Rural Grass Roots Coalitions: A Study of the Relationship Between Resources and Sustainability in Eliminating Health Disparities

by

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Abstract

Studies show that health disparities are the end result of culturally ingrained health related practices. There exists a need for multisectorial involvement which directs interventions upward from the areas of greatest need. Community coalitions are self organized groups composed of socially active individuals from within the community who possess the power to create community change, particularly as it relates to change in behaviors that contribute to health disparities. The efforts of these rural grass roots coalitions mirror countless efforts worldwide among indigent and third world populations seeking to improve quality of life as well as gaining access to much needed health care services for their community. This study focuses on the work of four rural grass roots coalitions in the Black Belt region of the United States whose purpose is to eliminate health care disparities among their constituents.

This study seeks to determine processes that sustain the efforts of rural grass roots coalitions. The Community Coalition Action Theory (CCAT) was used to identify coalition processes that are most effective in creating competent sustainable community coalitions. The objectives of this study are to (1) discover how rural community coalitions identify, access and mobilize resources to eliminate health disparities in their community; (2) link founding documents, organizational structure and budget with service provision strategies developed by these organizations; (3) determine the scope of approaches aimed at community advancement through interaction with various stakeholders; and (4) examine the outcome evaluation processes, subsequent responses, and their impacts on organizational longevity.

Data collection methods included observation at coalition meetings, survey administration, review of minutes from coalition meetings, internet search, review of coalition documents, interviews with key informants, and researcher experience in the area.

Results show that each coalition is viable, and each provides its constituents with the needed strategies and techniques to reduce or eliminate health disparities in this rural black belt county. Additionally, CCAT is an effective mechanism for identifying coalition characteristics related to potential for success.

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CHAPTER I. INTRODUCTION TO THE PROBLEM

Introduction

Over the last 20 years, coalition building has become a prominent intervention employed in communities across America. Coalitions provide opportunities for community organizations and interested persons in related fields with a chance to work with whole communities and to better understand how to create and enhance community change. According to Wolff (2001), a reflection on the past two decades of community coalition building, there are many questions to be answered about this phenomenon. They include: Why has there been such an upsurge in community coalition building activity? What is the impact of this activity? What have we as students of community learned? What are the questions that we need to be asking to improve the effectiveness of coalition building efforts and their evaluation?" (p. 1).

A community coalition is a group that involves multiple sectors of the community, and comes together to address community needs and solve community problems (Berkowitz & Wolff, 2000). The criteria generally used to label a collation a community coalition include: the coalition be composed of community members (individuals and/or groups); it focuses mainly on local issues rather than national issues; it addresses community needs, and seeks to fill these needs by building community assets; it helps resolve community problems through collaboration; it is community-wide and has representatives from multiple sectors; it works on multiple issues; it is citizen influenced if not necessarily citizen driven; and it is a long-term not ad hoc coalition.

Since many different community phenomena are called ‘coalitions’, one could clearly argue for expansion or contraction of any of the above criteria. In most communities and in the scholarly literature the definition of coalitions is at least, evolving and gaining clarity.

Positive Impact and Characteristics of Community Coalitions

Community coalitions have many significant attributes that allow them to be an effective vehicle of community change. Numerous communities have used coalitions to mobilize resources for successful resolutions of emerging problems. Communities have been able to impact programs, practices and policies related to a very broad range of issues including economic development, low income housing, substance abuse, tobacco control, domestic violence, racism, deteriorating neighborhoods, violence prevention, and toxic environments (Roussus & Fawcett, 2000).

There are several unique characteristics associated with effective community coalitions:

1. Community coalitions are holistic and comprehensive. The holistic approach allows coalitions to address issues that are considered high priority. These coalitions are not impeded by funding constraints. The comprehensive aspects are well illustrated by the Ottawa Charters (1986) definition of the prerequisites of help underlying many healthy community coalitions: peace, shelter, education, food, income, a stable ecosystem, sustainable resources, social justice and equity.

2. Community coalitions are flexible and responsive. They address emerging issues and modify their own strategic plan in response to new community needs.

3. Community coalitions build a sense of community. McMillan and Chavis (1986) suggest that this sense includes “a feeling of belonging, a feeling that members matter to one another and to the group, and a shared faith that members needs will be met through their

commitment to be together". These coalitions build up existing communities by creating a forum for solving local problems. Often the coalition is one of the few places where diverse members gather to meet, exchange information and solve problems. Members frequently receive personal and professional support for their participation in the social network of the coalition.

