Arthritis Council
Comprehensive Site Visit Follow-up Workgroup

PARTNERSHIP SURVEY
Executive Summary - April 2008

A Noticeable Improvement: *What State Arthritis Programs Have Learned About Partnership*

Introduction

This survey was developed and conducted by the National Association of Chronic Disease Directors Arthritis Council. The Comprehensive Site Visit (CSV) Workgroup was established to provide a mechanism for follow-up to the recommendations of the Comprehensive Site Visit Report *(Pain, Aching, Stiffness, and Swelling: Growing and Sustaining State Arthritis Programs – Results of a Systematic Review of State Arthritis Programs Funded by CDC 1999-2005)*, which was released jointly by the Centers for Disease Control and Prevention Arthritis Program and the National Association of Chronic Disease Directors. This report summarized the progress of CDC-funded State Arthritis Programs from 1999-2005 by gathering information on the successes and challenges experienced by the programs. As a result of the information provided, facilitators and barriers to success were identified, as well as, lesson learned. The intent is that this valuable insight will be used by all state arthritis programs in future endeavors with partners.

A standard protocol was developed to address overall program status and ten component-specific activities that state arthritis programs are engaged in. The ten components are: funding; program operations and staffing; surveillance; advisory group; partnerships; state plan; interventions; program evaluation; public awareness and education; and policy development.

Of the ten components identified, a major facilitator, or barrier, of state arthritis program activity is partnership. Each one of the comprehensive site visits found that partnerships can propel program activities to success, or can stifle progress.

How states can use the information

The goal of the Arthritis Council CSV Workgroup at the onset of the Partnership Survey was to assist state arthritis programs in building, planning, and maintenance of successful partnerships. The majority of a state arthritis program's work involves the strategic placement of evidence-based programs into community settings and organizations, or systems, and is reliant upon strong partnership with those at the ground level of program delivery.

The Workgroup, which is made up of members of the Arthritis Council, agreed that a point-in-time survey of existing state arthritis programs would capture the characteristics of those on-the-ground partnerships. It is our desire that the survey results will be used by state arthritis programs and others to determine the next course of action, as well as, what hasn't typically worked when developing and strengthening their vital partnerships.

Survey instrument

The CSV Workgroup developed a questionnaire for state arthritis programs concerning the "successful partnerships" that are currently in progress. We wanted to know from each respondent what made the partnership successful, and what roles the partners assumed to make it successful. We also wanted to know what hasn't worked in the past and why. We purposely left the definition of "successful partnership" vague so that respondents did not feel pressured to conform their definition of success to a pre-determined measure.

The CSV Workgroup utilized its monthly conference calls to discuss, create, and refine the questionnaire until it was ready for distribution. The finalized questionnaire asked the respondents to think of 2-3 successful partnerships in their state and, for each, answer a series of questions. The questions, seven in all, asked about the nature of the partnership i.e. what aspects have made it successful, what are the common goals of the partners, what are the top challenges. We asked about time commitment and provisions at the onset of the partnership. The complete questionnaire can be found in **Appendix A**.

The questionnaire was distributed electronically via the Arthritis Council to its entire membership. It is important to note, that although there are only 36 CDC-funded state arthritis programs, Arthritis Council membership is open to all states and territories regardless of the funding source. Initially distributed late May 2007, we allowed four weeks for responses, which was extended by an additional four weeks to allow for absences due to summer activities.

Survey responses

CDC-funded state arthritis programs responded to the survey. Of the respondents, 17 reported on two or more partners. As responses were received they were entered into a table containing the seven questions, or survey components**.** For each state: successful characteristics; common goals; provisions at onset of partnership; what worked and didn't work; biggest challenges; amount of time commitment; and difference in roles when partner initiates activities were all record on the table.

Once all the responses were recorded, discussion of the survey results concentrated on the components and how to summarize them into succinct pieces of information. The Workgroup agreed that it did not want to limit the essence of what was translated from the original survey, and, therefore, was not concerned with the length of each summarized component. There wasn't a basic formula to follow when compiling information from the surveys. Therefore, this report has only general themes or

distinctions between public, private, and intra/interagency partners. The complete summaries of each component can be found in **Appendix B.**

It was also agreed upon that we would alter the identities of responding states when it was clear or obvious with whom the comment originated. The rationale for doing this was to shield respondents from the potential fallout from divulging sensitive information. The group felt this could be accomplished without changing or diminishing the intended response.

