

PUBLIC-PRIVATE PARTNERSHIPS: AN EVALUATION OF PROPOSITIONS  
FOR SUCCESSFUL COMMUNITY COALITIONS

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TERESA TITUS-HOWARD

B.A., Columbia College, 1991  
M.S.W., University of Missouri-Columbia, 1993  
M.H.A., University of Missouri-Columbia, 1998

Kansas City, Missouri  
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Teresa M. Titus-Howard, Candidate for the Doctor of Philosophy Degree

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ABSTRACT

Objective: To evaluate coalition members' perceptions of key coalition building propositions (i.e., leadership, communication and formal structures) as predictors of coalition success (i.e., improving community outcomes by reducing hospital readmission rates and improving coordination of patient care).

Method: A survey was conducted and included a variety of coalition building propositions to measure coalition members' perceptions of coalition success. The survey questions related to leadership, communication and formal rules, structures and procedures were used for the purposes of hypothesis testing.

Results: The relationship between the set of all independent variables (i.e., leadership, communication and formal rules, structures and procedures) and the coalition's effectiveness at improving the quality of care transitions in their community is statistically significant ( $p = .000$ ) and a positive multiple correlation exists (.428).

Conclusion: The findings revealed a positive but weak relationship between all but one of independent variables (i.e., leadership, communication, formal structures and procedures) and the coalition's perceived effectiveness at improving the quality of care transitions in their community. In contrast, there does not seem to be a relationship between any of the independent variables (controlling for the others) and coalition members' perceptions of effectiveness in reducing hospital readmission rates.

## APPROVAL PAGE

The faculty listed below, appointed by the Dean of the School of Graduate Studies have examined a dissertation titled, “Public-Private Partnerships: An Evaluation of Propositions for Successful Community Coalitions,” presented by Teresa Titus-Howard, candidate for the for the Doctor of Philosophy degree, and certify that in their opinion it is worthy of acceptance.

### Supervisory Committee

Robert Herman, Ph.D.. Committee Chairperson  
Department of Public Affairs and Administration

David Renz, Ph.D.  
Department of Public Affairs and Administration

Max Skidmore, Ph.D.  
Department of Political Science

Greg Arling, Ph.D.  
Department of Public Affairs and Administration

Cathy Carroll, Ph.D.  
School of Economics

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# CHAPTER 1

## OBJECTIVES AND LITERATURE REVIEW

### Objectives

This dissertation has three research objectives. First, to summarize the current body of knowledge related to public-private partnerships and collaboration (PPPs) in the health care sector with a special emphasis placed on: (1) providing a historical overview of public-private partnerships in health care, (2) comparison of strengths and weaknesses of each partner in a PPP, (3) an overview of research-based characteristics of successful PPPs when they are used to form collaborative community coalitions.

The second objective is to provide an overview of a relatively new theoretical model for PPPs known as the Community Coalition Action Theory (CCAT). This theoretical model was selected because it is a model of personal interest to this investigator, it is relatively new and unexplored and it is a synthesis of other well-tested theoretical models; thus, only this model will be examined. This theory was developed in 2002 by Fran Butterfoss and Michele Kegler. According to Butterfoss and Kegler (2002), the underlying theoretical basis for the development and maintenance of community coalitions draws from many theoretical frameworks such as community development, citizen participation, political science, inter-organizational relations and group process. However, Butterfoss and Kegler (2002) believed a theory for community coalitions that incorporates all of these frameworks has not been established. Their intention was to build a theory that made a significant contribution to the understanding of how community coalitions work in practice.



The third objective is conduct survey research to test propositions about health care PPP success. Specifically, the CCAT propositions related to coalition leadership, formal structures and communication will be tested using a survey instrument specifically developed for this research project. The survey questions will be drawn from other validated survey instruments in the literature.

### Literature Review

The field of Public Administration has many well-established methods and traditions. The forefathers of public administration, like Max Weber, suggest that the hierarchical and orderly nature of the U.S. public administration system is necessary to adequately meet the needs of the public (Weber, Gerth & Mills, 1964). However, the ability of today's public administrators to meet these needs is increasingly challenged by the limited amount of financial and personnel resources. Thus, an alternate way of "doing business" on behalf of the public is in order and public-private partnerships (PPPs) may be one solution.

PPPs have a strong historical presence both in the United States and internationally (Adetokumbo, 2000, Austin, 1998, 2000 and 2002, Buse & Tanaka, 2011; Mattesich, 2001, Monaghan, et.al., 2001; Moulton and Anheier, 2001, Nikolic and Maikisch, 2006, Vaillancourt-Rosenau, 2000,WHO, 1999). Increasingly, those concerned with improving public policies have demonstrated increased awareness of the potential benefits of PPPs, especially in health care. According to Nikolic and Maikisch, 2006, the discussion about PPPs in the health care sector is very important. The health care industry is facing tremendous challenges in health care finance, management and provision (Nikolic and Maikich, 2006). Herein, I will discuss the historical context of PPPs both in policy making and health care. Also, a comparison of PPP partners including public, private and non-profit

sectors. This comparison will explore the potential range of each partner's contributing strengths, weakness, and management roles and responsibilities in relationship to PPPs.

### Key Definitions

Before proceeding with a more in depth discussion about PPPs and how they are used, it is important to define the following terms: public, private, public-private partnerships and coalitions. For purposes of my discussion and research, the term public sector refers to government agencies and organizations. The term private sector refers to for-profit or non-profit organizations, which are not government institutions. Public-private partnership refers to collaborative activities, sometimes contractually based, among the public and private sectors that exist to protect the interest of the public (Adetokunbo, 2000). A complementary working definition of PPPs suggests: (1) at least one partner is a for-profit or non-for-profit organization and the other is a public entity such as government or other public institutions; (2) partners jointly share responsibilities and benefits of the partnership (i.e., capital and labor); and (3) partners are committed to the creation of partnership that provides social value, like improved health status (Reich, 2000). Furthermore, PPPs are important cooperative long-term relationships because partners can not produce the same outcomes acting alone (Vaillancourt-Rosenau, 2000 and Nishtar, 2004). An important synonym for "partnership" is collaboration and PPPs are highly collaborative. Paul Mattessich (p. 2, 2001), director of research at the Wilder Foundation in St. Paul, MN, and a well-respected scholar in the area of collaboration defines collaboration as:

*A mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals. The relationship includes a commitment to mutual relationships and goals; a jointly developed structure and shared responsibility; mutual authority and accountability for success; and sharing of resources and rewards.*

One manifestation of a PPP is the emergence of a community coalition that is used to carry out one or more key objectives of the PPP. The word coalition comes from the Latin root *coalesere*, which means to grow together, implying a union. Merriam-Webster's dictionary defines a coalition as a temporary alliance of distinct parties, persons or states for joint action (Merriam-Webster, 2006). However, the term coalition has evolved overtime to connote a collaboration that is durable and sustained over time (Butterfoss, Goodman, and Wandersman, 1993). Brown (1984) defines a coalition as a diverse group of individuals that bring together both human and material resources to effectuate change that individuals alone are unable to do. Similarly, Feighery and Rogers (1989), define a coalition as a group of individuals working together to achieve a common goal. These definitions support the notion that coalitions are closely aligned with the objectives of PPPs.

Coalitions can be categorized in different ways such as types of membership, patterns of formation, types of functions, and types of structures that accommodate these functions. Membership coalitions may be characterized as grass roots, professional coalitions, or community-based coalitions. The size of a coalition membership may vary from a few individuals or organizations to a few hundred (Boissevain, 1974). Coalitions may be classified by the functions they perform such as information and resource sharing, technical assistance and training, self-regulation, planning and coordination of services (Croan & Lees, 1979). Finally, coalitions can differ according to the organizational structure. For example, a coalition may have an organization-set structure where cooperative organizations provide resources or services under an umbrella organization, like the United Way. The structure of network coalitions is subgroups that are loosely organized that provide services to a population or lobbying group. The last type of coalition structure is an action-set coalition

who addresses a specific issue and can be more or less formal, depending on the purpose of the coalition (Butterfoss, 2007). Now that I have defined key terms associated with PPPs, a review of the literature discussing the historical context, key partner and successful characteristics of PPPs can proceed.

### Historical Overview and Policy Impact in Health Care

Historically, PPPs have been most commonly referred to as purchase-of-service contracts. In this relationship, the public sector buys services from a non-profit or for-profit private sector organization in which both parties are mutually dependent but not equal in the relationship. This type of resource dependency relationship between the public and private sectors emerged during the Great Society Era in the 1960's and 1970's (Moulton & Anheier, 2001). As a result, the concept of third party government emerged as a new model for government. The model was welcomed by many public administrators, because it avoided the need to expand government overhead, especially at the federal level. Many scholars agree the resources provided by the new "partners" were more abundant and delivered more quickly to the public (Nishtar, 2004). In the end, a fundamental shift occurred from the old way of doing business to a more efficient approach through partnerships in which all parties have an interest in the public good (Moulton & Anheier, 2001).

In theory, PPPs require the close collaboration and the combination of the strengths of both the public and private sectors. For example, in health care, the Centers for Medicare and Medicaid Services (CMS), a public institution and The Joint Commission (TJC), a private entity, have formed a PPP. Currently, CMS partners with TJC to monitor the performance of other private institutions (e.g., hospitals). However, there are contrasting views about the value of this type of partnership. One view point suggests health care PPPs should not only

be an attempt to monitor an institution's performance but also involve the development of long-term relationships with other health care stakeholders. In contrast, some argue PPPs in health care should not just exist in form but should contribute to the improvement in health outcomes (Nishtar, 2004). CMS is able to demonstrate the improvement of health outcomes through its PPP with fifty-three Quality Improvement Organizations (QIOs). Similar to the TJC, the QIOs contract with CMS but their focus is to improve health care quality and outcomes for Medicare beneficiaries. For example, one of the focus areas of the QIOs health improvement efforts is a reduction in hospital and nursing home pressure ulcers and nursing home restraint use. The QIO PPP has proven to be most effective in the reduction of pressure ulcers in skilled nursing home facilities. In 2005, the Journal of American Medical Directors Association reported a dramatic decrease in pressure ulcers across twenty nursing homes in Texas. The QIO provided guidance to nursing home staff on performance measurement, staff education, and staff training, leading to better scores on eight of twelve indicators of quality of care. Homes with the greatest improvement had significantly lower incidence of pressure ulcers.

