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Community Coalitions to Control Chronic Disease: Allies Against Asthma as a Model and Case Study

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There is a rich and extensive literature regarding coalitions as vehicles for amassing resources, influence, and energy in pursuit of a health goal. Despite insufficient empirical data regarding outcome, a number of observers have posited the aspects of coalition processes thought to lead to goal attainment. The supplement, which this article is part of, is devoted to an examination of how these elements fitted together (or did not) in the seven areas across the United States where Allies coalitions devoted themselves to achieving asthma control. The aim of this article is to present the theoretical bases for the work of the coalitions. It illustrates and emphasizes how the community context influenced coalition development, how membership was involved in and assessed coalition processes and structures, and the community-wide actions that were instituted and the capacities they were trying to strengthen.

Keywords: *asthma; collaboration; coalitions; community-based approaches; chronic disease*

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► COALITIONS AS A MEANS TO ADDRESS PUBLIC HEALTH PROBLEMS

There is a rich and extensive literature regarding coalitions as vehicles for amassing resources, influence, and energy in pursuit of a health goal. The key feature of such efforts is collaboration (Alexander et al., 2003; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001), that is, the willingness of stakeholders in a problem to work together cooperatively toward its solution. Coalitions discussed in the health literature have involved stakeholders that share very similar perspectives and experience, as well as those with diverse memberships representing differing levels of political power, professional expertise, community wisdom,

Editors' Note: *This article is part of a special supplement of Health Promotion Practice that describes the development and implementation of the Allies Against Asthma (Allies) initiative. Funded by the Robert Wood Johnson Foundation with direction and technical assistance provided by the University of Michigan School of Public Health, Allies provides support to seven community-based coalitions nationwide to develop, implement, and sustain comprehensive asthma management programs. Through Allies, each coalition received grants totaling approximately US \$1.5 million to support the coalition, its targeted activities, and evaluation for 1 year of planning and 3 to 4 years of implementation. The supplement describes the first phase of the initiative, during which coalitions designed and implemented a range of activities including improved access to and quality of medical services, education, family and community support, and environmental and policy initiatives. More information about the initiative as well as tools and materials developed by the coalitions can be found at www.AlliesAgainstAsthma.net.*

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economic resources, and other attributes that can be put to problem resolution.

Health coalitions do not automatically involve or engender participation of community-based organizations or other community residents. For example, Alexander et al. (2003) discussed health partnerships comprising primarily staff of health care delivery systems attempting to enhance the coordination of care available in a community. On the other hand, Butterfoss, Goodman, and Wandersman (1993) examined coalitions where community residents and community based organizations play the major role in deciding how to enhance health care delivery. *Coalition* does not refer to the type of stakeholders engaged in collaboration. Rather, the term depicts a way of working. The word *coalition* is generally defined as “a body formed by the coalescing of originally distinct elements; a temporary alliance of distinct parties, persons or states for joint action” (Merriam-Webster’s, 1997). Any group of distinct entities wishing to coalesce around a common mission can form a coalition, and a coalition can comprise

from a few to many hundred individuals and agencies. Feighery and Rogers (1989) discussed three types of coalitions. The first is the grassroots coalition organized by volunteers in times of crisis to pressure policy makers to act. According to these observers, such coalitions are usually controversial in nature and often disband when the crisis is over. The second type is the professional coalition formed by professional entities or organizations either in a time of crisis or as a long-term approach to increasing their influence. The third type described by these authors is the community-based coalition of professional and grassroots leaders, generally, aiming to influence long-term health and welfare practices in their communities.

What Makes a Coalition a Community Coalition?

The type of coalition most discussed currently in the literature and, indeed, promoted most often in the field of public health is that which aims to give voice to constituencies not often at the table when the health problems affecting them and their families are considered. Butterfoss et al. (1993) discuss *community coalitions* somewhat more broadly than Feighery and Rogers (1989). By employing this term, Butterfoss et al. wished to describe a type of coalition that is representative of a given, defined community whose membership reflects all segments of that community’s population, not just one sector or type of stakeholder. Reflected in the term is the idea that much of the know-how for resolving problems rests with those who experience them most directly and that they and their experience must be acknowledged in decisions about solutions. These stakeholders can be individuals with the problem or representatives of community-based organizations that understand the problem in its most compelling form.