The workgroup noted that the majority of listed partners are either the State Unit on Aging or the Arthritis Foundation, with a fair number of intra-agency partnerships. Additional partnerships included: Regional Arthritis Centers; interagency collaborations; coalitions, networks, and consortiums; health service organizations; not-for-profits in addition to the Arthritis Foundation; and educational institutions.

Partners appear to fit one of two categories: *tier one* or *tier two*. *Tier one* consists of partners that appear to be "ideal" arthritis program partnerships i.e. partnership is thriving, shared goals and interests exist with little conflict. *Tier two* are the partners whose commitment may be determined by external factors and/ or is the "best that they have" in that particular state program. In this report, we offer some ideas and guidance to those with partners that fit into the *tier two* category using information gathered from the responses.

Summary excerpts

Summary of Successful Characteristics and Common Goals:

The most common characteristics of success included partners having shared goals, joint contribution of resources, and adequate communication. A similar target population was also identified as an important characteristic of successful partnerships. Each contributed to the partners' common goals of offering evidence-based programs, expanding program reach, and providing programs that help people with arthritis improve their quality of life. Physical activity for people with chronic disease and seniors were of particular interest.

Summary of Provision at Onset of Partnership:

The most widely reported provision at the onset of partnership was a contract between the two partners with specific requirements and reporting that was clear from the outset. This was followed closely by free training and classes and an in-kind donation of staff time, often by both parties involved. In-kind donation of space and services and free materials and equipment were equally reported. Funding was a provision for some at the onset of the partnership.

Summary of What Didn't Work and the Biggest Challenges:

Unclear partner expectations were identified as the primary reason for "why partnerships didn't work." Specifically, roles were unclear, partner provision of services was inconsistent, partners were "all talk, no action," partners were inflexible during crisis situations, and partners wanted their agendas to dominate. Limited staff and staff turnover was frequently cited as well as limited knowledge about partner organizations and issues surrounding evidence-based program implementation.

Limited resources i.e. staff and funding for all partners were identified as the "biggest challenge" facing the majority of respondents. This was followed by the effort required to maintain a good partnership, issues surrounding evidence-based program implementation, data issues, and management.

Summary of Amount of Time Involved in Project and How to Keep Partner Involved at Project End:

All respondents reported spending a significant amount of time developing and nurturing partner involvement both during a specific activity or project and during the times when activity is dormant. The majority of time is spent communicating with partners through various means. A little more than half of the respondents (16) reported that roles vary according to the partners' capacity, the activity at hand, and/or the availability and source of funding for an activity or project. However, almost half (11) reported that partners' roles remain consistent despite the variables.

C**onclusions**

Appendix C of this summary is a table comparison of the facilitators and barriers identified for the Comprehensive Site Visit Report and the Partnership Survey. Although almost identical, it should be noted that the Partnership Survey results are more detailed in nature; possibly denoting a deeper understanding of the facilitators and barriers first identified by the Comprehensive Site Visit Report. Over the course of two years, it can be determined that the state arthritis programs have applied the recommendations and the lessons learned from the Comprehensive Site Visit Report. This is apparent in a variety of ways: the understanding of the importance of staffing consistency, and support from higher levels, at both the state and partner organizations; the delicate balance of adequate communication with partners; the matching of similar missions and values to the work of the state arthritis program; and the vital importance of role clarification and what that entails for each individual partnership. Most importantly, to be successful, a partnership takes dedication and effort.

Based on the results of the survey, the Workgroup concludes that there have been several dynamics set into motion since the Comprehensive Site Visit Report. The one with the biggest impact is the Administration on Aging (AoA) Evidence-Based Disease Prevention Program grant; a three-year funding cycle that began in 2006. Of the 36 CDC-funded state arthritis programs when surveyed by the Arthritis Council, 11 are either moderately or heavily involved in the activities of this initiative, which is jointly managed by the State Unit on Aging and the State Health Department in each state. The

mandated focus of each state project is the implementation of the Chronic Disease Self Management Program, one of the evidence-based programs in the State Arthritis Program toolbox of approved programs.