Many well-respected health care PPPs have been formed by organizations such as the World Health Organization (WHO). The WHO supports the promotion of PPPs and agrees they should "not exist in form" alone. In fact, the partnerships must be mutually beneficial and include transparent arrangements that make significant contributions to the health of people, especially populations in developing countries (World Health Organization, 1998). The WHO recognizes health care PPPs present opportunities for public health organizations to confront challenges of shrinking public funding and increasing demand for quality patient care. Current literature supports the WHO's position and suggests when public organizations

partner with the private sector new sources of capital, expertise, and technology emerge. Furthermore, these collaborative relationships create a powerful mechanism for addressing complex issues as long as the driving motivation for the partnership is rooted in benefit to society as well as a mutual benefit to the partners (Nishtar, 2004; Monaghan, Malek, & Simson, 2001).

In the health care industry, among others, each partner's language, organizational norms and ways of doing business are widely varied. These differences will be one of the most significant hurdles to overcome in any PPP relationship (Vaillancourt-Rosenau, 2000). Thus, it is important to understand each partner's strengths and weakness as well as changes in management roles and responsibilities while engaged in a PPP relationship.

#### Partner Comparison

##### Public Sector

The public sector is a highly motivated partner for PPPs because the relationship affords opportunities to better meet the needs of the public. Historically, a perceived weakness of the public sector is its unyielding, hierarchical and bureaucratic nature as an organization. However, public sector managers can overcome these barriers when engaged in PPPs. In fact, he or she will need to learn new and innovative skills (e.g., the adoption of customer service and continuous quality improvement principles) that may be in direct contrast to the public sector's rigid structure (Vaillancourt-Rosenau, 2000). Also, the formation of PPPs can assist governments, in partnership with the private sector, to address financial and service delivery challenges (Nikolic & Maikisch, 2006).

Nikolic and Maikisch, 2006 in their 2006 report to the World Bank, titled, "Public-private partnerships and collaboration in the health care sector," state there are meaningful

gains that can be achieved for the public partner and the health care sector. For example, they contend the government could experience a reduction in spending, greater efficiency, and overall better health care management. Similarly, for public-sector leaders, Pauline Vaillancourt-Rosenau, author of *Public-Private Partnerships*, describes six leadership management roles and responsibilities in public administration leaders will gain, as a result of PPPs. First, the administrator will incorporate some type of management reform by “tapping into the discipline of the private market” through the incorporation of private sector language into their daily practice. Next, the administrator will align their problem solving practices with profit-seeking enterprises and third, they will be drawn into entrepreneurial activities that will strengthen their skills as managers. Fourth, public managers will become more confident in their ability to shift risk and/or restructure public service in a manner beneficial to both private and public sectors. Lastly, public administrators will learn how to give up some control by power sharing horizontally across to private sector in a manner in which cooperation and trust replace adversarial relationships.

In the end, the public administrator will become skilled at building long-term partnerships with the private sector. For example, David Watkins, city administrator of Lenexa, KS (December 10, 1997) stated, “I understand that the role of government does not lend itself entirely to the service model of the private sector, but certain values such as fairness, timeliness and unified decision-making are transferable” (Nalbandian, 1999, p. 22). Also, Jan Perkins (July 13, 1997) city manager in Fremont, CA notes that the “city manager needs to become entrepreneurial, customer focused, citizen involved” (Nalbandian, 1999, p. 11). In fact, Nalbandian (1999) argues, the public sector needs to gain a better understanding of the private sector. For example, for the private sector to successfully cooperate with the

public sector, it is necessary for the latter to understand and accept the basic legitimacy of private enterprise and the profit motive that drives it (Reich, 2000). While these points are well understood, the private sector has its own challenges when engaged in PPPs.

### Private Sector

The private sector brings a lot of strength to PPP relationships, including the ability to be creative and dynamic, bring access to financial resources, knowledge of technologies, managerial efficiency and entrepreneurial spirit. It is thought to be the best at performing economic tasks, innovating and replicating successful experiments, adapting to change by abandoning unsuccessful or obsolete activities and performing complex or technical tasks (Vaillancourt-Rosenau, 2000). However, incentives must be aligned for private sector entities to actively collaborate with public sector concerns toward common social goals.

Despite its overwhelming success, the private sector has only recently begun to recognize and accept the importance of public health goals (Reich, 2000). Unfortunately, a corporate mandate to incorporate this social responsibility into a manager's defined role and list of responsibilities is not fully realized by most private sector enterprises. However, increasing management accountability to public health goals is noted in emerging fields of managerial or business ethics (Showstack, Lurie, Leatherman, Fisher & Inui, 1996). The time is ripe, because vibrant societies require great cities, but cities cannot be great without significant leadership from the business community (Austin, 1998).

It is recognized the public sector may be able to do some things better than the private sector and vice versa. By joining together, PPPs hold the promise of a possible compromise in the form of constructive collaboration (Vaillancourt-Rosenau, 2000). "The idea of government and businesses partnering for some common purpose evokes images of wartime



solidarity and memories of small town life in America, where businesses and government shared talent and community responsibilities,” (p. 25) states Vaillancourt-Rosenau. However, cross-sector partnerships do not just happen, they are built. Constructing effective partnership across diverse organizations is hard work. The potential glue to seal the two sectors together may be best achieved by the third PPP partner, the non-profit sector.

### Non-Profits

The number of non-profit organizations has dramatically increased over the last twenty years motivated by market, government, and non-profit failures to individually address the needs of the public (Mendel, 2003). Many support this dramatic increase because the non-profit’s strongest asset is the compassion and commitment to individuals and the public. Non-profit organizations do well where customers or clients require trust or hands on personal attention (Mendel, 2003). This sector is positioned well to participate in PPPs.

According to Mendel (2003), a non-profit has many roles and responsibilities in PPPs. It serves as a “bridging and/or mediating institutional divide between public policy at the national and state levels with private action by people in local communities.” He argues this role is well-suited for the non-profit because of their ability to “identify, accommodate and use their primary, secondary and tertiary constituencies” around a common goal (Mendel, 2003, p. 229). Furthermore, the non-profit can potentially increase the degree of pluralism in our country by engaging more citizens in government activities.

Norton Long (1958) contends the non-profit is able to effectively develop a “Web of interconnections with other institutions with common goals.” (p. 254) He suggests the goals are achieved through competitive activities, strategies and tactics in a community otherwise known as games. These activities are called games because participants “keep score and win

or lose based upon their ability to recognize allies and ability to understand shifting dynamics on the playing field.” The non-profit might be the most important player because of their ability to bridge the connections or referee between the multiple players.

Jewel Scott, a former city manager and executive director of a Kansas City business leader’s civic group on July 25, 1997 commented, “If I were a public administrator today, I would find ways to work creatively with the private sector to provide services and to evaluate and design service delivery systems” (Nalbandian, 1999, p. 16). To cut across sector lines and to stimulate change in the private sector, many states and local governments have formed many partnerships and coalitions with trade associations, research centers and other institutions (Vaillancourt-Rosenau, 2000).

Comparatively, each partner definitely has its own strengths and weaknesses. Collectively, each partner’s unique characteristics provide a balance to the relationship. In other words, the quick to act temperament of the private sector is counterbalanced by the public sector’s careful and slow planning. The defining moment in the relationship is the non-profit’s ability to mediate the right balance between all partners. Despite their differences, stakeholder organizations agree the social, political and economic forces to bring the different sectors together are more aligned today than they have in the past (Moulton & Anheier, 2001). Indeed, future policy scenarios will increasingly include various partnerships between government, private business and non-profit representatives. Also, these future partnerships could include all type of partners or they may resemble a different combination of PPP relationships between government, private for-profit and non-profit organizations. However, these partnerships must possess specific characteristics to ensure their success

(Moulton & Anheier, 2001). Herein, I will discuss the successful characteristics of PPPs from the perspective of well-respected authors and community leaders.

### Successful Characteristics of PPPs

Each PPP partnership will be faced with its unique challenges and exciting opportunities. However, the creation and sustainment of a PPP within a collaborative coalition model is not easy. In fact, the creation and ongoing operation of these alliances is difficult. Long-term supporters of PPPs believe one of the most important features of new governance is the creation of PPPs that instill a greater spirit of collaboration (Vaillancourt-Rosenau, 2000). James Austin (1998) summarizes the need for PPPs best when he states,

*Cities cannot be rescued without business, but business can't do it alone. Business, government and civic organizations must join together to bring about effective community-building. Resources and commitment must be mobilized from all fronts so that the synergies can be captured. To be effective they have to build consensus.*  
(p.90)

From an interorganizational perspective, the management of a community public-private partnership can be challenging. Such partnerships require not only a shared vision but must also ensure that the benefits to each partner outweigh the costs. The partnership must also strategies to monitoring ongoing activities to ensure that the partnership goals are achieved. When strategies fail to meet defined goals, all members of the partnership must also be willing to take the action(s) needed to correct issues as they arise (Shortell, et.al., 2002). However, this is not an easy task, according to Shortell, et.al., (2002), because each organization in the partnership has its own culture, mission, vision and deep-rooted traditions they bring with them to the partnership. Fortunately, several other authors have taken note of the most successful characteristics of PPPs and another has recently developed a theoretical model offering specific propositions for individuals and/or organizations to consider when

entering into an interorganizational relationship, like a PPP. Herein, I will discuss four perspectives regarding the successful characteristics of a PPP when it establishes a collaborative community coalition to carry out its work.