Based on *Allies Against Asthma*’s (*Allies*) experience, the description of *community coalitions* could be expanded from the definitions noted above. Implicitly, *community coalition* appears to mean that the given coalition (a) serves a defined community (usually having a common location or experience) recognized by those within it as a community, (b) is purposeful and its duration is time specific, (c) exists to serve the broader community, (d) is viewed by community residents as representing and serving them, (e) reflects the diversity evident in the community, (f) addresses the problem(s) systematically and comprehensively, and (g) builds community independence and capacity.

The Rationale for Allies Against Asthma

In 2002, some 20 million Americans, including an estimated 6.1 million children, were affected by

asthma, and its prevalence has increased dramatically during the past two decades (National Heart, Lung, and Blood Institute, 2002). As the leading chronic illness among children, asthma accounts for approximately 14 million missed school days annually (Centers for Disease Control and Prevention, 2002). The cost of caring for children diagnosed with asthma in the United States was US \$4.6 billion in 1996 (Summer & Simpson, 2001).

The Robert Wood Johnson Foundation (RWJF) has had a long experience sponsoring coalition approaches to health problems. In 1975, RWJF funded a coalition of church and community leadership to develop an ambulatory health services center in Chicago. More recently, RWJF initiated Fighting Back, a program that required communities to establish a broad-based, community-wide consortium to address issues related to combating drug and alcohol abuse. Other coalition-based initiatives funded by RWJF have included efforts to identify and enroll eligible children in health care insurance plans and statewide coalitions developing comprehensive tobacco-reduction strategies.

The Case for Addressing Asthma in Children

The decision by RWJF to fund seven coalitions and assess their impact on asthma held promise for understanding community-wide change designed to achieve control over the disease. In the initial years of Allies, project staff identified more than 160 asthma community coalitions at various stages of development around the United States. Asthma coalitions are also evident in other parts of the world, including the United Kingdom, Canada, and Australia.

The interest in community coalitions has been linked to the fact that although the past decade has seen significant advances in asthma management, many children continue to suffer with asthma because of a complex set of factors. These include a lack of quality clinical care based on established asthma guidelines, undermanagement of the disease by children and their families, and a dearth of support for effective asthma management within institutions and across communities. As noted, the Allies program was designed to support community-wide efforts to improve asthma control. In addition, it aimed to bring together parents and caregivers of children with asthma, medical providers, insurers, public health and environmental agencies, housing professionals, schools, community organizations, local officials, business and industry, and grassroots advocacy groups to develop and implement innovative approaches to improve care and coordinate efforts across organizations and agencies. Finally, the Allies program was designed

to improve asthma health outcomes, including reductions in hospital admissions, emergency room visits, and missed school days, and to enhance the quality of life of children with asthma and their parents.

Asthma is a multi-faceted medical problem but also a community problem and public health problem. No single intervention is going to decrease rates of asthma. . . . It needs this type of community coalition to have a real impact.

Coalition Member, Long Beach Alliance for Children with Asthma (LBACA)

► COALITION FUNCTIONING AND STAGES OF DEVELOPMENT

Coalitions at different stages of evolution were intentionally selected for the Allies program. Working with new to very mature coalitions was thought to increase the potential for understanding how they function and reach their goals over time. A number of observers (Butterfoss et al., 1993; Mizrahi & Rosenthal, 1992) have described the phases of development of community coalitions. There is consensus regarding four major stages. It should be noted that these stages overlap and frequently are not clearly distinguishable from one to another.

The first stage is formation. Butterfoss et al. (1993) described the factors that stimulate coalition formation by communities. One, for example, is the shared view that coordination of efforts will improve a situation: for purposes of our discussion, the given health problem, asthma. Collective recognition of a mutual need is another stimulus to coalition formation. Scarce resources can lead to creation of coalitions, as can the failure of existing efforts to address a problem of common concern. External forces can also cause the establishment of coalitions, such as legislative or administrative mandates or the availability of funding for forming such entities.