Prior to the AoA initiative, the only federal level agency promoting the Chronic Disease Self Management Program to its grantees was the CDC Arthritis Program. When the AoA initiative commenced, many of the state arthritis programs spearheaded the effort along with their aging counterparts. Many more were included in the active planning of the state's progress. This was all a as a result of the experience and expertise of the state arthritis programs in the implementation of evidence-based self-management programs, specifically the Chronic Disease Self-Management Program, which was included in the the toolbox after the completion of the Comprehensive Site Visit Report.

State arthritis programs were quickly elevated to a level of partnership rarely seen in the past. The dynamics surrounding partnership changed at an equally fast pace. Roles between the two main partners were identified, agreed upon, and written into the workplan based upon the perimeters of the grant. Although, there have been quirks and challenges along the way, this arrangement has helped the state arthritis programs tremendously in role clarification between them and their partners, both current and future.

Another dynamic that changed during the period between the Comprehensive Site Visit Report and the Partnership Survey was the state arthritis programs' own role clarification. The CSV was the impetus to sharpening program direction, with a clearer focus on the expansion and system-wide implementation of specified evidence-based self-management programs like the CDSMP.

As mentioned earlier, the *Tier One* partners, like the State Units on Aging, fit snugly into this honed program focus. The grant requirements narrowed the agency focus to concentrate on the evidence-based programs; the same as the state arthritis program, and workplan activities and role descriptions were crystal clear. However, this also allowed for better collaboration with *Tier Two* partners; those that didn't fit quite as comfortably and who developed due to variables exclusive of AoA funding and directives.

Lessons learned from the implementation of the AoA initiative can, and have been, applied to other partnerships, both long-standing and new. Responses from the Partnership Survey identified ways that state programs have dealt with the challenges of successful and productive partnerships. Things such as common missions and values, adequate communication and various communication methods, Memorandums of Understanding, contractual commitments, providing in-kind support and partner recognition, and entering into the partnership on a long-term basis and not just to complete specific activities are all partnership building strategies highlighted by the state programs.

Although the responses of the Partnership Survey are only a snapshot in time, they highlight the breadth of the progress made by state arthritis programs in this area.

Coupled with the facilitators and recommendations of the Comprehensive Site Visit Report, the knowledge and experience gained from the Partnership Survey can be used to identify, develop, and nurture current and future partnerships.

APPENDIX A

Dear Arthritis State Program Coordinator:

The Arthritis Council Comprehensive Site Visit (CSV) Outcomes Workgroup is interested in learning about the mechanics of your successful partnerships. For those of you that participated in the CSV during 2004-2005, some of these questions may seem repetitive; however, please note that we want to learn from each of you in this critical area. Our intent is to:

- Collect this information and compile it into helpful "partnership fact sheets" for the state arthritis programs AND,
- Provide relevant feedback to our funding source on the topic of partnership-building.

1. Please think of 2-3 successful partnerships in your state. For each partnership, please answer the following questions.

PARTNER 1:_____

a. What aspects of the partnership have made it successful and how?

b. What are the common goals shared by the partner and your program?

c. What did you and your partner provide to develop the partnership i.e. in-kind, funding, contract/MOU, etc? Please list.

d. What didn't work with the above partnership and why?

e. What are the top three biggest challenges that you face when dealing with the partner and why?

f. For those partnerships that are actively involved with a project, what is the amount of time the project usually lasts? How do you keep the partner involved after the project ends?

g. Are the roles that you and your partner assume different when the partner approaches the state arthritis program with a collaborative idea? If so, how (please be specific)?

PARTNER 2:_____

a. What aspects of the partnership have made it successful and how?

b. What are the common goals shared by the partner and your program?

c. What did you and your partner provide to develop the partnership i.e. in-kind, funding, contract/MOU, etc? Please list.

d. What didn't work with the above partnership and why?

e. What are the top three biggest challenges that you face when dealing with the partner and why?

f. For those partnerships that are actively involved with a project, what is the amount of time the project usually lasts? How do you keep the partner involved after the project ends?

g. Are the roles that you and your partner assume different when the partner approaches the state arthritis program with a collaborative idea? If so, how (please be specific)?