First, James Austin (2000) contends the success of a coalition is dependent on the ability to align its stated objectives with the Seven C's of Collaboration which are: (1) clarity of purpose; (2) congruency of mission, strategy and values; (3) creation of value; (4) connection with purpose and people; (5) communication between partners; (6) continual learning; and (7) commitment to the partnership. In addition to the Seven C's of Collaboration, Austin argues the effectiveness of cross-sector coalition requires the attainment of five intangibles such as: (1) respect creation; (2) trust development; (3) communication complexities; (4) decision-making dynamics; and (5) relationship-building. The first two intangibles, respect and trust are developed over time through a history of concrete deeds and tangible activities among the partners. Communication and decision-making are intangibles that require a great deal of coordination and good working relationships. The ability to communicate with different partners is critical when each one might possess their own foreign language. Furthermore, when an inclusive approach to decision-making is employed the ability to build consensus among the partners is more likely to happen. Lastly, the art of relationship-building is an intangible characteristic that should be seen as an "investment" in developing both personal and professional ties with partners. "The mission connection is the driver but the personal relationships are the glue that binds the organizations together" (Austin, 2000a, p. 55).

The third perspective comes from Paul Mattessich (2001) author of *Collaboration: What Makes it Work* who suggests twenty factors that influence the success of collaboration

formed by non-profit organizations, government agencies and other organizations. To simplify the discussion of these factors they are grouped into the following six categories: (1) environment; (2) membership characteristics; (3) process and structure; (4) communication; (5) purpose; and (6) resources. It is immediately apparent that Mattessich's list contains similar characteristics of suggested by Austin and Sullivan. Thus, it would be more useful to compare and contrast the three perspectives to clarify similarities and differences.

Austin and Sullivan, Mattessich agree a strong history of collaboration in the community or environment is needed. More importantly, the leading or coordinating partner in the coalition must be seen as a legitimate leader in the community. They agree a favorable political and social climate must exist and that the coalition must remain focused on its founding objectives. The membership should be cross-sectional where members mutually respect and trust each other. One membership feature highlighted primarily by Mattessich is the coalition members' ability to compromise with each other. The ability to compromise creates a partnership process and structure that is flexible and adaptable to meet with needs of the community. All three experts agree communication must be open and frequent. In particular, Mattessich elaborates suggesting both informal relationships and communication links aid the communication process. Both Austin and Mattessich strongly emphasize the need for establishing a concrete purpose as a framework for attaining the coalition's goals and objectives. Sullivan would agree, but adds the goals must be measurable to determine if the desired objectives have been met. Lastly, all three experts would agree sufficient funds or resources to support the coalition must be attained to carry out the coalition objectives. (Austin, 1998, 2000a, 2000b, 2002; Mattessich, 2001; & Sullivan, 2005).

Finally, Butterfoss and Kegler suggest that the development, maintenance and success of community coalitions draws from many theoretical fields such as community development, citizen participation, political science, interorganizational relations and group process. A theoretical model developed by Butterfoss and Kegler (2002), titled, Community Coalition Action Theory (CCAT) proposes that coalitions progress through different stages of development from formation to maintenance followed by institutionalization. Coalitions not only develop in stages but they also recycle through these same stages. This occurs when new members join the coalition, strategic plans are renewed or new health or social issues emerge (Butterfoss & Kegler, 2002). Consequently, the process of building and maintaining coalitions is a cyclical process and not a linear one (McLeroy, Kegler, Steckler, Burdine and Wisotzky, 1994). The CCAT holds that within each stage of development key propositions, such as actions, events or moderating factors that should be met and if not, can impact the success or failure of a coalition. These propositions are categorized as community contextual factors, a lead agency or convener group (i.e., leadership), coalition membership, structures, communication, decision-making and conflict management processes, member engagement, pooling of internal and external resources, assessment and planning, and the implementation of community change strategies. An explanation of each stage of coalition development and the corresponding key propositions will be discussed further supporting the use of the CCAT as a framework for PPP development.

The initial formation stage of a coalition begins with a lead agency or convener that has the leadership capacity to bring together individuals and organizations to form the coalition (Butterfoss & Kegler, 2002; Butterfoss, 2006). For example, when a specific health or social issue arises, a lead agency or convener provides the leadership to mobilize a group

of community members to address the issue. These issues create new opportunities for community members to come together. Also, a lead agency or convener might bring together community members because of a threat, such as the lack of funding for critical health services. The lead agency or convener may form a coalition because of a mandate by a government entity or funder (Butterfoss, 2007), too. When the coalition forms it is likely to be successful if the lead convener group enlists community gatekeepers who understand the community. This level of community understanding will enhance the lead convener's ability to build trust with others in the community (Butterfoss, 2007). Furthermore, there has been exhaustive research on the importance of leadership and organizational success. In effect, strong leadership can improve coalition functioning and make collaborative synergy more likely (Butterfoss, 2007). Wells, Ward, Feinberg, and Alexander (2008) found the leadership style (i.e., positive recognition of members) by the coalition leadership has a positive correlation with coalition success. When coalition leaders show a general appreciation for member contributions, the level of participation by the membership increases; thus, contributing to coalition success. Also, Shortell et al., (2002) recognized the importance of leadership as a predictor of a success for a coalition. Leaders must be able to recognize and manage the interorganizational dynamics of the coalition. They must be able to recognize the changes occurring in each organization that may cause a fluctuation in the organization's level of commitment over time. If the commitment level decreases this could negatively impact the success of the coalition (Shortell et al., 2002). Therefore, for this study, I predict there will be a positive correlation between a coalition member's perception of his/her coalition's leadership effectiveness and the coalition's success at improving community health outcomes.

Another proposition associated with this stage of the CCAT model includes formalized processes (i.e., rules, structures, and procedures). The literature suggests coalitions are more likely to be successful when they have formalized processes in place (Butterfoss & Kegler, 2002). The first type of a formalized process is coalition rules. Formal coalition rules may include operating procedures, attendance and other policies, membership criteria, bylaws and meeting guidelines. In comparison, another type of process, such as formal structures, may include steering committees, procedure manuals; clearly defined written roles or job descriptions; mission statements, goals, and objectives; organizational charts; regularly scheduled meetings with agendas and communication pathways, and written memoranda of understanding. Lastly, formalized processes may include official policies and procedures that help coalitions make well-defined decisions, problem-solve, resolve conflicts. The policies and procedures might also include a process for new member orientation and training as well as how to conduct community assessments, planning, evaluation and resource allocation practices (Butterfoss & Kegler, 2002). Therefore, for this study I predict there will be a positive correlation between a coalition member's perception of his/her coalition's ability to implement formalized processes and the coalition's success at improving community health outcomes.

Finally, in the formation stage it is important that a coalition incorporate well-defined communication and conflict management processes. For example, the literature suggests open and frequent communication among staff and members, as well as effective conflict management skills help create a positive climate and can make collaborative synergy more likely. Consequently, improving the likelihood the coalition will improve community health outcomes (Butterfoss & Kegler 2002). Shortell, et.al., (2002) also recognizes the importance



of effective communication and conflict management. Partnerships (i.e., coalitions) that achieved greater success were able to implement different strategies to effectively communicate and manage conflict in a positive direction. Actually, partnerships that anticipated potential conflicts and “likely trouble spots” were more successful at creating interdependencies among coalition members (Litwak & Hylton, 1962; Thompson, 1967; Lynn, Heinrich & Hill, 2001; Weiner, Alexander, & Zuckerman, 2000). For example, one partnership cited by Shortell, et.al, (2002) was able to develop a partnership structure that encouraged open communication. The partners spent time working through possible areas of conflict on a proactive basis which ultimately lead to an increase in the level of trust among members. Therefore, for this study, I predict that there will be a positive correlation between a coalition member’s perception of his/her coalition’s ability to implement effective communicate and conflict resolution processes and the coalition’s success at improving community health outcomes.

Next, a coalition will experience the maintenance stage which includes taking concrete steps such as assessing, planning and implementing interventions strategies aimed at addressing a specific health or social issue. The primary task during this stage is to sustain member involvement by actively engaging them in the process of accomplishing the coalition’s mission, goals and objectives (Butterfoss & Kegler, 2002). The ability to sustain member involvement is correlated with the coalition’s ability to pool member resources both internally and externally. The pooling of member resources is an important predictor of coalition success. Consequently, coalitions are more likely to be successful at creating change in a community when members are satisfied and willing to participate fully in the work of the coalition, because the work load is shared or pooled (Butterfoss & Kegler, 2002).

The importance of coalition membership willingness to participate can't be understated as confirmed by Goodman et al., (1998). They found coalition leaders tend to see the coalition members' willingness to participate as vital to coalition success. Wells, Feinberg, Alexander, and Ward (2009) found coalition members who are willing to participate; by devoting more effort to coalition activities do have a more positive perception of the coalition's ability to be successful. Consequently, according to Butterfoss (2007), the pooling of member internal and external resources is one way to increase coalition members' willingness to participate which, based on the supporting evidence, is a predictor of future success.

Finally, the institutionalization stage occurs when the coalition's strategies to address a health or social issue becomes institutionalized in the community and/or adopted by participating organizations. In fact, coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes. An important factor to note is that the members or partners in the coalition determine whether or not strategies implemented have resulted in community change outcomes. If change has occurred, it is likely that these changes will become institutionalized into the community as a permanent or long-term community strategy (Butterfoss & Kegler, 2002). The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes. Consequently, the success of coalition's efforts can build a community's capacity to apply lessons or new skills learned to other health and social issues (Butterfoss, 2007).

As noted, current research literature provides information about successful characteristics of PPPs and collaboration. Also, a significant amount of literature exists on coalition effectiveness (Wolff, 2001; Ellis & Lenczner, 2000; Martinez, Fearne, Caswell, &

Henson, 2000; Florin & Wandersman, 1990). However, the literature lacks evidence of a formal assessment of PPP and coalition participants' perception of the likelihood of the PPPs or coalition's success. Consequently, this research is different because the unit of analysis will be the individual coalition members and their perceptions of their coalition's effectiveness. This will improve the body of literature because specifically, the QIO community and its CT community coalitions have not been surveyed before on this scale.

