not shown), the question becomes, "Why do local grantees recognize schools as key partners while state grantees do not?" We interpret our findings as an indication that it is easier for local grantees to see schools as key collaborators because local grantees are more focused on outreach than state grantees, and schools offer direct access to eligible children and families.

Grantees tend to partner with groups that are different from the grantee's organization.

CKF grantees are themselves sponsored by a varied set of organizations; just like the partners they choose, some are community-based organizations, others are government agencies, others are health care providers, etc. Do grantees that are sponsored by one type of organization

tend to collaborate with their peers or do they seek out collaborators from different sectors? In general, we found few clear preferences; most types of agencies collaborated with a variety of agency types (Table 2). There were a few interesting exceptions, however. CKF grantees that are health care providers or provider associations rarely chose other providers or provider associations as collaborators, instead choosing government agencies as key collaborators most often. This may be a result of their long familiarity with government agencies that reimburse them for Medicaid and SCHIP patient services or that sponsor public health programs that draw providers into collaboration. In contrast, CKF grantees that were government agencies were most likely to choose to collaborate with other government agencies. In more than half of the cases, these grantees named a different type of government agency; in other words, a grantee located at a county health district named a human services or children's agency as the key collaborator (and did not name another health district). It may be logistically easier for public agencies to cooperate with other public agencies since they are governed by similar legal mandates and limitations on connections with nongovernmental organizations.

The collaborator preferences of CKF grantees sponsored by schools and foundations vary greatly from the patterns found for all grantees (shown in the "All Grantees: Key Collaborator Choices" column in Table 2). However, since there are only seven and five respondents, respectively, in these categories, small numbers seem to be skewing the patterns in these instances.

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TABLE 2

WHICH ORGANIZATIONS DO DIFFERENT TYPES OF GRANTEES CHOOSE AS KEY COLLABORATORS?
(In Percentages)

Collaborator Organization Types	All Grantees: Key Collaborator Choices (n=107) (Percent)	Grantees, by Organization Type: State or Local Gov't Agencies (n = 13) (Percent)	Community-Based Service or Advocacy Organizations (n = 46) (Percent)	Health Care Providers or Provider Associations (n = 28) (Percent)	Schools (n = 7) (Percent)	Foundations (n = 5) (Percent)	Other (n = 8) (Percent)
State or Local Gov't Agencies	76	62	74	79	114	40	88
Community-Based Service or Advocacy Organizations	42	46	39	50	43	20	38
Health Care Providers or Provider Associations	36	46	41	14	0	120	50
Schools	19	38	22	18	0	0	13
Foundations	6	0	7	7	14	0	0
Other	16	8	11	25	29	20	12
Selected Only One Key Collaborator		0	7	7	0	0	0

Source: CKF telephone interview data, fall 2003.

Note: Column two (All Grantees: Key Collaborator Choices), taken from Table 1, reports the types of organizations named as key collaborators by all grantees. For columns three through eight, grantees could choose two types of key collaborators, thus each column totals 200 percent. When an individual cell is greater than 100 percent, it means that some grantee(s) named key collaborators that were both from the same type of organization.

Grantees receive community support from their partners, including financial support, in-kind contributions, and access to key groups.

Coalitions can flourish when they receive support from their surrounding community and other community organizations. Such support comes in a variety of forms—financial, in-kind

contributions, and even "moral" support, to name a few—and CKF grantees rely on various organizations (including but not limited to their key collaborators) to support their work.

As a measure of community support, we asked grantees to describe whenever their work is supported through other (non-CKF) grants or in-kind contributions.[7] While this is an imperfect measure for assessing how much community support grantees actually receive (because the interviews capture subjective opinions, and because the response terms were not defined for grantees), most grantees indicated that they received support via other grants or in-kind contributions. Forty percent of grantees reported that their work is supported by other grants or in-kind contributions to a large extent (Table 3). Another 32 percent of the grantees said their work is supported by other grants or in-kind contributions to some extent, while 21 percent said they receive a little of this type of support.[8]

TABLE 3

EXTENT TO WHICH GRANTEES RECEIVE SUPPORT VIA OTHER GRANTS OR IN-KIND CONTRIBUTION (IN PERCENTAGES)

Extent of Support	All Grantees (n = 107) (Percent)	State Grantees (n = 36) (Percent)	Local Grantees (n = 71) (Percent)
To a large extent	40	44	38
To some extent	32	22	37
A little	21	28	17
Not at all	7	6	7
Don't know	1	0	1

Source: CKF telephone interview data, fall 2003.