4. Community coalitions build and enhance resident engagement and community life. Putnam (2000) noted the decline of civic engagement and the resulting loss of social capital (i.e., connections among individuals — social networks and the norms of reciprocity and trustworthiness that arise from them). After documenting this decline, Putnam called for the revival of civic engagement. Community coalitions can be a structure used to "re-weave the fabric of communities". Coalitions often become forums where multiple sectors and citizens engage with each other to address local concerns.

5. Community coalitions provide a vehicle for community empowerment. Zimmerman (2000) defines an empowered community as "one that initiates efforts to improve the community, responds to threats to quality of life, and provides opportunities for citizen participation". These efforts can be focused on an internal problem using local resources, or on external institutions and forces. In both cases, coalitions may use a variety of techniques to create change (e.g., advocacy and confrontation). As community coalitions successfully address and solve problems at the local level, they build social capital and hope by demonstrating the capacity of local residents to have an impact on their community.

6. Community coalitions allow diversity to be valued and celebrated as a foundation for the wholeness of the community (The Boston Foundation, 1994). As American communities become increasingly diverse, there are increased tensions reflecting prejudice, racism and inter

group conflict. Coalitions provide an opportunity to bring together various components of the community to identify common ground and goals.

7. Community coalitions are incubators for innovative solutions to large problems facing not only the community but the nation as a whole. Blackwell and Colemenar (2000) noted that local social entrepreneurs are creating innovative solutions to problems and are "pushing government and more established institutions to think differently about how to create opportunities, achieve equity and improve lives". Local leaders with broad vision, commitment and experience in building communities are solving our most difficult challenges. In fact, they are considered national leaders. Thus, because the world needs to know about these leaders and their work, they need bigger platforms to function as national leaders.

Reasons for the Creation of Community Coalitions

The forces and influence that have fostered the recent widespread appearance of community coalitions across the country are numerous. They include: (1) expanding the interventions to the whole community, (2) devolution of services from the national to state and local levels and cutbacks in human services, (3) doing more with less; (4) limitations of the health and human service systems; and (5) increased civic engagement. In addition, in recent years federal legislation has tied local program funding to requiring the locality to submit evidence of local citizen or group involvement in programs operations.

The creation of community coalitions was one of many responses to the increasing decline in civic engagement (Bradley, 1998; Lappe & Dubois, 1994; Putnam, 2000). Before the rise of coalitions, the key institutions in local communities struggled alone with the same problem — alienation of their constituencies. The schools worked to engage parents, churches to involve parishioners, politicians and to get out the vote, and police created community policing.

All aimed at reconnecting with their core constituents. There was increased pressure to create settings where constituents could regain ownership over their local institutions and communities. Coalitions became a vehicle for this by focusing on re-engaging all sectors of the community with a emphasis on addressing local problems. The National Civic League, a national organization deeply committed to increasing civic engagement, recognized this potential and became the first national sponsor of the Healthy Community movement as one way of creating the desired change.

One can see that community coalitions are potentially powerful forces for creating community change. They allow citizens and others in the community to understand the whole community and learn ways to potentially improve the quality of life in the community. The significant questions raised by the work of community coalitions are as important as their impressive results. From the viewpoint of practice, it is necessary to determine which approaches will be most effective in creating competent community coalitions; however, the internal and external variables that effect the development of these coalitions are enormous. Therefore, trying to bring coherence to the vast experience of communities is a significant challenge. Questions of research and evaluation pose similar challenges. The complexity of the interventions, the spread of the community sectors engaged and the reluctance to become involved in the evaluation process have created barriers to developing comprehensive evaluation strategies for coalition interventions, the spread of the evaluation pose similar challenges

Statement of the Problem

Healthcare disparities are costly and devastating, and they have had a negative impact on the quality of healthcare services in the United States, and particularly in the Black Belt region of the southeastern United States. Disparities in service provisions, access, and quality have been

acknowledged by policy makers for many years. Reducing health disparities for African Americans with any number of chronic illnesses presents a great challenge to healthcare professionals. These challenges are due to a range of environmental and socio-economic factors. The growing concern over finite resources and the sustainability of life through the efficient, effective, and equitable use of resources has affected the community at all levels. These concerns are the catalyst for this research, and these disparities can be addressed at the community level through the work of these grass roots community coalitions, especially through the application of the Community Coalition Action Theory.