## CHAPTER 2

### STUDY METHODS

To address the gaps in the literature, research is needed to further understand the complex dynamics and critical elements of successful coalition building and improved community health outcomes when pursued through private-public partnerships (PPPs). For example, the PPP between the Centers for Medicare and Medicaid Services (CMS) and the Quality Improvement Organizations (QIOs), a group of private organizations, and the coalitions they form to improve community health. The mission of the QIO Program is to improve the effectiveness, efficiency, economy, and quality of services delivered to Medicare beneficiaries. The core functions of the QIO Program are to: (1) Improve the quality of care for beneficiaries; (2) Protect the integrity of the Medicare Trust Fund by ensuring that Medicare pays only for services and goods that are reasonable and necessary and that are provided in the most appropriate setting; and (3) Protect beneficiaries by expeditiously addressing individual complaints, such as beneficiary complaints; provider-based notice appeals; violations of the Emergency Medical Treatment and Labor Act (EMTALA); and other related responsibilities as articulated in QIO-related law.

The QIO program involves a complex contracting process with CMS, creating a public-private partnership to improve the quality of care for beneficiaries. One focus area for fourteen of the fifty-three QIO contracts is improving the continuity and coordination of care for Medicare beneficiaries after an acute hospital stay; otherwise, known as the Care Transitions (CT) Project. The aim of the CT project is to measurably improve the quality of care for Medicare beneficiaries who transition among care settings through a comprehensive

community effort. These efforts aim to reduce readmissions following hospitalization and to yield sustainable and replicable strategies to achieve high-value health care for sick and disabled Medicare beneficiaries (Centers for Medicare and Medicaid Services, 2009). Each participating QIO is evaluated on specific performance measures (i.e., the reduction of hospital readmission rates) as predictors of its success in improving the coordination of patient care.

The primary goal of this study is to conduct a survey of individual QIO coalition members' perceptions of their QIO coalition. The survey included survey items used in prior research. For example, validated survey instruments from Hayes, Hays, DeVille, Mullhall (2000); Kegler, Steckler, McLeory and Malek (1998); and Rogers, Howard-Pitney, Feighery, Altman, Endres, Roeser (1993) were used in the survey instrument. In support of this approach, Wells et al., (2009) confirmed attributes of community-based coalitions were associated with member perceptions of the coalition's impact in the community. Coalition membership perceptions of coalition impact, perceived success or satisfaction is important because they can affect the member's decision to remain invested in the coalition's efforts (Wells et al., 2009). Successfully identifying items that correlate with an important performance indicator will aid with the secondary goal of this study - to validate a survey instrument that could be used for future development of performance measurement purposes in the next scope of work for the QIO program. To evaluate the perceptions of individual QIO coalition members the following hypothesis were tested using multiple questions in the survey instrument.

H<sub>0</sub>: There is no correlation between membership perception of leadership and coalition success.

H<sub>1</sub>: There is a positive correlation between a coalition member's perception of

his/her coalition's leadership effectiveness and the coalition's success at improving community health outcomes.

H<sub>0</sub>: There is no relationship between membership perception of formalized processes and coalition success.

H<sub>2</sub>: There is a positive correlation between a coalition member's perception of his/her coalition's ability to implement formalized processes and the coalition's success at improving community health outcomes.

H<sub>0</sub>: There is no relationship between membership perception of communication processes and coalition success.

H<sub>3</sub>: There is a positive correlation between a coalition member's perception of his/her coalition's ability to implement effective communicate (e.g., conflict resolution) processes and the coalition's success at improving community health outcomes.

A survey methodology was used to test the research hypotheses. The survey instrument included a variety of variables to measure the perceptions of coalition members. However, the survey questions related to leadership, communication and formal rules, structures and procedures were used for the purposes of hypothesis testing. The rationale for this approach was determining the relationship between the independent variables (i.e., leadership, communication, rules, structures and procedures) and the dependent variables (i.e., likelihood of reducing hospital readmissions and improving community care transitions).

Each QIO awarded the CT contract was asked to solicit participation of their membership currently involved in the QIOs' CT community coalition. A total of 14 coalitions were invited to participate. The coalitions were located in various urban and rural localities across fourteen different states in the United States, specifically Alabama, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, Nebraska, New Jersey, Pennsylvania, Rhode Island, Texas and Washington. The members of the QIO coalitions include diverse stakeholder partners from public, private and non-profit organizations. In

total, the coalition members in these states represent 66 hospitals, 277 skilled nursing homes, 316 home health agencies and 89 other stakeholder organizations. Other stakeholder organizations included public organizations such as local, state and federal agencies (e.g., local health department and state departments of health) and/or private organizations and health care providers (e.g., hospitals, physician office and nursing home staff). Also, members from non-profit professional organizations (e.g., hospital associations and nursing home associations) were included in the population surveyed. Individually, each QIO coalition has a range of five to twenty-five members yielding a target population of up to 500 respondents (the actual number of potential respondents turned out to be 455). It is worth noting each member of a QIO coalitions belonged to only one coalition. In other words, no member of one coalition was a member of another.

All of the coalitions are following the same Care Transitions project objectives as noted above. Each QIO coalition is assigned the same tasks to complete such as community participant recruitment, intervention development and implementation, data analysis, monitoring and reporting project progress. Some variation will exist in the specific strategies the QIO coalitions use to recruit providers and implement interventions. There is a need for the coalitions to be autonomous in their strategy selection so they may effectively address local community needs.

The survey was administered electronically to 455 QIO coalition members during the fall of 2010, for a two-week period. The survey included both Likert scale and multiple choice questions (See Appendix B). The survey was administered via Survey Monkey and divided into multiple sections. Also, it included a demographic section for respondents to provide information such as gender, race and ethnicity, age, education level and organization

type. The data collected via Survey Monkey was captured in an excel file which was exported to SPSS software to complete the survey analysis.

Overall, a response rate of 37% (n = 167; 167/455) was achieved. The analysis of the survey data was completed in five steps. First, a descriptive analysis was conducted to determine the frequency of responses for each survey question. The findings can be found in Chapter 3. Second, after the descriptive analysis was completed, a scale reliability analysis was completed for each set of survey questions related to leadership and communication. A summary of the individual questions is provided in Chapter 3. This analysis was completed to determine the reliability of the scales used to measure member perceptions of leadership and communication. The Cronbach's alpha (a common measure of scale reliability) was the method selected to determine the reliability of the leadership (n=12) and communication (n=4) scales. The reliability analysis revealed that both sets of survey question scales were highly reliable with a leadership alpha score of .929 and a communication alpha score of .896. As a result, the leadership survey questions were collapsed into one new independent variable; likewise, the communication survey questions were collapsed into one variable (See Table 1 and Table 2).

Table 1

*Leadership Reliability*

Cronbach's Alpha	Number of Items
.929	12

Table 2

*Communication Reliability*

Cronbach's Alpha	Number of Items
.896	4



Next, the set of survey questions related to coalition rules, structures, and procedures were analyzed. A summary of the individual questions is provided in Chapter 3. Each set of variables were summed creating one new variable for rules, structures and procedures. Each new variable was aggregated to determine the mean and standard deviation for all rules (mean = 1.19, standard deviation = 1.44), all structures (mean = 6.55, standard deviation = 3.02) and all procedures (mean = 3.58, standard deviation = 2.59) identified by the respondents (See Table 3).

Table 3:

*Infrastructure Descriptive Statistics*

	N	Minimum	Maximum	Mean	Std. Deviation
RulesALL	167	.00	5.00	1.1916	1.43927
StructuresALL	167	.00	10.00	6.5569	3.02520
ProceduresALL	167	.00	9.00	3.5868	2.59575
Valid N (listwise)	167				

Fourth, after completing the reliability analysis for the sets of survey questions (i.e., variables) related to leadership, communication, rules, structures and procedures, an analysis to determine the relationship between all of the variables was conducted. The analysis revealed the variables were moderately correlated and statistically significant ( $p < .05$ ) (See Table 4).

Table 4

*Independent Variable Correlations*

		Communi- cation	Leader- ship	Rules ALL	Structures ALL	Procedures ALL
Communi- cation	Pearson Correlation	1	.565**	.256**	.483**	.437**
	Sig. (2-tailed)		.000	.002	.000	.000
	N	147	146	147	147	147
Leadership	Pearson Correlation	.565**	1	.095	.260**	.291**
	Sig. (2-tailed)	.000		.237	.001	.000
	N	146	156	156	156	156
RulesALL	Pearson Correlation	.256**	.095	1	.460**	.403**
	Sig. (2-tailed)	.002	.237		.000	.000
	N	147	156	167	167	167
Structures ALL	Pearson Correlation	.483**	.260**	.460**	1	.642**
	Sig. (2-tailed)	.000	.001	.000		.000
	N	147	156	167	167	167
Procedure ALL	Pearson Correlation	.437**	.291**	.403**	.642**	1
	Sig. (2-tailed)	.000	.000	.000	.000	
	N	147	156	167	167	167

\*\*Correlation is significant at the 0.01 level (2-tailed).

Finally, a linear regression analysis was completed to determine if a statistically significant relationship ( $p < .05$ ) existed between the newly formed independent variables (i.e., leadership, communication, rules, structures and procedures) and the two dependent variables (i.e., reducing hospital readmissions and improving care transitions). Herein, the findings will be presented in both graphical and narrative format including a summary of findings, limitations, conclusions and recommendations for future research.

## CHAPTER 3

### RESULTS

The aim of this research was to survey coalitions that are actively involved in the improvement of health care delivery. The objective of the survey was to assess coalition members' perceptions of the effectiveness of their coalition. In the fall of 2010, the survey was conducted and included validated and reliable survey questions used in prior research. The coalitions undertook this endeavor because it is important to understand coalition members' perceptions of the coalitions' effectiveness in their communities. The perceived success or satisfaction of coalition members can affect a member's decision to remain invested in the Coalition's efforts (Wells et al., 2009). Herein, a summary of the results of the Coalitions' survey are presented in two ways. First, a descriptive statistical summary of the overall results listed within various categories such as overall demographics, member engagement, leadership, infrastructure, communication, decision-making, cohesiveness, satisfaction and community impact will be presented. Second, a formal statistical analysis of the survey results will be presented, highlighting the linear multiple regression analysis findings for each of the three research hypotheses noted earlier.