Note: Due to rounding errors, columns may not total 100 percent.

[7]We gave them the choices listed in Table 3 to describe the extent to which CKF work is supported by other grants or in-kind contributions. We did not define these terms for them.

[8]The CKF program requires grantees to obtain financial support from other funders equaling 50 percent or more of the total RWJF grant amount by the beginning of the third year of their four year grant period. Much of the reported community support would have been solicited in grantees' efforts to obtain the "match." While the percentages shown here reflect differences in the level of community support grantees receive, they are also likely an artifact of the different start and end dates of grantees, with some needing to meet their match requirement earlier than others.

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As a second measure of community support, we analyzed data from a separate instrument, the Coalition Self-Assessment Survey or CSAS instrument. Survey respondents reported that most coalition members or member groups did *not* give grantees financial support. As shown in Table 4, just over half of respondents said their organizations do not provide funds to grantees, although nearly all donate time to the grantee. Coalition members also help grantees in other areas, particularly offering help with access to target groups and policymakers, as well as helping them mobilize support for CKF in the community.

TABLE 4

COALITION MEMBERS: TYPES AND LEVELS OF SUPPORT THEY PROVIDE TO CKF GRANTEES[a]

				Help in Gaining Access to…		
Support Level	Funds (n = 419) (Percent)	Time (n = 433) (Percent)	Help Mobilizing a Constituency to Support the Policy Objectives of the Coalition (n = 425) (Percent)	Target Groups (n = 430) (Percent)	Key Policymakers or Community Influentials (n = 425) (Percent)	The Media or Public as a Whole (n = 422) (Percent)
Quite a lot	15	39	18	33	19	14
Somewhat	16	40	25	38	32	24
A little	16	19	32	20	24	27
Not at all	54	2	25	10	26	35

Source: CSAS data, 2003.

Note: Missing responses excluded.

[a]Data for all grantees are presented (figures for state and local grantees followed the same patterns).

Grantees reported that they expect collaborators to play a key role in sustaining the work of CKF after the grants end.

Since CKF grants last only four years, grantees must plan how to sustain the work after the grant period ends. Among grantees we interviewed by telephone in 2003, 85 percent reported that they have considered how they will sustain their activities when the grant ends.[9] Of those, all reported that they expected collaborators to take on their activities through a variety of actions. Thirty-one percent said that the activities would be sustained through institutionalization, meaning that policies or practices initiated under CKF would be integrated into organizations' ongoing operations (Yin 1979) (Table 5). For example, a health care provider collaborator might now train its intake staff to automatically ask uninsured individuals

[9]Nine percent said they had not considered how they will sustain their activities; three percent said they did not know the answer to this question; and three percent did not answer the question.

about Medicaid and SCHIP eligibility, thus institutionalizing an outreach effort within that provider. Thirty percent envisioned having their goals and efforts sustained by coalition members taking on the work; several noted purposely recruiting "strong" partners into their coalitions, such as health plans, in the hopes that these members might continue CKF's work after RWJF funding ends. One quarter of grantees expected the host agency to take on the activities; several of them said they were actively looking for grants to fund staff so that many of the CKF functions would continue, at least initially. Fourteen percent thought that other members of the community would take on the activities. For example, one grantee said that they were currently working on a study of emergency room utilization data, showing the benefits of enrolling uninsured individuals in Medicaid and SCHIP, in hopes of persuading a local hospital to adopt CKF activities after RWJF funding ends.

TABLE 5

SUSTAINABILITY PLANS OF GRANTEES

Plan	All Grantees (n = 91) (Percent)	State Grantees (n = 31) (Percent)	Local Grantees (n = 60) (Percent)
Institutionalization of activities	31	29	32
Have coalition members take on the activities	30	42	23
Continue to do the activities themselves (some said funding was still being sought, while some said funding constraints might mean they would scale back on activities)	25	10	33
Have other members of the community take on the activities	14	19	12

Source: CKF telephone interview data, fall 2003.