Purpose of the Study

The purposes of this study are to (a) discover how rural community coalitions identify, access, and mobilize resources to eliminate health disparities in their community; (b) link founding documents, organizational structure, and budget with service provision strategies developed by these organizations; (c) determine the scope of approaches aimed at community advancement through interaction with various stakeholders; and (d) examine the outcome evaluation processes, subsequent responses, and their impacts on organizational longevity. The study will also test the utility of applying Community Coalition Action Theory (CCAT) to the analysis of the operations of rural community coalitions, and it will use the results of the analysis to inform the coalitions studied of ways in which they might strengthen their coalitions and their work.

Significance of the Study

There is a need for continuous excellence in coalition work, using the Community Coalition Action Theory (CCAT), to help eliminate health disparities in all local communities. This study has special significance to those connected to the health care industry and policy

makers because of current economic, environmental, and social issues. First, it will determine how coalitions work to eliminate health disparities and improve the quality of life in a rural context and do so in one community, a Deep South Black Belt county, which like such counties throughout the South is composed of mainly poor African Americans. Secondly, this study will provide supplementary research-based information on how well CCAT can be used to describe and evaluate rural community coalitions and their work. Finally, the research findings will be shared with the coalitions studied with the goal of assisting them to improve their chances of successful goal attainment.

Research Questions

The major research questions that will guide the study are:

1. What is a "health disparity?"

2. How useful is Community Coalition Action Theory (CCAT) for guiding research on community coalitions in the rural context and for assessing a coalition's effectiveness?

If CCAT is a useful tool, it should lead to answers to the following questions.

a. How do rural grassroots coalitions identify access and mobilize resources to eliminate health disparities in their communities?

b. Do founding documents, organizational structure, budget and service provision strategies developed by the coalition's link to the elimination of health disparities?

c. What are the outcomes of the evaluation process used by the coalitions, subsequent responses, and their impacts on organizational longevity?

d. Which of the four coalitions as they are now organized and operating are most likely to succeed in their goals? Why?

Limitations of the Study

The scope and character of this study will be limited in the following ways. They are as follows:

1. The data involved in the study will be taken from four local coalitions working within one county. This will limit the generalizability of the results, but as the literature review will indicate, community context is important to coalition formation, operations, and outcomes. The similarity in socio-economic and political characteristics will facilitate comparison of the groups.
2. The coalitions studied are relatively young; so, evaluation of long-term outcomes will not be possible.
3. Materials used in this study are limited to a survey of assessment of resources to promote sustainability, interviews with the coalition leaders and members, copies of the minutes of the three meetings from each coalition, and orientation materials.

Definition of Terms

The following terms will be used in the literature review and other sections of the dissertation.

Asset mapping: Asset mapping is a strategic method of increasing available community capacity by identifying unknown but existing assets in a community (Robinson, 2003).

Baldridge Criteria: Baldridge criteria are a measure employed by a diverse array of organizations and industries to reflect quality focused based on seven areas (e.g., leadership, information analysis, strategic planning, human resource development and management, business, customer focus, and customer satisfaction (Arcaro, 1995).

Coalition: A coalition is a flexible organization compromised of volunteers that have a greater collective strength or voice than individuals or individual organizations. These organizational structures may consist of individuals or groups at local, county, state and national or international levels. Coalitions are considered an emerging vehicle of choice for health promotion. It is an organization of organizations or a group of groups or individuals that voluntarily come together and combine their resources to collaborate to achieve health or public policy outcomes (Krakauer, Crenner, & Fox, 2002; Roberts, 2004; Rudd, Goldberg & Dietz, 1999).

Community advancement: Community advancement is both a process and product that includes problem-solving, community building, and systems interaction. Community may include a geographic element or collections of persons engaged with shared or diverse perspectives on a common issue. Advancement can encompass development from an industrial or economic perspectives as well as the capacity of people to work collectively and extensively in addressing their common needs and interests. The process of community advancement grows out of societal responsibility coupled with local action of working toward a goal (Wise & Andrews, 1998).

Devolution: Devolution is a form of decentralization which has been described as a transfer of power from the central government to lower levels of government, and is seen as responsible for bottom up communication (Yuliani, 2004). Devolution is an interestingly delicate balance of challenges and opportunities, benefits and consequences for states (Gold, 1996). Democratic renewal or self-governance can be a primary focus of change in the devolution of central governmental authority to state and local government communities (Himmelman, 1997). In support of the concept of sustainability, one segment of devolutionist

concern with sustainable economic healthcare resources, argued that each generation should produce enough financial resources to sustain itself through old age and long-term healthcare, relieving the federal government and future generations of such involvement (Brown, 1999). Both evolution and decentralization are seen to have characteristics in common with the concept of multi-sectorial approaches and strategies to eliminate health disparities. The three terms devolution, decentralization and sustainability are often tied together with some authors using them interchangeably.