#### Demographics

##### Role in Coalition

The majority (67%) of the respondents identified themselves as a "general" member of the Coalition. A little more than fifteen percent identified themselves as a Coalition "project work group" member or "leader." A small percentage (12%) of the respondents was either a member of the "board of directors" or "executive work group."

### Length of Membership

More than one-third (40%) of the respondents have been a member of one of the Coalitions' surveyed for one to three years. Another third (38%) have been a member for either six months to one year (22%) or less than six months (16%). A small percentage (15%) of respondents has been a member of one of the Coalitions' surveyed for more than three years.

### Organization Type

Sixty-five percent of the members who responded best described their primary organization as a hospital. A small percentage of respondents were from a physician office (1%), state or local department (1%), home health agency (4%) or other types of health care provider organizations (11%). A small number (18%) identified themselves as "other."

### Position

A little more than half (57%) of the respondents described their position within their organization as either a Director/ Manager (41%) or as Executive/ Senior Management (16%). Another one-third (32%) stated they were a health care professional (e.g., physician, nurse, social worker). While the remaining identified themselves as a supervisor (2.7%), associate employee (4%) or "other" (6%).

### Race/Ethnicity

The majority of the respondents were of a White/non-Hispanic race and ethnicity (90%) and female (69%). Very few respondents were either White/Hispanic (3.3%) or African American/Black/Non Hispanic (2.7%). Another small percent of respondents were Native American (1.3%).

## Gender and Education

A majority of the respondents were female (78%) and 23% were males. The majority (>60%) of respondents were between the ages of 35 and 60 years old. All of the respondents have some college education or higher, with a majority possessing a graduate school level of education (60%).

## Member/Organization Engagement

### Activity

The majority of the Coalition members who responded perceive themselves as being either somewhat active (45%) or very active (34%). A small amount identified themselves as being not very active (14%) or not active at all (2%). About five percent were not sure how active they were in their Coalition.

### Common Vision

Almost all (89%) of the respondents agree or strongly agree that they share a common vision with their Coalition for their community. A small percentage either disagreed (2%) or strongly disagreed (7%) with the statement, Coalition members share a common vision for our community. Less than four percent did not know if they shared a common vision.

### Abilities Used Effectively

The majority (75%) of the respondents agreed (64%) or strongly agreed (11%) with the statement, “My abilities are effectively used by the Coalition.” Less than ten percent of the respondents either disagreed or strongly disagreed with this statement. Several of the respondents (15%) didn’t know if their abilities were effectively used by their Coalition.

## Commitment

When asked, “I feel strongly committed to this Coalition,” over fifty percent (56%) stated they agreed with this statement. Another twenty-three percent commented that they strongly agreed with this statement. Twelve percent either disagreed or strongly disagreed that they are strongly committed to the Coalition. Less than 10 percent didn’t know if they were strongly committed to the Coalition.

## Organization Endorsement of Mission

A high percentage of the members who responded have very much (66%) either endorsed or adopted the mission of their Coalition at their organization. Also, more than one-fourth (28%) either endorsed or adopted their Coalition’s mission. A small percentage either stated not at all (2%) or don’t know (4%).

## Organization Carries Out Activities

Over half of the respondents indicated they have very much (53%) carried out activities in the name of their Coalition by their organization. One-third (33%) of the respondents somewhat carries out activities in the name of their Coalition. A small percentage equally stated either not at all (7%) or don’t know (7%).

## Organization Publically Endorses or Co-Sponsors

Over forty percent (44%) of the respondents stated their organization “very much” publically endorses or co-sponsors their coalition activities. Also, over one-third (36%) of the respondents indicated their organization “somewhat” publically endorses or co-sponsors their Coalition activities. A small percentage of the Coalition members surveyed didn’t know (12%) or did not at all endorse or co-sponsor their Coalition activities.

## Leadership

### Leaders Come From

Equally, at forty-percent, the respondents indicated that the leadership in their Coalition comes from either Coalition Staff/Committee Work Group Chairs (40%) or Coalition members (40%). A small percentage (4%) of respondents indicated their Coalition leadership comes from non-coalition participants. Likewise, a small percentage did not know (14%) where their Coalition leadership came from.

### Leaders Encourage Points of View

Over one-third (39%) of the respondents indicated they strongly agreed with the statement, “The leaders encourage and explore all points of view.” Another half (53%) agreed with this statement, too. A small percentage (8%) of respondents either disagreed or strongly disagreed that leaders’ of their Coalition encourage and explore all points of view.

### Leadership and Conflict

The majority of respondents have not noticed much tension (46%) or no tension (31%) at all in the Coalition. A small percentage of respondents have noticed either some (21%) or a lot of (2%) tension in their Coalition. However, if there is tension, the respondents agree (72%) or strongly agree (20%) their leaders effectively manage the conflict. A small percentage of the respondents either disagree (4%) or strongly disagree (2%) that their leaders effectively manage conflict. Also, if there is conflict the majority of respondents agree (84%) or strongly agree (10%) their leaders effectively channel the conflict toward their Coalition goals. A small percentage of respondents disagree (5%) or strongly disagree (1%) with the aforementioned statement.



## Leadership Characteristics

The respondents agree or strongly agree with the following statements about the Coalition's leadership:

- Makes you feel welcome at meetings (94%)
- Has a clear vision for the coalition (93%)
- Asks members' to assist with specific tasks (94%)
- Give praise and recognition (92%)
- Is respected in your community (95%)
- Intentionally seeks out member views (87%)
- Makes an effort to get to know members (86%)
- Is skillful in resolving conflict (92%)

Across each of the above leadership characteristic statements, less than 15 percent of the respondents disagree or strongly disagree with them. An even smaller percentage for each of the above statements responded "didn't know."

## Infrastructure

### Formal Rules

Almost half (46%) of the respondents did not know (i.e., were not aware of) what formal rules were in place at their Coalition. However, another half was able to identify that the Coalition has formal rules such as meeting guidelines (46%). Less than a quarter of the respondents were aware of their Coalition's operating procedures (23%), by-laws (14%), attendance policies (18%), and membership criteria (18%).

## Formal Structures

In regards to formal structures, the majority of respondents were able to identify almost all of the key structures in place at their Coalition such as mission statement (64%), action plans (67%), meeting agendas (85%), minutes (91%), communication channels (69%), work groups or committees (58%), regularly scheduled meetings (80%), and record of attendance (68%). A little less than two-thirds (59%) of the respondents noted that a member roster was in place. A small percentage (25%) was able to identify if an organizational chart was in place for the Coalition.

## Formal Procedures

The majority of respondents identified planning (65%) as a formal procedure in place at their Coalition. In comparison, slightly more than half were able to identify that decision-making (55%), problem-solving (56%) and evaluation (53%) procedures were in place. However, half or fewer of the respondents were able to identify other types of formal procedures such as conflict resolution or mediation (21%), member orientation (17%) and training (23%) as well as assessment (46%) and resource allocation procedures (23%).

## Communication

### Between Coalition Staff and Members

The majority of the respondents rated the quality of communication between their Coalition staff and members as either good (44%) or excellent (43%). A small number rated the quality of the communication as fair (10%) or poor (2%). Likewise, the majority of respondents rated the frequency of communication between Coalition staff and members as

good (45%) or excellent (45%). A small number rated the frequency of the communication as fair (7%) or poor (3%).

#### Between Coalition Members

The majority of the respondents favorably rated the quality of communication between their Coalition members as either good (54%) or excellent (28%). A small number rated the quality of the communication as fair (12%) or poor (6%). Likewise, the majority of respondents rated the frequency of communication between their Coalition members positively, with fifty-eight percent the frequency as good and nineteen percent rating it as excellent. A small number rated the frequency of the communication as fair (13%) or poor (9%).

### Decision-Making

#### Level of Influence

When respondents were asked how much influence they have in specific decision-making processes most of the data was spread across responses of not much influence, some influence and a lot of influence. Over half of respondents felt they had some influence (49%) or a lot of influence (17%) in setting goals and objectives for the coalition, while a third felt they did have much influence (25%) or no influence (9%). Over half of the respondents felt they had some (50%) or a lot of (16%) influence setting coalition activities, while a third felt they did have much influence (25%) or no influence (9%). Similarly, over half felt they had some (44%) or a lot of (16%) of influence deciding general coalition policies and actions. In comparison, over a third respondents felt they either had no (12%) or not much influence (28%) in the decision-making process for these two areas.

#### Decision-Making Methods

When respondents were asked to identify the different methods their coalition uses to make formal decisions, two-thirds (60%) of respondents noted their coalition typically discusses the issue and comes to a consensus on the decision to be made. The second and third highest method of decision making identified by the respondents was members vote with majority rule (20%) or the coalition executive committee (14%) makes final decisions. Almost one-third (255) did not know what method their coalition uses to make decisions.

### Cohesiveness

The majority (>60%) of respondents agrees or strongly agrees with the following statements about cohesiveness in their Coalition and is listed in the highest ranking order:

- This is a down-to earth, practical coalition (82%).
- This is a decision-making coalition (78%).
- There is a strong emphasis on practical tasks in the coalition (78%).
- There is a feeling of unity and cohesion in the coalition (70%).
- There is a strong feeling of belonging (70%).
- Members of the coalition feel close to each other (60%).

Two-thirds (66%) of the respondents disagree or strongly disagree with the statement, There is not much group spirit among members of this coalition; however, almost one-fourth (21%) agree or strongly agree with this statement. The majority (76%) of respondents disagrees or strongly disagree that the coalition rarely has anything concrete to show for its efforts; however a small percentage (14%) agreed with this statement. Finally, two-thirds (67%) of respondents disagree or strongly disagree with the statement, this coalition has a hard time resolving conflicts; however, a small percentage (11%) agrees with this statement.

## Satisfaction

In regards to overall satisfaction, the majority (84%) of the respondents are either strongly satisfied (45%) or somewhat satisfied (39%) with the work of their coalition. A small percentage of respondents were somewhat unsatisfied (6%) or strongly unsatisfied (2%). Another small percentage didn't know (7%) how satisfied they were with their Coalition.