PARTNER 3:_____

a. What aspects of the partnership have made it successful and how?

b. What are the common goals shared by the partner and your program?

c. What did you and your partner provide to develop the partnership i.e. in-kind, funding, contract/MOU, etc? Please list.

d. What didn't work with the above partnership and why?

e. What are the top three biggest challenges that you face when dealing with the partner and why?

f. For those partnerships that are actively involved with a project, what is the amount of time the project usually lasts? How do you keep the partner involved after the project ends?

g. Are the roles that you and your partner assume different when the partner approaches the state arthritis program with a collaborative idea? If so, how (please be specific)?

2. In your opinion which takes more time and effort, identifying and establishing new partnerships or maintaining already established ones? Why?

APPENDIX B

Arthritis Council Partnership Survey

Question A: What aspects of the partnership have made it successful and how?

Summary of Successful Characteristics

- Shared goals (16)
- Communication (7)
- Joint contribution of resources (7)
- Target population (6)
- Statewide presence (5)
- Funding from partner (5)
- Funding from arthritis program (4)
- Personal relationships, established trust, previously developed working relationship (4)
- Strategic thinking, problem-solving approach (3)
- Capacity of partners to provide needed expertise (3)
- Shared focus on evidence-based programs (3)
- Willingness to collaborate (2)
- Opportunity to build on existing efforts (2)
- Mutual understanding of each organization's operations, functions and needs (2)
- Success in achieving goals (2)
- Training capacity for evidence-based programs (2)
- Flexibility (1)
- Shared ownership (1)
- Mutual partners (1)
- Clear delineation of roles (1)

Question B - What are the common goals shared by the partner and your program?

Summary of Common Goals

- Expand program reach – includes all programs (12)
- Provide evidence-based programs (10)
- Provide programs that help people with arthritis improve quality of life (10)
- Promote physical activity, particularly for people with chronic disease and older adults (6)
- Provide activities to promote healthy aging for older adults (6)
- Provide programs for low income populations (5)
- Raise awareness among people with arthritis and other chronic diseases of the importance of self-management activities (3)

- Reach and meet the needs of older adults (3)
- Reach rural communities (2)
- Educate legislators and other key stakeholders about arthritis and it's impact
- Improve quality of health care practice for people with arthritis (2)
- Enhance and strengthen surveillance and monitoring of arthritis and chronic disease (2)
- Increase awareness about impact of arthritis (2)
- Assist with medication costs for people with arthritis (1)
- Increase awareness of the availability of programs for people with arthritis (1)
- Increase awareness among health professionals of the importance of chronic disease self-management (1)
- Keep elderly in their own homes longer (1)
- Provide programs for adults at risk for chronic diseases and conditions (1)
- Increase program sustainability (1)

Question C - What did you and your partner provide to develop the partnership i.e. in-kind, funding, contract/MOU, etc. Please list.

Summary of Provision at onset of partnership

Free training and classes (13)
Reach data (3)
Strategic planning partnership (3)
Funding (7)
Funding training (4)
Contracts (14)
Grants (3)
MOU's (4)
In kind donation of staff time (11)
In kind donation of space and services (9)
Free materials and equipment (9)
Conference calls
Site visits
Communications and access to website (2)
Support partner events
Partners provide knowledge of community for site selections
State program provides contact information for potential partners
TA (5)
Identified rural locations to conduct workshops (2)
Participation in arthritis coalition (4)
Recruitment for Evidence based program
State program and partner provided funding for MT training sessions
Marketing

Question D - What didn't work with the above partnership and why?

Summary of "What Didn't Work/Why?"

(7) No Problems Identified
- Not Applicable (N/A)
- Have a good relationship
- Still Determining
- Evaluation strategies failed
- New partnership

(2) Funding

Limited Funding

Confusion with how to use CDC Funding

(8) Staffing

Limited Staff
- Staff overwhelmed
- May have problems when staff goes on maternity leave

Staff Turnover

Takes time to build trust

Learning the best ways to work with new staff is time consuming

Contact person for partnering organization doesn't live in the same state.

(12) Partner Expectations

Roles unclear

Grant said one thing but different factors i.e. funding availability, training workshops, changed the order of implementation causing disorder and frustration

Partner wanted to brand the program as their own. Eventually, agreed with the intervention of a steering committee member.

Partner had same objectives but had their own agenda which was to promote them. Name recognition was important to them because it meant dollars and cents for them in the long run.