The second stage of coalition development is implementation of activities designed to enable the coalition to reach its goals. This phase is characterized by the formulation of ways in which the stakeholders will work together. This stage can entail creation of formalized rules, roles, and operating procedures. In this stage,

the emergence of leadership is thought to be essential for movement into the next phase of development (Feighery & Rogers, 1989). Roberts-DeGennaro (1986) noted that regardless of the size of a coalition, it tends to have a few core leaders who dominate activities. According to Brown (1984), coalitions whose leaders pay attention to individual member concerns are able to garner resources and have strong negotiation, problem-solving, and conflict-resolution skills are more likely to reach peripheral members and maintain operations. Reaching across the membership of a coalition is thought to be fundamental to its ability to implement its activities. In the words of Butterfoss et al. (1993), a coalition's membership is its primary asset.

The third phase of coalition development is maintenance, meaning the ability of the collective to continue until the accomplishment of its goals. The major feature of maintenance may well be that the stakeholders find sufficient benefit in their participation to offset the costs. It is reasonable to assume that many, if not most, community coalition members represent a constituency or organization, and benefits to participation must be evident to the individual and the entity that person represents. A number of investigators have described the benefits of being involved in a coalition (Bailey, 1986; Bernard, 1989; Hord, 1986; Wandersman & Alderman, 1993; Zapka et al., 1992). These may include perceived organizational rewards, such as information sharing, access to resources, networking, and enhancement of the organization's image. Some benefits may appeal to a stakeholder's sense of mission, such as involvement in an important cause or reaching an important and desired outcome. Some benefits may enhance a personal situation, for example, the coalition work might provide personal recognition, enhance one's skills, or be a source of enjoyment. Negative impact and costs of participation can range from time, energy, and expenditure of resources to the risk of losing autonomy through shared decision making.

As coalition members work to maintain their organization and meet their goals, relationships are likely to reform and evolve as new members come on board and others depart. Strong coalitions appear to comprise members who may initially come to the table simply as stakeholders but over time become partners in change (Doctor, 2005). Maintenance of a coalition requires attention to the social environment for partnership. Doctor (2005) suggested this tending by coalition leaders involves the 10 functions presented in Table 1.

The final phase in coalition development is attainment of goals, including sustainability of the organization and/or its impact. In the case of asthma coalitions, for example, these community-wide goals might include

TABLE 1
Leadership Actions to Engender Optimum
Collaboration in Community Coalitions

Create a flexible organizational structure
Create a vision of what can be accomplished
Foster trust and nurture relationships
Create "space" for open dialogue
Acknowledge and address concerns regarding power and control
Value and build diversity
Gauge readiness of members for action
Engage in strong and intentional facilitation of tasks and processes
Maintain a sense of energy
Be patient

SOURCE: Adapted from Doctor (2005).

improved quality of health services and availability of care and lower levels of morbidity and mortality from asthma. Measuring goal attainment across complex communities is not an easy matter, so it is no surprise that this is the stage for which there is the least amount of empirical data available in the literature. Some observers have noted that early or short-term successes can increase motivation to take on more complex tasks and enhance a coalition's credibility and chances for goal attainment (Cohen, Baer, & Satterwhite, 2002; Hord, 1986). However, the analysis of factors contributing to achieving outcomes is hampered by the dearth of studies that carefully and thoroughly examine these outcomes. Far more plentiful are explorations of coalition processes that may include, for example, community satisfaction with a coalition's work and the coalition's ability to reach relevant stakeholders.

One might argue that community coalitions are justifiable regardless of their ability to produce particular outcomes compared with more authoritarian means of effecting change. Perhaps, in a democratic society, most important decisions and actions should be taken via democratic processes, that is, with full participation of the citizens affected with only passing attention to efficiency or magnitude of ultimate results. The process, rather than outcome, is the most salient factor. However, from a public health perspective, when resources are scarce and levels of health disparate among populations, it is important to know the extent of the impact of community coalitions. Are their effects significant? Are they durable? Does the health of the public improve?

TABLE 2
Factors Associated with Coalition Success

<i>Membership</i>	<i>Goals, Structure, Process</i>	<i>Resources</i>
Collaborative history	Shared vision	Good leadership
Mutual understanding and trust	Attainable goals	Paid staff
Collaboration is in one's interest	Clear roles and guidelines	
Key stakeholders participate	Open and frequent communication	
	Members share a stake in process and outcomes	

NOTE: Adapted from Mattesich, Murray-Close, & Monsey (2001).