## Community Impact

Finally, when respondents were asked how likely or unlikely do you think their Coalition will reduce rehospitalization rates in their community, more than half (51%) responded somewhat likely and almost one-fourth (24%) responded strongly likely. A small percentage of the respondents stated it was somewhat unlikely (12%) or strongly unlikely (1%) that their Coalition would reduce rehospitalization rates. Another small percentage didn't know (11%) how likely or unlikely their Coalition would reduce rehospitalization rates.

When respondents were asked how likely or unlikely do you think the coalition will improve the quality of care transitions in your community, almost half (49%) of the respondents indicated somewhat likely and a one-third (35%) responded strongly likely. A small percentage of the respondents stated it was somewhat unlikely (6%) or strongly unlikely (2%) that their Coalition would improve the quality of care transitions in their community. Another small percentage didn't know (8%) how likely or unlikely their Coalition would improve the quality of care transitions in their community. In Tables 5 and 6, a break down by different coalition member characteristics and their mean responses to the following two questions is provided: (1) How likely or unlikely do you think the coalition

will reduce rehospitalization in your community?, and (2) How likely or unlikely do you think the coalition will improve the quality of care transitions in your community?

Table 5

*Likelihood of Reducing Hospital Readmissions*

Coalition Member Role	Mean	N	SD
Board of Directors	3.11	9	0.927
Executive Work Group Member of Leader	2.77	9	0.833
Project Work Group or Leader	3.17	23	0.886
General Member	3.31	101	0.835
Coalition Staff	4.00	3	1.000
State or local Health Department	3.00	2	1.410
Coalition Member Organization Type	Mean	N	SD
Hospital	3.23	98	0.917
Physician Office	4.50	2	0.707
Home Health Agency	3.66	6	0.816
Dialysis Facility	3.00	1	
Coalition Member Position Type	Mean	N	SD
Executive / Senior Management	3.16	24	0.816
Director/ Manager	3.39	61	0.880
Supervisor	2.75	4	0.500
Associate/Employee	3.50	6	1.040
Coalition Member Length of Service	Mean	N	SD
Less than six months	3.75	20	1.010
Six months to One Year	3.20	35	0.677
One to Three Years	3.15	64	0.912
More Than Three Years	4.16	6	0.983

Table 6

*Likelihood of Improving the Quality of Care Transitions*

Coalition Member Role	Mean	N	SD
Board of Directors	3.11	9	0.927
Executive Work Group Member of Leader	3.11	9	0.927
Project Work Group or Leader	3.30	23	0.973
General Member	3.40	101	0.709
Coalition Staff	3.66	3	1.150
State or local Health Department	3.50	2	0.707
Coalition Member Organization Type	Mean	N	SD
Hospital	3.34	98	1.410
Physician Office	4.00	2	1.410
Home Health Agency	3.50	6	0.547
Dialysis Facility	3.00	1	
Coalition Member Position Type	Mean	N	SD
Executive / Senior Management	3.29	24	0.858
Director/ Manager	3.44	61	0.742
Supervisor	3.00	4	
Associate/Employee	3.00	6	0.632
Coalition Member Length of Service	Mean	N	SD
Less than six months	3.60	20	0.882
Six months to One Year	3.40	35	0.650
One to Three Years	3.23	64	0.830
More Than Three Years	3.50	6	0.711

## Regression Analysis

As a reminder, the primary objective of this research is to answer three specific questions in such a way that the results, conclusions and inferences drawn from the study can be offered with confidence and integrity. Therefore, a linear multiple regression analysis was conducted to determine not only if a relationship exists, but also the relative importance of

the relationship between the independent and dependent variables identified in the following hypothesis:

H<sub>0</sub>: There is no correlation between membership perception of leadership and coalition success.

H<sub>1</sub>: There is a positive correlation between a coalition member's perception of his/her coalition's leadership effectiveness and the coalition's success at improving community health outcomes.

H<sub>0</sub>: There is no relationship between membership perception of formalized processes and coalition success.

H<sub>2</sub>: There is a positive correlation between a coalition member's perception of his/her coalition's ability to implement formalized processes and the coalition's success at improving community health outcomes.

H<sub>0</sub>: There is no relationship between membership perception of communication processes and coalition success.

H<sub>3</sub>: There is a positive correlation between a coalition member's perception of his/her coalition's ability to implement effective communicate (e.g., conflict resolution) processes and the coalition's success at improving community health outcomes.

#### Regression Part I: Community Health Outcomes - Reducing Hospital Readmission Rates

The hypotheses were tested to determine the relationship between all five of the independent variables (i.e., leadership, communication, formal rules, formal structures and formal procedures) and coalition members' perceived likelihood of improving community health outcomes (i.e., reducing hospital readmissions and improving care transitions) in their community. This approach was taken because as previous noted the independent variables appear to be modestly correlated with one another; thus, to prevent likelihood of a type I error the variables were tested together. The statistical analysis conducted will provide insight regarding how strong the relationship is between variables tested. First, when respondents were asked "How likely or unlikely do you think it is that the coalition will reduce hospital readmissions in your community," the overall mean response was 3.27 (SD =



.84, N = 143). The relationship between the set of independent variables all independent variables (i.e., leadership, communication and formal rules, structures and procedures) and the coalition's effectiveness at reducing hospital readmissions was not found to be statistically significant ( $p = .05$ ; significance level set at  $p < .05$ ). However, despite the lack of statistical significance the analysis revealed a positive multiple correlation (.277), but the strength of the relationship is still weak ( $R^2 = .077$ ; adj.  $R^2 = .043$ , see Table 7). It is important to note that since the coefficient is low it may be due to common method variance (Podsakoff, MacKenzie, Lee, & Podsakoff, 2003).

Table 7

*Statistical Model Summary for Likelihood of Reducing Hospital Readmissions*

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.277 <sup>a</sup>	.077	.043	.82047	.077	2.281	5	137	.050
ANOVA <sup>b</sup>									
Model		Sum of Squares	df	Mean Square	F	Sig.			
1	Regression	7.677	5	1.535	2.281	.050 <sup>a</sup>			
	Residual	92.225	137	.673					
	Total	99.902	142						
Coefficients <sup>a</sup>									
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.			
		B	Std. Error	Beta					
1	(Constant)	2.265	.517		4.379	.000			
	ProceduresALL	.057	.035	.165	1.616	.108			
	StructuresALL	-.058	.039	-.156	-1.496	.137			
	RulesALL	.005	.053	.008	.088	.930			
	Leadership	.180	.182	.100	.993	.323			
	Communication	.189	.140	.148	1.352	.179			

## Regression Part II: Community Health Outcomes – Improving Quality of Care Transitions

When respondents were asked “How likely or unlikely do you think it is that the coalition will improve the quality of care transitions in your community,” the overall mean response was 3.37 (SD = .77, N= 143). The relationship between the set of all independent variables (i.e., leadership, communication and formal rules, structures and procedures) and the coalition’s effectiveness at improving the quality of care transitions in their community is statistically significant ( $p = .000$ ) and a positive multiple correlation exists (.428). However, the strength of the relationship is somewhat low ( $R^2 = .183$ ; adj.  $R^2 = .153$ , See Table 8). While these values are not substantial, they seem likely to reflect both a statistically significant as well as important relationship.

Table 8

*Statistical Model Summary for Likelihood of Improving Quality of Care Transitions*

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.428 <sup>a</sup>	.183	.153	.71350	.183	6.134	5	137	.000
ANOVA <sup>b</sup>									
Model		Sum of Squares	df	Mean Square	F	Sig.			
1	Regression	15.613	5	3.123	6.134	.000 <sup>a</sup>			
	Residual	69.744	137	.509					
	Total	85.357	142						
Coefficients <sup>a</sup>									
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.			
		B	Std. Error	Beta					
1	(Constant)	1.853	.450		4.120	.000			
	ProceduresALL	.068	.031	.212	2.207	.029			
	StructuresALL	-.087	.034	-.253	-2.574	.011			
	RulesALL	.036	.046	.066	.773	.441			
	Leadership	.319	.158	.191	2.019	.045			
	Communication	.249	.122	.210	2.046	.043			

Of particular note, in Table 8, the multiple regression analysis shows, when controlling for the other IVs, that leadership, communication, procedures and structures all were significant. In fact, only rules were not significant in the analysis. One could argue that the observed R and R2 values are strong enough to make common method variance less of an explanation here. One possible explanation could be that “quality of care transition” is less of a precisely knowable outcome and it may be defined differently by members, therefore, they perceive most of the independent variables as somewhat more closely related to this outcome.

#### Influence in Decision-Making

Although not in the original hypothesis, a related variable measured was the perceived level of influence coalition members had in the coalition decision-making process (See Appendix B question 20). The analysis revealed a strong reliability of the items used to measure member’s perceptions of their level of influence in decision-making. This variable were determined to be highly reliable (alpha = .933). The regression results have a similar pattern to those for the previously analyzed IVs. Influence is not significantly related to a coalition’s perceived effectiveness in reducing readmissions (R=.126, R2 =.016; adj. R2=.009, see Table 9). Influence in decision-making is statistically significantly, although rather weak, related to perceptions of effectiveness in quality of care transitions (R=.253, R2 =.064; adj. R2=.057, see Table 10).

Table 9

*Model Summary of Influence in Decision-Making Related to Reducing Hospital Readmissions*

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.126 <sup>a</sup>	.016	.009	.82141	.016	2.230	1	139	.138

  

ANOVA <sup>b</sup>					
Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	1.505	1	1.505	2.230	.138 <sup>a</sup>
Residual	93.786	139	.675		
Total	95.291	140			

  

Coefficients <sup>a</sup>					
Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	2.914	.243		11.975	.000
Influence in Decision Making	.128	.086	.126	1.493	.138

Table 10

*Model Summary of Influence in Decision-Making Related to Improving Care Transitions*

Model Summary									
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics				
					R Square Change	F Change	df1	df2	Sig. F Change
1	.253 <sup>a</sup>	.064	.057	.74556	.064	9.516	1	139	.002
ANOVA <sup>b</sup>									
Model		Sum of Squares	df	Mean Square	F	Sig.			
1	Regression	5.290	1	5.290	9.516	.002 <sup>a</sup>			
	Residual	77.264	139	.556					
	Total	82.553	140						
Coefficients <sup>a</sup>									
Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.			
		B	Std. Error	Beta					
1	(Constant)	2.708	.221		12.263	.000			
	Influence in Decision Making	.240	.078	.253	3.085	.002			

## CHAPTER 4

### DISCUSSION, CONCLUSIONS AND SIGNIFICANCE

Based on the survey data, the general impression of the coalitions surveyed is positive. Overall, member engagement is good and respondents appear satisfied with the leadership of their coalition. The quality and frequency of communication between coalition staff and members as well as between coalition members is good, if not excellent, as perceived by some.