Inconsistencies of provision of services

Partner took on leadership role but failed to meet partner expectations that embraced collaborative goals when opportunities available – all talk, not action

Partner Inflexibility esp. in time of need

Not all local programs equally committed to projects

(3) EB Programs

- ❖ Inability to get necessary Paperwork Completed/Signed
- ❖ Programs are too long in duration
- ❖ Contracts not read, unaware of obligations before signing i.e. time to administer programs
- ❖ Limited awareness of CDC approved EB Programs

(3) Limited Knowledge about Partner Organizations

Not knowing enough about Partner Organization e.g. mission, goals, staff

Being unsure limits the degree to which we can collaborate or integrate our services/programs

Who is in charge? Leadership?

Initially, moved too fast. Needed time to understand how each approached doing business, priorities of each organization. Had to step back to better understand each others "worlds."

(1) Statewide Contract

Progress reports weren't occurring on a regular basis.

Areas with the greatest need not a focus

Initiating and developing relationships in these areas not occurring

Sustaining existing relationships in these greatest needs area not a priority

(1) Partner lacked organizational support for collaborative partnership

(1) Past history – individual experiences, agency attitudes

Question E - What are the top three biggest challenges that you face when dealing with the partner and why?

Summary of "Biggest Challenges"

(3) No challenges

New Partnership

Not enough Resources for all partners (2)

(7) Funding

Must provide inkind when possible

No financial flexibility to increase expectations in contracts

Lack of funding to facilitate request for services and thus reduction in communication also noted

(13) Staff

Limited staff time

Partners can't devote FT attention to arthritis programs w/o funding
Staff Turnover
Not enough volunteers/staff --- they want to know, what's in it for me
EB programs are small portion of staff work, many other responsibilities
Time commitment to implement EF at new sites
Requests to commit more staff time than what was originally agreed upon in grant

(1) Time to meet with partners.
Due to contact partner person location limits convenience with face-to-face meetings.

(2) Lack of Awareness/Understanding about arthritis - lupus

(1) Consideration of other factors i.e. farming to maximize implementation success

(9) Maintaining a good Partnership
Defining/Clarification of Roles
Connecting with Partners
Communication
Working with one organization that has multiple chapters and dealing with different corporate cultures
Lack of Trust – possibly centered on possible lack of future funding
Replicating models that have been successful to other networks – promotion improving

(2) Promotion
Presenting Arthritis/EB Program Information
Not getting enough time to present
Would like to present information in the main body of the presentation rather than at the end
Still working with partners i.e. AF to convince them to address arthritis public health issues at their annual conferences

(6) Data
Emphasizing the Importance of Data
Importance of Data gathering i.e. Team Approach
Obtaining Accurate Reach Data – staff is spread thin to take on this task to the best of their ability

(1) Inability to obtain results from volunteers

(2) Geographical Location

(3) Money/Costs
Costs not consistent with supplies, etc.

Funding – unsure how much is necessary to carry out scope of work

Had difficulty understanding that grant money had to spent on specific program and if funds left over, they couldn't spend on other things unrelated to program
Movement of Money – how to expedite the efficiency of flow from Fed to Local Levels

Timing – fiscal years are different from those of some partners, planning projects proven difficult as a consequence

(1) Evaluation of needs and how they can be met

(3) Expectations
Partner must bill for their time and there isn't any reimbursement for these programs
Setting up programs that can't be sustained in the long run – programs offered free, no money after grant/private $ gone

(2) EB Programming nor Arthritis a Priority
Making EB programming a priority for the Partner
Program not a high priority to Partner
Some partners only interested in only a few health priorities, arthritis isn't on that list yet

(3) Resistant to Change
Don't understand evidence-based programming
Don't understand their role and how it relates to the bigger health picture

(1) Partners not comfortable working beyond their established parameters in the community

(5) Management
Dealing with the team to get things done
Remaining organized so as to be timely with responding (with deliverables)
Remaining flexible to respond to recommendations
Maintaining a balance between internal projects and meeting project deadlines
Responding to changes in leadership

(8) EB Programs
Liability with EB programs
AF Paperwork Requirements
Where are the leaders and programs geographically (hoping Team Approach will be helpful)
Finding new partners
Convincing partners the importance of providing physical activity programs at least two times a week (fidelity)

(4) Communication

est. monthly conference calls, face to face too difficulty
Maintaining an open line of communication
Willingness to share challenges/barriers as well as successes
Facilitating communication between partners difficult so all may remain up-to-date with the latest programming details using websites, etc.