Disparities: Disparities represent inequalities in the quality of life for segments of the population and are considered a national problem. They reflect inequities in the quality and delivery of services and affect healthcare at all points in the delivery process, at all sites of care, and for all medical conditions (National Healthcare Disparity Report [NHDR): Summary, 2004). Inequities can exist in both minority populations (e.g., African Americans and Hispanics) and geographically defined groups such as rural residents.

Founding outcomes: Founding outcomes are operationally defined as written strategies for sustainability, survival, and growth, which provide focus, boundaries, and performance goals. Operationally they include a statement of mission, vision, and goals. Lack of documented outcome strategies have been attributed by Sidhu (2004) as the primary cause of organizational frustration and failure. Further, such strategies are thought to contribute to better performance in that they improve internal and external analysis, timely detection of threats and opportunities while facilitating the development of appropriate strategic responses.

Health: Health is the state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity (World Health Organization: FAQ, 2006).

Health disparities: Health disparities are defined as "differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific duration groups in the US" (Health Disparities Interest Group (HDIG), 2006).

Organizational longevity: Organizational longevity is the length of time the organization, or in this case the coalition is together before it evolves into another type of entity. Reasons for change may be numerous such as effective problem resolution, and grant funding. Kerell, (2000) writes that organizational longevity implies that the organization is alive and there is a concern with what makes a living thing live or last longer. The most common factors that impact longevity are: (1) the internal workings of the organization, and (2) the organization's interaction with the environment.

Participatory action research: Participatory action research is a research orientation that is empowering and driven by community priorities, systematic, participatory, and orientated towards community and social change. It nurtures community strengths and problem solving abilities. It represents ground up rather than top-down approaches (Milkner, 2000).

Priority populations: Priority populations include low income individuals and those experiencing a worsening of poverty, hunger, ill health, literacy, and/or deterioration of the ecosystem processes (Agenda 21, 1992); racial and ethnic minority groups (e.g., as African Americans, Asian and Asian Pacific Islanders, Hispanic and Latino, Native Americans and Native Alaskans) (Grady, 2000); women; children; the elderly; individuals with special health care needs, the disabled, and people in need of long-term care, people requiring end-of-life care, in place of residence (e.g., rural communities) (National Healthcare Disparity Report, Summary, 2004).

Resources: Resources are conceptualized as synonymous with capital. Most resources are considered tangible, actual and potential. The contextual definition of the term resource is an asset that enhances or provides advantage to the quality of life for a situation. Assets are viewed to add to the long-term net worth. Resources are also viewed to impact sustainability. Conversely, sustainability is determined by resources. Resources may be identified from documentation that clearly defines focus, goals, missions and organizational processes such as collaboration; adaptive/action learning assessment of problems; evaluation of process: cycle repetition for subsequent decisions; reporting; interconnections—visible and invisible—in which day-to-day choices affect the intricate balance of social, economic and ecological systems, knowledge or language used by external reporting frameworks. Human resources may be considered the greatest resource of an organization and include actual members/constituents with their identified abilities and interests. Other resources include local and national professional memberships, professional and issue networks, connectivity, and in-kind services, meeting space, and information or constituent knowledge which may be either or both traditional or scientific (Anderson et al., 2006; Global Reporting Initiative, 2002; Sternin, 2007; Sustainability Leadership Institute, 2008; Taylor-Ide & Taylor, 1995; Tsu, 2006). Some resources are intangible but also important to sustainability and longevity. Reputation is a prime example.

Sustainability: Sustainability is conceptualized as continued meeting of the needs of the present generation in areas such as healthy economic, environmental and/or social existence, life, longevity, evolution, and adaptation (Overview: WSSD, 2002), without compromising the ability of future generations to meet their needs (Sustainability Leadership, 2008).

CHAPTER II. LITERATURE REVIEW

Introduction

This review of the literature explains what a "health disparity" is, the constructs and propositions related to community coalition formation, structure, and process. Also, it examines relationships of founding documents and sustainability, relationships of community advancement to sustainability, relationships of organizational longevity to sustainability, theorist influences on participatory action, sustainability indicators, and summary. All are related to Community Coalition Acton Theory (CCAT) which will also be examined.