The members that responded appear to have a good recall of basic components of the coalition's infrastructure (i.e., formal rules, formal structures and formal procedures). Some components of the coalition's infrastructure were not identified by the respondents, but this could be related to the non-existence of such structures or the need for additional member education.

The respondents perception of influence over decision-making were more widely varied; thus, less strong when compared to the other survey categories. The sense of cohesiveness among members is strong and the respondents' perception of the coalition's likelihood of making a positive impact in their community is moderately strong.

There appears to be a positive but weak relationship between the all but one of independent variables (i.e., leadership, communication, formal structures and procedures) and the coalition's perceived effectiveness at improving the quality of care transitions in their community. In contrast, there does not seem to be a relation between any of the independent variables (controlling for the others) and coalition members' perceptions of effectiveness in reducing hospital readmission rates. Why such a difference exists may be due to the nature



of the dependent variables and is a question that obviously deserves further investigation. Similarly to these results, there is a relationship between a member's influence in decision-making and quality of care transitions in their community, but not for reducing hospital readmission rates. Furthermore, when a relationship exists you want to understand why it exists. For example, does the original variable change as a result of the second variable? From this analysis, we can conclude that when there is variability in the set of independent variables (i.e., leadership, communication, rules, structures or procedures) then it is likely there will be variability in coalition community outcomes, in this study specifically in quality of care transition perceptions and perhaps in others.

Finally, this study supports the literature in several areas. First, this study finds that leadership does play a role in improving the quality of care transitions for respondents surveyed, confirming similar findings by Butterfoss (2002), and Shortell et al. (2002). They found leaders must be able to recognize and manage the interorganizational dynamics of the coalition. Therefore, they concluded leadership was an important predictor of a success for a coalition.

Second, the literature argues open and frequent communication among staff and members helps create a positive climate improving the likelihood the coalition will be successful at improving community health outcomes (Butterfoss & Kegler, 2002; Shortell et al., 2002; Litwak & Hylton, 1962; Thompson, 1967; Lynn, Heinrich & Hill, 2001; Weiner, Alexander & Zuckerman, 2000). This study found this argument to be valid, too for perceptions about quality of care transition.

Third, the literature suggests coalitions are more likely to be successful when they have formalized processes (i.e., rules, procedures and structures) in place (Butterfoss &

Kegler, 2002). This study validated this hypothesis in part – for procedures and structures in relation to quality of care transitions.

This dissertation is an innovative research project because the QIO community and its CT community coalitions have not been surveyed before on this scale. A better understanding of the dynamics of the QIO CT community coalitions is now available which benefits the participating QIOs. For example, now the QIOs have survey-based research to improve the effectiveness of their community coalitions which will significantly impact the performance and evaluation outcomes expected by CMS, as their public partner.

The information obtained from this study is new and different, thus, the QIOs can use this information to place them in a more competitive position for future CT work solicited by CMS. Also, the proposed research has made the following contributions: 1) It has successfully offered explanations for factors that may influence the success or failure of PPPs that form coalitions by employing quantitative research methods to assess the validity and reliability of the propositions related to leadership and communication, and 2) It has successfully reported insight and valuable lessons learned to others by studying the “real-life” context in which coalitions occur. Both of these contributions will assist practitioners with “making the case” for future PPPs to form coalitions.

## CHAPTER 5

### LIMITATIONS AND FUTURE RESEARCH

#### Limitations

When conducting social science research the limitations inherent in the design and execution of research should be noted. This research is no exception to this general rule of thumb and several study limitations do exist. The first major limitation of this study is the low response rate. A greater than 30% response rate was achieved; however, a larger response rate would strengthen the validity, reliability and generalizability of the data to the QIO coalitions that participated in the survey.

Second, the findings of this research are limited to the demographic nature of the group of respondents. For example, the participants were predominantly white females and highly educated. Thus, the generalizability of the findings may be limited to highly educated females, which is typical of the QIO population. Third, this research is focused on QIOs and the coalitions they have formed to improve the patient care transitions from one provider to another as well as reduce the number of rehospitalizations in a given community. The QIOs found the information to be of valuable to them in regards to assessing their coalition's effectiveness; however, some caution should be used when applying these findings to other coalitions of similar nature. Next, the survey results are time-limited and represent coalition members' perceptions at one point in time. It is highly likely the perceptions of the members' have either improved or deteriorated since the survey was administered. All of these limitations should be considered before future research is conducted.

## Future Research Needs

The future for researching the effectiveness of coalitions is still a viable opportunity. Future research dedicated to the investigation of the various aspects of effective coalition building is not only timely but potentially highly valued by both public and private sector entities. As resources and time continue to be constrained to achieve positive community health outcomes the need to reveal the most effective way of doing business or practice is critical.

Multiple research questions could be proposed to investigate the factors that contribute to a coalition's effectiveness. At least two areas should definitely be pursued. One opportunity to continue future research may consist of investigating the relationship between decision-making and perceived coalition effectiveness. For example, one might ask, "Is there is a positive correlation between a coalition member's perception of his/her coalition's decision-making processes and the coalition's success at improving community health outcomes? Member engagement in decision-making can be critical to the coalition's success. Also, it would be a worthwhile endeavor to investigate the question, "Is there a relationship between the degree of perceived cohesiveness or satisfaction by coalition members and perceived coalition effectiveness?" Again, coalition members' satisfaction and their sense of belonging could have a dramatic impact on the coalition's success. Finally, it would be worthwhile to investigate member perceptions of likelihood of readmission rates and actual readmission rates.

## APPENDIX A

### COMMUNITY COALITION ACTION THEORY PROPOSITIONS

- Proposition #1: Coalitions develop in specific stages and recycle through these stages as new members are recruited, plans are renewed, and/or new issues are added.
- Proposition #2: At each stage, specific factors enhance coalition function and progression to the next stage.
- Proposition #3: Coalitions are heavily influenced by contextual factors in the community throughout all stages of coalition development.
- Proposition #4: Coalitions form when a lead agency or convening group responds to an opportunity, threat or mandate.
- Proposition #5: Coalition formation is more likely when the convening group provides technical assistance, financial or material support, credibility and valuable networks/contacts.
- Proposition #6: Coalition formation is more likely to be successful when the convener group enlists community gatekeepers who thoroughly understand the community to help develop credibility and trust with others in the community.
- Proposition #7: Coalition formation usually begins by recruiting a core group of people who are committed to resolve the health or social issue.
- Proposition #8: More effective coalitions result when the core group expands to include a broad constituency of participants who represent diverse interest groups and organizations.
- Proposition #9: Open and frequent communication among staff and members helps to create a positive climate, to ensure that benefits outweigh costs, and to make collaborative synergy more likely.
- Proposition #10: Shared and formalized decision-making helps to create a positive climate, to ensure that benefits outweigh costs, and to make collaborative synergy more likely.
- Proposition #11: Conflict management helps to create a positive climate, to ensure that benefits outweigh costs, and to make collaborative synergy more likely.
- Proposition #12: Strong leadership from a team of staff and members improves coalition functioning and makes collaborative synergy more likely.
- Proposition #13: Paid staff who has the interpersonal and organizational skills to facilitate the collaborative process improves coalition functioning and make collaborative synergy more likely.
- Proposition #14: Formalized rules, roles, structures and procedures make collaborative synergy more likely
- Proposition #15: Satisfied and committed members will participate more fully in the work of the coalition.
- Proposition #16: The synergistic pooling of member and external resources prompts comprehensive assessment, planning and implementation of strategies.

- Proposition #17: Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur.
- Proposition #18: Coalitions are more likely to create change in community policies, practices and environments when they direct interventions at multiple levels.
- Proposition #19: Coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes.
- Proposition #20: The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.
- Proposition #21: As a result of participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues.

APPENDIX B

Building Effective Collaborative Coalitions

A Coalition Member

SURVEY

June 14, 2010

This survey instrument is not to be used without permission

Developer contact Information:

Teresa Titus-Howard, MSW, MHA

Coalition\_building@sbcglobal.net

816-225-1874

### Purpose

The purpose of this survey is to assess a coalition's effectiveness. The findings will provide coalition leaders and members with a self-assessment that will identify strengths and areas for improvement. The findings will also be helpful to other organizations that frequently lead community coalition activities targeted at improving the health of a community. For the purposes of this survey, coalition members can be organizations or entities that have directly participated in improving care transitions, such as providers, or supporting organizations, such as associations, community groups, or similar entities.

### Confidentiality

All of the information you provide will be kept strictly confidential and your participation is voluntary. Your responses will be combined with the responses of others in your coalition. The information from your coalition may be summarized and reported back to your coalition if requested by your coalition leadership. Neither your name nor the name of your coalition will be identified in any published reports of this research.

### Instructions

Please answer the following questions as they pertain to your involvement in your coalition. It will take approximately 15 minutes or less to complete the survey. At the end of the survey is a short set of demographic questions that we would like for you to answer, too. The responses to these questions will help us understand something about why participants vary in their responses. Please do not leave any questions unanswered.

We appreciate your willingness to participate.