Fewer state grantees, compared to local grantees, expect to continue to do the work themselves, although more state than local grantees expect their coalitions to continue CKF activities. The fact that more state than local grantees expect to have coalition members take over activities reveals several differences between state and local coalitions. Members of state coalitions often have access to greater resources for CKF activities. State coalitions have more often "piggybacked" onto existing coalitions focused on health issues, and they are continuing because they have other issues to sustain them.

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DISCUSSION

By design, the CKF program emphasizes collaboration. For CKF, collaboration is embodied by existing organizations' willingness to host CKF grant activities (in addition to their own ongoing activities) as well as through partnerships built among a myriad of community groups. These advocacy groups, schools, state and local government agencies, and providers have cooperated to pursue expanded access to health insurance for uninsured children and their parents.

Collaborations have advantages and drawbacks, however. Since the coalition model is a key design tenet of the CKF program, it is important to consider what grantees have gained through the coalition requirement, as well as what challenges they have faced.

For CKF grantees, the benefits of the coalition model appear numerous. CKF grantees have partnered with a variety of organization types to achieve CKF goals. In turn, they have received support from their community partners: sometimes financial, more often in-kind (donated time; contact with key groups such as policymakers, community leaders, and targeted populations). Sustainability may be another key benefit of the coalition model: of the 91 grantees who had considered how they would sustain their activities when the grant ends, all of them reported that they expect their collaborative partners (including host organizations) to continue the work begun under CKF.

Working within a collaborative model also has presented challenges to some grantees. When we asked about barriers to accomplishing CKF goals, 16 percent of grantees named issues related to their coalitions as a significant barrier to achieving the goals of CKF (Hoag et al. 2004). Challenges reported by grantees included recruiting members into the coalition, working with the coalition, and (in one instance) a lack of support from the coalition, all of which speak to the difficulties of working with a group. During site visits, some grantees also reported challenges related to their coalitions, such as getting coalition members to be more "hands-on" and less of a sounding board, keeping coalition members enthusiastic about and interested in the work, and maintaining diversity in coalition membership.

The mail survey of coalition members identified weaknesses of the coalition model (Lavin et al. 2004). For example, many coalition members reported being unaware of who makes coalition decisions or how the decisions are made; 10 percent did not identify a significant source of coalition leadership; and 30 percent said that differences of opinion had led to some or a lot of conflict within the coalition (Lavin et al. 2004).

Although we cannot determine whether the benefits of coalition participation outweighed the costs of coalition participation, coalitions do show promise. Grantees' expectations about their partners' abilities to sustain the work begun under CKF holds promise that the coalitions enhanced the sustainability of the projects past what might have occurred had the grants been designed for individual organizations to pursue on their own. Future research can help document whether and how the coalitions aided CKF sustainability efforts.

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APPENDIX A

TABLE A.1

36 STATES INCLUDED IN THE TELEPHONE SURVEY[a]

Alabama	Missouri
Alaska	Nebraska
Arizona	Nevada
Connecticut	New Hampshire
Delaware	New Jersey
District of Columbia	North Carolina
Florida	North Dakota
Georgia	Ohio
Hawaii	Oklahoma
Idaho	Oregon
Indiana	Pennsylvania
Iowa	Rhode Island
Kentucky	Tennessee
Louisiana	Utah
Maine	Washington
Maryland	West Virginia
Michigan	Wisconsin
Mississippi	Wyoming

[a]Kansas, Montana, South Carolina, and Vermont were excluded because they received smaller "liaison grants," which allow them to participate in meetings and disseminate information. South Dakota was excluded because its CKF application was pending at the time of the survey. The other 10 states excluded from phone interviews were the site visit states, shown in Table A.2, although data from these states were included, where available.

TABLE A.2
10 STATES INCLUDED IN THE SITE VISITS

Arkansas	Minnesota
California	New Mexico
Colorado	New York
Illinois	Texas
Massachusetts	Virginia