Health Care Disparities and Sustainability

With the launch of Healthy People 2010 in January 2000, the Department of Health and Human Service (DHHS) committed the nation to an overarching goal, to "eliminate health disparities." Like the preceding Healthy People 2000 initiative, Healthy People 2010 outlines a comprehensive disease prevention and health promotion agenda. Although this goal has met with considerable support throughout the nation, upon further examination, it is clear that the term "health disparity" has been used with a number of very different meanings. Since the scope of the eliminating disparities goal for the DHHS Initiative the Eliminate Racial and Ethnic Disparities in Health is narrower than that of Healthy People 2010, discussion of the two goals in the same context can lead to confusion.

Disagreements exist regarding the definition and use of the terms "disparity," "inequality," and "inequity." These disagreements center on which term to use, whether a

judgment of what is avoidable and unfair is included, and how these judgments are made. These conflicting views have implications for resource allocation and reflect differing political ideologies. Sometimes the term "disparity" is used interchangeably with terms such as "racial/ethnic differences in health. "Those who work in public policy often refer to social class or racial/ethnic health disparities as "inequities," using the term as shorthand in describing differences between better-and worse-off groups (Pokras, & Baquet, 2002).

Concern for the relationship between resources and sustainability and the implications of grassroots significance was made apparent during the 1992 United Nations Conference on Environment and Development in Rio de Janeiro. According to the American Planning Association (2003), the disparity in per capita income between the richest and poorest nations rose from 30:1 to 78:1 during 1960 to 1994. Today, we are confronted with intractable inequities in resource distribution which is reflected in the worsening of poverty, hunger, ill health, illiteracy and continuing deterioration of the ecosystem (Agenda 21, 1992). According to the 2004 National Health Disparities Report (NHDR), those experiencing disparities in health care include racial and ethnic minority groups (i.e., African Americans, Asian and Asian Pacific Islanders, Hispanics, Native Americans and Native Alaskans) (Grady, 2000); women, children, the elderly, individuals with special health care needs, the disabled, people in need of long-term care, people requiring end-of-life care, and people living in rural communities (NHDR, 2004). The historic solution to poverty, economic growth, has generally served to exacerbate inequities, while degrading the resources upon which all life depends (American Planning Association, 2003)

In 1972, the first world conference on the environment focused on economic, environmental, and social interactions as global concerns for the relationship between resources

and sustainability (Overview: WSSD, 2002). The term "sustainable" was introduced during the 1987 United Nation's World Commission on Environment and Development in the Brundtland Report. This report stated that "humanity has the ability to make development sustainable-to ensure that it meets the needs of the present without compromising the ability of future generations to meet their needs" (Sustainability Leadership, 2008, p. 1).

In the United States, the first effort to quantitatively identify health disparities was "The Hackler Report," the result of research conducted by the Department of Health and Human Resources (DHHR) from 1983 to 1985 (Clancy, 2006; NHDR, 2005). This initial report was based on an analysis of national mortality data for more than 40 disease categories from 1979 to 1981 (Center for Disease Control and Prevention, 1986), and is the foundation for the commitment of national resources to not only measure disparities, but to discern why they occur and how they can be eliminated. In 1999, Congress passed Public Law 106-129, the Healthcare Research and Quality Act, in response to research findings of numerous public and private professional organizations focused on quality of health services. This law directed the Agency for Healthcare Research and Quality (AHRQ) to develop two annual reports, a National Healthcare Quality Report (NHQR) and the NHDR (NHDR: Summary, 2004). The directive for the NHDR requires that this annual report track "prevailing" disparities in health care delivery as they relate to racial factors and socioeconomic factors in priority populations. The NHDR reveals disparities in the ability of Americans to access health care as well as in the quality of health care (NHDR: Summary, 2004). Several studies show that viewing health disparities as a population concern rather than an individual concern minimizes inherent biases that contribute to cultural insensitivity (Brown &Swanson, 2003; Kagawa-Singer & Blackhall, 2001; Krakauer, Crenner & Fox, 2002).

The federal government is the largest purchaser and provider of healthcare services in the United States, and oversees employer-based health care coverage, ensuring fair competition in the health care market (Quality Interagency Coordination Taskforce, 2001). Provision of healthcare services is via the "patchwork" safety net system (e.g., Medicaid, and Federal Employee's Health Benefits Plan) which lacks uniformity and structure (Safety Net Monitoring Initiative, 2003; Wilson & Kizer, 1997). Financial resources allocated to health care are increasing at a dramatic pace and show no possibility of slowing unless changes are made in the current focus and delivery of health care services in the United States. Healthcare disparities equate to problems in quality and include a wide variation in health care services, under use and overuse of some services, and an unacceptable level of errors. The lack of access to quality health care services contributes to disparities in health care (President's Advisory Commission, 1998).