(2) Lack of Awareness about Partner Organization

Not knowing enough details to more effectively collaborate so as to integrate services/programs.

Understanding the organizational structure/policies of partners – may be reluctant to take a stand on the issue to benefit the consumer

(1) How to keep the interest of org leaders/program managers so they will increase their willingness to take the lead on some aspects of process.

(1) Some counties must go through different channels to use grant money, MOUs will not work in this partner's system. Adapting to new processes delays program implementation.

(1) Territorial issues between partners within the same organization

(1) Trust

(1) Leadership

(1) Disorganization

(1) Past history – partners have been exploited by state grantees/contractors, poor role delineation, weak collaboration, confusion regarding organizational priorities

Question F - For those partnerships that are actively involved with a project, what is the amount of time the project usually lasts? How do you keep the partner involved after the project ends?

Summary of Amount of Time Involved in Project/How to Keep Partner Involved at Project End

Communication/ Time Commitment (25)

1. Maintenance of programs/instructors is ongoing using a variety of methods such as:

A. Quarterly newsletters, site visits, recognition at annual meeting, development of interpersonal relationships, and other opportunities to network in the same circles (19).

1. Monthly advisory meetings
    a. keep partners in the know
    b. ongoing work is for a specific reason
        - Trainings, planning the annual meeting, or time intensive mini-grants then the focus remains clear and work becomes regular.

2. Partnership building activities last years whereas projects last months (6).
    - The former includes both formal and informal communication and includes making the partner a member of the Coalition group and active participation at various Coalition-based meetings.

3. For some, statewide coalition or advisory meetings are a way of establishing the upcoming year's work or foci. Meeting summaries guide the next year's activities/projects. Sustainability discussions start almost immediately as to how to continue programs/ activities when funding ends.

4. If both partners are located in the same office/ location, then it's less time consuming to sustain as compared to if their physically separated from each other.

Partner capacity changes (7)

1. Dependent upon the project/ activity, some may last weeks, months, or years.

A. Partners jump in and out of projects depending on what their needs are. New, time-limited

B. Partners may be brought to the table by well established and committed partners to participate in a specific project for a limited time.

C. Requires ongoing communication and editing of documents, etc.

D. Partner recognition is a necessity from a thank you to formally listing them in a finalized document and then providing them with a supply of their own.

E. Involve partner in a decision making capacity within the Coalition.

F. There is constant preparation for renewed or new funding cycles and having a partner waiting in the wings to commence work (dependent upon funding for many).

Oversight and care of multi-year projects (3)

1. Renewal of contract and/or continued payment of program instructors. For some, contract renewal is based upon implementation of a different EBP, rather than continuing to fund same program. This creates need for partner to find new resources to sustain the current program(s).

    A. Continue to replenish and supply course materials to the ongoing programs (sustainability) while trying to expand reach into new locations and organizations

    B. Ongoing partnership some times involves shift in project/ task focus especially as the state program becomes more defined and goes beyond just the completion of projects and activities to becoming ingrained in the partner's annual workplan.

Question G - Are the roles that you and your partner assume different when the partner approaches the state arthritis program with a collaborative idea? If so, how (please be specific)?

Summary of How Roles May Differ When Partner Initiates Activities

Roles vary (7)

1. Roles vary depending on the project but if it was their idea then they usually take more responsibility in the planning and execution of it.

2. It depends on which program makes more sense at that time. Sometimes the lead partner is whoever has more time to devote to the project/program.

3. The state program notes that, compared with other partners, state health units have a much more hands on approach with the project especially when local partners are involved.

4. When working with other state programs, all share responsibility to participate in health fairs. There are times when some pitch in extra funding for projects that will benefit all such as strategic planning.

Roles differ (4)

1. The [partner] has a different focus than the Department of Health. We do our best to support them, but we are working hard to work within the scope of the CDC grant.

2. The focus of the outcome may be different i.e. fundraising as opposed to expanding programs.

3. The state arthritis program has such a narrow focus that it is difficult to identify how to assist partners that can't or won't implement the self-management programs. Other partners want assistance in implementing an education program for the general public or provide an educational program for physicians and we can not provide much assistance in those areas.