► EVALUATION OF COMMUNITY COALITIONS

A few evaluators have taken on the difficult task of assessing health-related outcomes attributable to the work of coalitions. Roussos and Fawcett (2002) conducted a comprehensive review of 34 studies that used experimental or quasi-experimental evaluation designs spanning, in general, 4 or fewer years in duration. The primary review question was: What is the evidence that coalitions improve population-wide health outcomes? Roussos and Fawcett found that methodological problems and the length of time required for community-wide change to be observable in reliable indicators precluded most collaboratives from obtaining the required data. Instead, most settled for assessing more proximal and (frequently proxy) outcomes, such as health behavior in selected samples of the population. Nonetheless, 10 studies did provide population-wide outcomes where improvements appeared to be attributable to the efforts of a coalition. Examples are declines in lead poisoning in New York City (Freudenberg & Golub, 1987), reduction of infant mortality in African American infants in Boston (Plough & Olafson, 1994), and reduction of teen pregnancy in South Carolina (Vincent, Clearie, & Schluchter, 1987).

Although the studies reviewed by Roussos and Fawcett (2002) indicated that coalitions can change community-wide outcomes and behaviors, the degree of statistical effect was smaller than anticipated. The absolute or cumulative importance to public health of such outcomes has not been assessed. Furthermore, in most of the evaluations examined, it was difficult to impossible to determine whether systems (health care and welfare, for example) changed as a result of coalition efforts and if outcomes, therefore, were durable. Goal attainment is the driving force of most community

coalitions but the least well understood stage in the life of these collaborative efforts.

Potential Predictors of Success

Despite insufficient empirical data regarding outcome, a number of observers have posited the aspects of coalition processes thought to lead to goal attainment. Table 2 is adapted from a review of these process observations (Beery, Cheadle, Schwartz, & Senter, 2003; Mattesich, Murray-Close, & Monsey, 2001).

More and more comprehensive studies are needed to illuminate the connection between these aspects of coalition functioning and changes in community-wide behavior, health care delivery systems, and health-related conditions. However, much is known about Stages 1 through 3 of community-coalition development, that is, formation, implementation, and maintenance. In the following pages of this supplement, observers of the Allies coalitions will provide data to illustrate how these stages were manifest in communities around the country and how progress was recognized toward Stage 4, attainment of goals.

► THE CONCEPTUAL BASIS FOR ALLIES AGAINST ASTHMA

Collectively, the leaders of Allies coalitions in the District of Columbia; Hampton Roads, Virginia; King County, Washington; Long Beach, California; Milwaukee, Wisconsin; Philadelphia, Pennsylvania; San Juan, Puerto Rico; and the Allies National Program Office (NPO) set about to introduce (or strengthen) community coalitions in seven sites across the country and to understand the processes and outcomes of entities devoted to asthma control through community-wide collaborative effort. Periodic joint meetings enabled the group to