The 1992 United Nations' conference on sustainable development activated international, government, political, and nongovernmental communities to work for a global partnership (Agenda 21, 1992). This partnership required integrated sustainable programs that responded to the diverse needs of communities and individuals (Gold, 1996; Himmelman, 1997; Kingsley & Gibson, 1999; Taylor-Ide & Taylor, 1995).

Multi-sectoral approaches to sustainable solutions involve a combination of complementary approaches, joining different functions and activities (Taylor-Ide & Taylor, 1995). These approaches are influenced by factors such as the availability of resources, time, and needs of those involved (Reed, Fraser, Morse, & Dougill, 2005). With a multisectoral approach, the largest challenge is for leaders to relinquish their power in order to enable others to find their own solutions (Marsh, Schoreder, Dearden, Sternin, & Sternin 2004; Sternin, 2007).

Taylor-Ide and Taylor (1995) suggested that social mobilization should start with national leaders; however, its sustainability will depend on society's continued participation.

Sustainability indicators provide a plan for public policy. These indicators also emphasize significant social, economic, and environmental problems and provide a means to measure the efficacy of programs designed to improve these problems. Literature focused on developing sustainability indicators belongs to either the reductionist or participatory methodological paradigm (Bell & Morse, 2001). The reductionist paradigm is associated with the development of universally applicable indicators. The participatory paradigm is based upon a bottom-up, participatory philosophy, which focuses on the importance of understanding the local environment. According to Bossel (2001), the participative process is essential to community involvement from the grassroots perspective. Community involvement will assure inclusion of the community's spectrum of knowledge, experience, and mental models of social and environmental concerns. Use of the participative approach to data collection ensures a comprehensive indicator set and viable performance measures that simultaneously reflect an understanding of the challenges of a particular environment.

Sustainability monitoring should be an ongoing learning process for communities and researches. Local involvement is considered essential to ensure that indicators are dynamic and evolve over time as goals are met or circumstances change (Reed et al., 2005). In addition, the rationale for a community-led process is based on theories of social motivation and participatory action research (Taylor-Ide, Daniel, & Taylor, 1995). In order to deliver these benefits effectively, indicators must be relevant to the local community, and the methods used to collect, interpret, and display data must be easily and effectively used by non-specialists (Reed et al., 2005).

Taylor-Ide and Taylor (1995) identified tools and methodologies which describe criteria or indicators that reflect sustainability: Self Evaluation with Essential Data (SEED), Participatory Rural Appraisal (PRA), and Rapid Assessment Procedures (RAP). Baldridge criteria provides a systems perspective for understanding performance management. The criteria reflect validated, leading-edge management practices against which an organization can measure itself. The National Health Care Disparities Report (2003) includes criteria on client demographics such as age, education, income of clients, insurance status, and disease focus. Asset mapping criteria may include data on individual or organizational skills or service-related areas where development or learning is desired (Mapping Assets, 2002).

Sustainability includes becoming aware of all interconnections—visible and invisible—in which daily choices affect the balance of social, economic, and ecological systems. Measurement of progress toward sustainable development has become widely and globally adopted as a foundation of public policy and organizational strategy (Global Reporting Initiative [GRI], 2002). The general objective of such assessment or measurement of progress is to improve knowledge about the potential impact of policy or programs, inform decision-makers and affected people, and facilitate adjustment of the proposed policy in order to mitigate the negative and maximize the positive impacts (Gothenburg Consensus Paper, 1999). The interest in and trend toward the global reporting initiative has been fueled by government interest in sustainability reporting through broadly defined and accepted performance indicators, rising visibility and expectations for organizations' performance, and measurement of progress toward sustainable development (GRI, 2002). Development of a sustainability report notifies an organization of difficulties and unanticipated opportunities while at the same time, enabling

communication between organizations in such areas as actions taken, outcomes of actions, and future strategies (GRI, 2002).

In order to impact social, economic, and environmental resources in a positive manner, all members of the community must participate (Clancy, 2006; NHDR: Summary, 2004). Active participation by the grassroots community is essential to successful behavioral change because, unlike outside researchers, community members know what will and will not work from a cultural and behavioral perspective.

Demographics, rising health care costs and the existence of other growing health care disparities are evidence that traditional means of providing for health care needs in this country have not produced efficient, effective or equitable outcomes. In response to these disparities, national leaders are lessening their use of the traditional top-down approach to policy determination. Instead, they are empowering communities affected by the disparities to make important decisions. Many communities have responded by uniting and self-organizing at the grassroots level, forming coalitions that work to participate in finding effective, measurable ways to eliminate health disparities.