4. The arthritis program is so limited in what it can do as far as interventions that can be promoted and implemented. It is difficult to provide support either through technical assistance or financially for other programs that are beneficial for people with arthritis if it is not an approved intervention. We are working at different ends of the continuum.

Roles consistent (11)

1. All project partners knew what their roles were when they started the partnership.

2. All ideas are respected and considered.

3. We have a true opportunity-based collaboration built around our shared vision of the [EBP].

4. Roles do not differ because entire partnership is approached with a collaborative idea. They then decide whether it's viable at the time.

5. We are equal in the decision making in how we direct our efforts state-wide, based on the requirements of the CDC grant.

N/A (4)

1. Length of time as a partner hasn't been long enough
2. They haven't asked for anything

Funding (5)

1. The state program makes sure that funding wasn't the only reason for the partner's outreach and/ or the state arthritis program acknowledges that it's about the funding for the partner but finds a different reason for itself to get involved (by focusing on expansion and reach).

2. Typically when a partner approaches the state arthritis program with a collaborative idea they are looking for funding. However, because [most partners] are dedicated to the best use of existing resources and reduced fragmentation within service delivery systems, they are more inclined to suggest possible collaboration on a project that is a modest undertaking not requiring a huge commitment of resources.

3. The [partners] had an idea for this project by considering DOH obesity data for African-Americans. The enthusiasm and focus made it clear to the arthritis program mgr that her primary role was to eliminate as many barriers as possible by ensuring funding was available, and checking in with relevant partners to show continuing interest.

In-kind (3)

1. Opportunities such as these allow for the possible development of new partnerships
   A. Presentations at statewide conferences
   B. Internship placement for graduate students
   C. Arthritis speakers and exhibits

Collaboration (2)

1. Collaborative ideas evolve from the Coalition. This allows for the idea to be brought forth to the Arthritis Program from a group and not an individual organization. It has worked well since the statewide coalition is stable and comprised of many different stakeholders.

2. Working collaboratively on several projects w/ a shared goal of increasing evidence-based programs for seniors. We want to expand programs i.e. reach, number and type

3. The partner would not have approached DOH with a collaborative idea b/c they do not have a perception of themselves as a PH ally. However, because of their localized and specific identity, the partner was an excellent fit for [another partner], which translated its mission and purpose to fit the partner's commitment to community service. It was these initial "hooks" that enabled the partnership to form and grow.

Other

1. They ask us to offer our expertise in an area rather than to "fill in the blanks"

2. It is a much more mutually beneficial relationship rather than the arthritis program always asking for something

Question unclear (2)

Appendix C

	Comprehensive Site Visit Report	Partnership Survey
BARRIERS	Lack of role clarity for activities	√; may be exasperated by new staff coming on board mid-point
	Changes in leadership and staff turnover	√
	Lack of interpersonal skills to maintain partnership	Balancing communication so that it is adequate and not too much/little
	Limited time, funding, and staff to invest in finding and maintaining partnership	√
	Partner views the state health department as being in control of all things	How to best replicate models that work
	State program and its major partner have different expectations from the partnership	√; may also have different priorities, needs, and organizational requirements
		Geographical distance between partners; territorial disputes
		All aspects of program recruitment
		Lack of [planning for] program sustainability
		Clear understanding of the term "evidence-based" and what it entails
FACILITATORS	Partner and state program has overlapping visions/missions	√ emphasize commonalities; thorough comprehension of evidence-based and program fidelity
	Partners meet each others' needs to help achieve missions	√ by providing coordination to the "big picture"; providing specialty i.e. training, recruitment, TA, on-the-ground experience; shared mailing lists; sit on each others advisory boards; collaborate on variety of activities; work off partners' strengths
	Partners participate with both monetary and in-kind support	√ in-kind support includes: sharing office space; identifying program sites and target populations; printing; staff time
	Partners have mutually supportive relationship	√ established, trusted, and time-tested relationships; frequent communication
	Credit for successes is shared	√ this can be accomplished by: highlighting results at annual meeting
	Roles for partners are clearly defined; they may overlap but are complementary	√ MOUs, contracts, Letters Of Understanding, mutually agreed upon deliverables
		Partner has a large network capable of reaching the target population

APPENDIX D

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