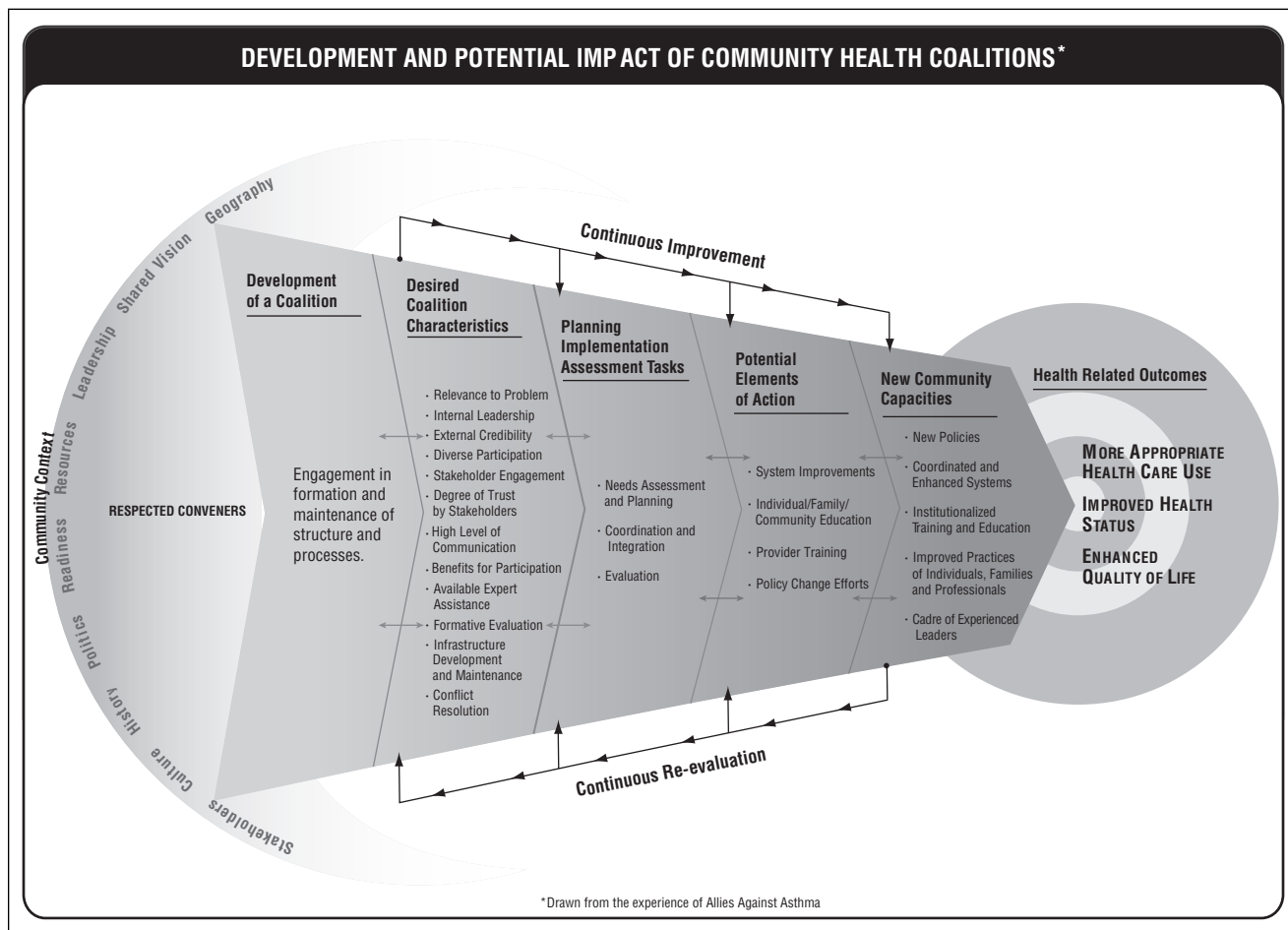


FIGURE 1

discuss processes and analyze data collected at intervals over time. Figure 1 provides a description of factors evident in the development and maintenance of an asthma community coalition and the anticipated outcomes of its work as experienced firsthand and understood by these observers. The coalitions' experience relative to these factors is explored below including the questions that surfaced during the program or in reflecting on the Allies experience.

Fitting the Coalition Pieces Together

Figure 1 depicts several elements that continuously interact to enable or prohibit coalition formation, functioning, and impact. The figure holds still for an instant the dynamic movement of many factors that are thought to contribute to success. However, it is important to acknowledge that it is only in the figure that elements are static. Each factor influences every other one continually and over time within the turbulent field

that constitutes any community. Nonetheless, it is likely that at given moments over the life of a community coalition, it is possible to get very rough measures of these factors. The articles to follow describe the factors from the view of community coalition leaders; wherever possible, data are presented to illustrate how they were manifest in Allies sites.

Community Context

A pervasive factor for any coalition is the collective characteristics of the community where it strives to do its work. A set of community characteristics provides a backdrop for the coalition's efforts and can either support or inhibit its success. It is, therefore, important for coalitions to pay attention to these characteristics, particularly during its formative stage. Questions for consideration should include: Are there agreed-on boundaries to the community, and is there a focus for participation and activity? How does geography affect

the community and what is possible to do? What are the types and number of stakeholders in the problem? In the case of asthma coalitions addressing the situation of children, these stakeholders can include parents, community organizations, health care providers and facilities, schools and preschools and/or day care centers, health departments, insurers, business and industry, and so on. If there are many stakeholders with strong interest, there may be greater ability to generate resources. On the other hand, many strong stakeholders might heighten the chance of competition and dissension. What is the social, political, and economic history of the community? Is there a history and culture of collaboration in the community or will the coalition be introducing the idea of cooperation and creating a new culture? What is the degree of trust among stakeholders? Are stakeholders in agreement about the problem and ways to resolve it? Are they ready to act? Is there a leader or leaders who have the confidence and credibility to move the coalition idea forward?