Relationship of Founding Documents and Sustainability

There is limited data related to variables such as founding documents, community advancement, and organizational longevity associated with smaller grassroots organizations in rural or limited access environments. Most of the available data is found in the business literature, particularly in the area of small and medium-sized enterprises (SME's) and in environmentally focused literature.

Founding documents are operationally defined as written strategies for sustainability, growth, focus boundaries, and performance goals. The number one cause of organizational

frustration and failure is the lack of a statement identifying the competitive boundaries of the organization (Sidhu, 2004). This statement may contribute to better organizational performance because it improves competitor analysis, allows timely detection of threats and opportunities and aids in the development of appropriate strategic response. A study by Sidhu (2004) showed the comprehensiveness of the strategy planning process and strategy context and concluded that firms with a written business-domain statement had significantly higher performance.

O'Gorman and Doran (1999) replicated and earlier study by Pearce and David (1987) that focused on mission statements from companies listed in *Fortune 500* magazine. The performance of these SME's was studied in terms of the existence of the mission statement and components determined in the earlier study to be indicative of high performing organizations. The results of this study showed that only 58% of the companies had a written mission, statement. O'Gorman and Doran concluded that owners/managers of smaller firms might choose to communicate their vision for the organization through direct interaction with employees rather than through a mission statement. The centralized and direct management style of many small business managers may reduce the necessity for employees to understand the organization's mission.

A study by Kirkpatrick, Wofford, and Baum (2002) measured motive imagery contained in the vision statement. Results of this study showed that although vision is a central concept in leadership theory and has been shown to impact performance, empirical studies have coded vision statements in non-comparable ways. These results also identified studies that showed no relationship between vision attributes and performance or outcome variables. However, their research identified two existing datasets that identified actual vision statements and performance.

Kantabutra and Avery (2003) focused on the relationship between visionary leadership and organizational performance, particularly in SME's. Their study showed only 51% (56 of 110) of stores reported having a vision implementation plan, and only 15 of these 56 stores reported needing additional resources for the implementation of their vision. Again, company size was a factor for the non-existence of vision implantation strategies.

Relationship of Community Advancement to Sustainability

Bozeman's (2003) research on value mapping focused on publicly funded scientific research and concluded that social outcomes and transformations are often promoted by science. The social impacts of scientific research is poorly understood because satisfactory tools for understanding the areas of sustainable social impacts as well as useful guideposts for managing their occurrence do not exist and are rare, repetitively. Bozeman (2003) used the conceptual tool of Public Value Mapping (PVM) to develop a systematic understanding of multiple determinants of social outcomes. This tool is applicable to any large-scale, public scientific mission. Key variables in PVM include social goals, missions, viability of strategies linking and mobilizing actors and individuals and human, organizational, and financial resources. PVM acknowledges diverse contributions from "knowledge value collective", such as resource providers, developers, entrepreneurs, equipment producers, suppliers and vendors, interest groups, advocacy groups, and consumers. Each of these contributors simultaneously produces knowledge, using it or enabling its use and translating the knowledge into social impacts. Bozeman concluded that knowledge embodied in human beings is of a higher order than disembodied knowledge contained in formal sources.

Agrawal (2002) analyzed and examined numerous case studies of successful common-pool resource (CPR) governances. Study results showed that national governments in most

developing countries have resorted to the use of local-level common property institutions to decentralize the governance of the environment. Regularities in successful management pertain to one of four sets of variables: (a) characteristics of resources, (b) nature of groups that depend on resources, (c) particulars of institutional regimes through which resources are managed, and (d) nature of the relationship between a group and external forces and authorities such as markets, states, and technology.

Villalonga (2004) used the Resource-Based View (RBV) in his investigation of the donation of resources that results in a sustained competitive advantage over time. This study acknowledged the importance of intangible resources (e.g., physical and financial assets) as the key to sustainability. This study defined intangible assets as accumulated consumer information, reputation and corporate culture, capabilities, core competencies, and knowledge. Study findings suggest that intangible assets can also be a disadvantage. Nonetheless, the RBV predicts that an increased number of intangible resources gives an organization a sustained competitive advantage.