COALITION MEMBERSHIP

Answer the following questions in regards to your involvement in the coalition

1. How long have you been a member of the coalition? \_\_\_\_\_ months (Kegler 1998)

2. Some coalition members are very active. Others are fairly inactive. Would you say that you are: (Kegler 1998)

1	2	3	4
very active	somewhat active	not very active	not at all active

3. Coalition members share a common vision for our community. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

4. My abilities are effectively used by the Coalition. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

5. I feel strongly committed to this coalition. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

6. My organization has endorsed or adopted the mission of the coalition. (Rogers, 1993, Kegler 1998)

1	2	3	4
Not at all			Very Much

7. My organization has carried out activities in the name of the coalition. (Rogers, 1993, Kegler 1998)

1	2	3	4
Not at all			Very Much

8. My organization publically endorses or co-sponsors coalition activities. (Rogers, 1993, Kegler 1998)

1	2	3	4
Not at all			Very Much

LEADERSHIP

For the questions below, the following definitions will apply.

- Lead agency – An organization that assumes a lead role in the coalition in response to an opportunity, threat or mandate.
- Coalition members – Individual/s or organization/s participating in the coalition.
- Non-coalition participants -- Individuals or organizations that support the coalition but do not directly participate in coalition activities.

Answer the following questions in regards to your coalition.

9. The leadership in my coalition comes from the following: (Check all that apply)

- a. Lead agency
- b. Coalition members
- c. Non-coalition participants
- d. Other:
- e. Don't Know

10. The leaders encourage and explore all points of view. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

11. Some coalitions have to deal with conflict and tension caused by differences of opinions, personality clashes, hidden agendas and power struggles. How much or how little tension have you noticed in your coalition? Have you noticed: (Kegler, 1998)

1	2	3	4
A lot of tension	Some tension	Not much tension	No tension

12. If there is conflict, the leaders effectively manage it. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

13. If there is conflict, the leaders' effectively channel it toward the coalition's goals. (C.E. Hays, 2000)

1	2	3	4
Strongly Disagree	Disagree	Agree	Strongly Agree

14. Consider the following statements about leadership (coalition and committee chairs) of your coalition. Please indicate a response for each statement (Kegler, 1998)

The coalition leadership	Strongly Disagree	Disagree	Agree	Strongly Agree
• Makes you feel welcome at meetings.	1	2	3	4
• Gives praise and recognition at meetings.	1	2	3	4
• Intentionally seeks out your views.	1	2	3	4
• Asks you to assist with specific tasks.	1	2	3	4
• Makes an effort to get to know members.	1	2	3	4
• Has a clear vision for the coalition.	1	2	3	4
• Is respected in your community.	1	2	3	4
• Is skillful in resolving conflict.	1	2	3	4

## STRUCTURES

For the questions below, the following definitions will apply.

- Formal rules include operating procedures, attendance and other policies, membership criteria, bylaws and meeting guidelines.
- Formal structures include committees, written roles or job descriptions; mission statements, goals, and objectives; organizational charts; scheduled meetings, and written memoranda of understanding.
- Formal procedures include well-defined decision-making and problem-solving and conflict resolution processes, new member orientation and training, structured community assessment, planning, evaluation and resource allocation practices.

Answer the following questions in regards to your coalition.

15. Which of the following formal rules are in place at your coalition: (Check all that apply) (Rogers, 1993)

- Operating procedures
- Meeting guidelines
- Bylaws
- Policies (e.g., attendance)
- Membership criteria
- Other:
- Don't Know

16. Which of the following formal structures are in place at your coalition: (Check all that apply) (Rogers, 1993)

- Mission statement
- Goals and objectives
- Action or work Plan
- Organizational charts
- Steering or Executive Committee
- Work Groups or Committees
- Written role or job descriptions
- Regularly scheduled meetings
- Record of meeting attendance
- Meeting schedules
- Member roster
- Agenda
- Minutes
- Communication Channels (e.g. email, list servs, newsletters)
- Other:
- Don't Know

17. Which of the following formal procedures are in place at your coalition: (Check all that apply) (Rogers, 1993)
- a. Decision making
  - b. Problem solving
  - c. Conflict resolution or mediation
  - d. Orientation
  - e. Training
  - f. Assessment
  - g. Planning
  - h. Evaluation
  - i. Resource allocation (i.e. budget)
  - j. Other:
  - k. Don't Know

### COMMUNICATION

Answer the following questions in regards to your coalition.

18. Please rate the communication between QIO staff and coalition members on the following scales: (Rogers, 1993)

1	2	3	4
Poor			Good
1	2	3	4
Infrequent			Frequent
1	2	3	4
Unproductive			Productive

19. Please rate the communication between coalition members on the following scales: (Rogers, 1993)

1	2	3	4
Poor			Good
1	2	3	4
Infrequent			Frequent
1	2	3	4
Unproductive			Productive

## DECISION MAKING

20. How much influence do you have in making decisions for the coalition? (Kegler, 1998)

	No influence	Not much influence	Some influence	A lot of influence
• Setting goals and objectives for the coalition	1	2	3	4
• Setting coalition activities	1	2	3	4
• Deciding general coalition policies and actions.	1	2	3	4

21. When my coalition makes a formal decision it uses the following methods. (Check all that apply)

- a. Coalition members vote with majority rule
- b. Discuss the issue and come to consensus
- c. Coalition chair makes final decisions
- d. Coalition executive or steering committee makes final decisions
- e. Lead agency makes final decisions
- f. Other:
- g. Don't Know

## CULTURE

22. How much do you agree or disagree with the following statements about your coalition: (Kegler, 1998)

	Strongly Disagree	Disagree	Agree	Strongly Agree
• There is a feeling of unity and cohesion in this coalition.	1	2	3	4
• There is a strong emphasis on practical tasks in this coalition.	1	2	3	4
• There is not much group spirit among members of this coalition.	1	2	3	4
• This is a down-to-earth, practical coalition.	1	2	3	4
• There is a strong feeling of belonging in this coalition.	1	2	3	4
• This coalition rarely has anything concrete to show for its efforts.	1	2	3	4
• Members of this coalition feel close to each other.	1	2	3	4
• This is a decision-making coalition.	1	2	3	4
• This coalition has a hard time resolving conflicts.	1	2	3	4

## OUTCOMES

23. Up until now, how satisfied or dissatisfied have you been with the work of the coalition?  
(Rogers, 1993)

1	2	3	4	5
Not at all satisfied	Not very satisfied	Neutral	Somewhat satisfied	Very Satisfied

24. How likely or unlikely do you think it is that the coalition will reduce hospital  
readmissions in your community? (Rogers, 1993)

1	2	3	4	5
Strongly unlikely	Somewhat unlikely	Neutral	Somewhat likely	Strongly likely

25. How likely or unlikely do you think it is that the coalition will improve the quality of care  
transitions in your community? (Rogers, 1993)

1	2	3	4	5
Strongly unlikely	Somewhat unlikely	Neutral	Somewhat likely	Strongly likely

26. What is your role in the coalition? (Check all that apply)

- a. Member of the steering or executive committee
- b. Coalition officer
- c. Chair/co-chair of the coalition committee
- d. Member
- e. Staff
- f. Other (please specify)

27. Choose the category that best describes your primary organization.(Check only one)

- a. State health department
- b. Local health department
- c. Hospital
- d. Physician office
- e. Home health agency
- f. Hospice agency
- g. Employer
- h. Other type of health care provider organization
- i. HMO and other health organization
- j. School college/ university/ professional training school/academic institution
- k. Other (please specify)



28. What is your position in that organization? (Check only one)
- a. Executive/Senior management
  - b. Director/Manager
  - c. Supervisor
  - d. Associate/Employee
  - e. Healthcare Professional (e.g. Physician, Nurse, Social Worker)
  - f. Other (please specify)
29. Your gender:
- a. Female
  - b. Male
30. Your Race or Ethnicity:
- a. African American/Black
  - b. White
  - c. Asian American
  - d. Native Hawaiian or other pacific islander
  - e. Native American
  - f. Latino or Hispanic
  - g. Other race or ethnicity (please specify):
31. Your age at last birthday: (Check only one)
- a. 18-24
  - b. 25-29
  - c. 30-39
  - d. 40-49
  - e. 50-59
  - f. 60-65
  - g. Over 65
32. Your education:
- a. Grade 6 or less
  - b. Grade 7 or 8
  - c. Some high school
  - d. Graduated from high school
  - e. Graduated from technical or vocational school
  - f. Some college or professional school
  - g. Graduated from college
  - h. Some graduate school
  - i. Completed graduate school

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## VITA

Teresa Titus-Howard was born on June 16, 1969 in Bellevue, Nebraska. She was educated in local public schools and graduated from Hickman High School in Columbia, MO in 1987. She attended the University of Missouri-Columbia in Columbia, MO for two years (1987-1989) and then transferred to Columbia College in Columbia, MO in the fall of 1989. She received her Bachelor of Arts degree in psychology from Columbia College and graduated magna cum laude with honors in 1991.

In the fall of 1991, she continued her education at the University of Missouri-Columbia (UMC) in Columbia, MO by pursuing a Master Degree of Social Work (MSW) from the UMC School of Social Work. She graduated with her MSW in 1993. After working in the health care field as a clinical social worker and health administrator for five years, Ms. Titus-Howard pursued her Master of Health Administration (MHA) degree at the University of Missouri-Columbia in Columbia, MO. In 1998, she earned her MHA from the University of Missouri-Columbia, School of Medicine Health Administration Executive Program (As of 2012, known as the School of Health Management and Informatics).

Between 1998 and 2004, Ms. Titus-Howard held various healthcare administration positions in home health, hospice, hospital inpatient, managed care and community non-profit settings. In 2004, she began the pursuit of her Interdisciplinary Ph.D. at the University of Missouri-Kansas City, School of Business and Public Affairs and Administration. In 2007, she joined the Centers for Medicare and Medicaid Services (CMS) as an Associate Regional Administrator in Kansas City, MO. In 2010, she moved to the greater Baltimore/ Washington DC area with CMS as the Deputy Group Director for the CMS Innovation Center Quality Improvement, Learning and Diffusion Group. Her passion and expertise is in quality



improvement science, operations research, public-private partnerships, effective collaboration and coalition building. Upon completion of her degree requirements in spring 2012, Ms. Titus-Howard plans to continue her career at CMS where she will lead national Affordable Health Care Act (i.e., health reform) efforts to prototype and diffuse new models of patient care delivery or payment reform that have been proven to improve the health care delivery, population health and lower health care costs for all Americans.