Respected Conveners and Development of a Coalition

An asset identified by Allies coalitions is the respected convener(s). Is there a respected person or agency seen by the community as important to resolving the problem and at the same time not closely associated with perspectives, factions, or authorities that are not trusted? For example, in one Allies site, a respected nonprofit health promotion council was able to bring hospitals, managed care organizations, and other service providers and organizations that had a long history of competition together with community organizations that had ideas about needed services. Through strong facilitation and relationship-building skills, the council provided a collaborative environment in which individuals representing competing organizations could put aside their institutional interests to act for the benefit of the community.

Additional questions that must be considered at the very initial stage of coalition development are whether a convener(s) can bring together stakeholders for sufficient time and with sufficient mutual support to form a new, inclusive organization. Can the stakeholders collectively develop a structure for the coalition, agree on a fiduciary, and formulate decision-making and other operating procedures?

Coalition Characteristics

The way in which a coalition operates is dependent on many factors, as is its success in reaching its goals.

There is a need for ongoing internal leadership. Members must have an adequate understanding of the magnitude and importance of the problem the coalition is addressing. An infrastructure for functioning must be developed and maintained. Credibility in the wider community and participation that is diverse and representative of the entire community must be engendered. Stakeholders' commitment to the mission must be elicited and maintained. Trust levels must be sufficient to enable real collaboration, and mutual benefit must be recognized. Communication must be adequate and benefits for participation clear. Expert assistance must be available and used as needed. Continuous feedback about the extent or level of these characteristics in a coalition is crucial to effective stakeholder engagement and commitment.

Planning Implementation Assessment Tasks

When optimal structures and internal procedures are in place and a coalition reflects the organizational characteristics of success, it can effectively move toward its goals. Careful planning that draws on the collective wisdom, experience, and skills of the stakeholders is necessary. Strategies to translate the plan into action are required. Ongoing evaluation and continuous feedback are necessary to continually refine and modify plans and strategies and/or put new ones into place. The added value of a community coalition is its potential to coordinate and integrate efforts across the community. These tasks require the full involvement and support of diverse members and underscore the importance of sound coalition structures and processes.

Potential Elements of Action

If the coalition can structure itself so that its processes are characterized by these attributes, it is positioned to facilitate action. Action can be in the form of coordination and integration of community services, establishment of programs or services, leadership in advocacy, or any other collective effort that moves towards the goal. With Allies, action was focused on making health care more coordinated and systematic community-wide; on providing children and families, as well as community-based organizations, with the skills to manage the disease; on training health providers to practice at the standard of care and support family management efforts; and on advocating for policy changes that would improve indoor and outdoor environments, ensure adequate provision of quality care, and direct resources to asthma control.

New Community Capacities

Should these actions be deemed acceptable and beneficial to the stakeholders and wider community, they can become institutionalized, that is, part of routine practice. Policies are changed; for example, in one Allies site, diesel trucks are no longer allowed to idle in poor neighborhoods. The health system is enhanced; for example, in another site, all health care facilities utilize the same diagnostic and referral protocols. Education and training for professionals and families are continuously available, for example, at hospitals, schools, and community centers and by professional associations. Practices of professionals, patients, and their families improve, and good asthma management becomes normative behavior for individuals and the community. Furthermore, developing and maintaining a community coalition and implementing action plans result in a cadre of leaders experienced in bringing about change and able to transfer those skills to new problems.

Health-Related Outcomes

These new capacities, over time, enable a community to reach its health goals. Better management of the disease leads to improved health status, more appropriate health care use and enhanced quality of life for, in this case, children with asthma, their families, and communities.

► A PRACTICAL LOOK AT THE MODEL

This supplement is devoted to an examination of how these elements fitted together (or did not) in the seven areas across the United States where Allies coalitions devoted themselves to achieving asthma control. The emphasis is on how the community context influenced coalition development, on how membership was involved in and assessed coalition processes and structures, and on the community-wide actions that were instituted and the capacities they were trying to strengthen. It is hoped that the comprehensive evaluation of the initiative, currently under way and described in an accompanying article, will contribute significantly to our understanding of the potential of community coalitions to address chronic diseases such as asthma.

As the articles in this issue illustrate, when people who do not generally come together work collaboratively to enhance community health, the challenges are many. On the other hand, as we think the following articles also demonstrate, the rewards are often even greater.

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