Theorist Influences on Participatory Action

Writing in 2002, Butterfoss and Kegler described an emerging interest in how community coalitions work to address current and future health issues. Their Community Coalition Action Theory (CCAT) evolved as an attempt to increase the understanding of how community coalitions function. They noted that the practice of coalition building has outpaced the development of coalition theory. The CCAT evolved through a combination of disciplines based on the assumption that people must learn the skills needed for community approaches to problem solving. Participation research focuses on reasons why people choose or choose not to participate. Inter-organizational relations studies focus on why organizations join collaborative

efforts, while the balance between acquiring resource and reducing uncertainty is the focus of resource dependence theory. Institutional theory focuses on attempts to achieve legitimacy. Political science focuses on power distribution, potential conflict and negotiation (Butterfoss & Kegler, 2002). Butterfoss and Kegler also used case studies of coalitions to inductively develop the theory which has been expanded over the years. (See Butterfoss and Kegler [2009] for the most recent rendition.)

With regard to health promotion, community organizations generally focus on changing systems, rules, social norms, or laws, in order to ultimately change the social acceptability of certain behaviors. A change in policy is usually involved and often requires involvement of community elected officials, business, community groups, the media, and local and state legislatures in order to create positive changes in the community.

CCAT differs from Community Based Participatory Action Research Theory (CBPR), because CCAT focuses on the work of the community coalition itself. CBPR, on the other hand, focuses on the equity or relationships between an academic institution and the community with a research goal/purpose. CCAT actually looks at the community coalition where it is. It emphasizes a recycling of stages, resource development, structures and processes and the outcomes of the work processes of the coalition. Although academic institutions in many instances are either the convener group or the lead organization in supplying resources to a coalition, their role in CCAT is not essential. However, both stress the need for broad based community involvement.

The CCAT is composed of a set of constructs and propositions. (The number of propositions has varied between 20 and 26 as the theory has been refined.) Together, these constructs and propositions build a rationale for CCAT. Table 1 presents the propositions.

Table 1

Community Coalition Action Theory Propositions[1]

	Stages of Development
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.
2.	At each stage, specific factors enhance coalition function and progression to the next stage.
	Community Context
3.	Coalitions are heavily influenced by contextual factors in the community (history of collaboration, geography, politics, and economics) throughout all stages of coalition development.
Formation Stage	
	Lead Agency/Convener Group
4.	Coalitions form when a lead agency or convening group responds to an opportunity, threat or mandate.
5.	Coalition formation is more likely when the convening group provides technical assistance, financial or material support, credibility and valuable networks/contacts.
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.
	Coalition Membership
7.	Coalition formation usually begins by recruiting a core group of people who are committed to resolve the health or social issue.
8.	More effective coalitions result when the core group expands to include a broader constituency of participants who represent diverse interest groups, agencies, organizations and institutions.
	Operations and Processes
9.	Open and frequent communication among staff and members helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely.

(table continues

Table 1 (continued)

10.	Shared and formalized decision-making processes helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely.
11.	Conflict management helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely.
	Leadership and Staffing
12.	Strong leadership improves coalition function and makes collaborative synergy more likely through member engagement and pooling of resources.
13.	Paid staff make collaborative synergy more likely through member engagement and pooling of resources.
	Structure
14.	Formalized rules, roles, structures and procedures improve collaborative functioning and make collaborative synergy more likely through member engagement and pooling of resources.
Maintenance Stage	
	Member Engagement
15.	Satisfied and committed members will participate more fully in the work of the coalition.
	Pooled Member and External Resources
16.	The synergistic pooling of member and external resources prompts comprehensive assessment, planning and implementation of strategies.
	Assessment and Planning
17.	Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur.
	Implementation of Strategies
18.	Coalitions are more likely to create change in community policies, practices and environments when they direct interventions at multiple levels.

(table continues

Table 1 (continued)

Institutionalization Stage
Community Change Outcomes
19. Coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes.
Health/Social Outcomes
20. The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.
Community Capacity
21. By participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues.

[1]Source: Table 2 in Butterfoss and Kegler (2009).

According to CCAT, coalitions progress through three stages: formation, maintenance, and institutionalization. As new issues arise or as planning cycles are repeated, a coalition may regress to earlier stages (Propositions 1–2) each stage is impacted by community-related factors such as the sociopolitical climate, geography, history and norms surrounding collaborative efforts (Proposition 3). The community-related factors can and will change with time and impact the coalition and its operations at all three stages of development. They may also force the coalition back to an earlier stage of development if the changes are not handled properly.

During the formation stage, a convener or lead agency with given strengths and linkages to the local community unites core organizations with the aim of recruiting community members to initiate a coalition effort focusing on a health or social issues of concern (Propositions 4–8). Structural and process elements in the coalition help to ensure a positive organizational climate, an engaged coalition membership, and the pooling of member and external resources

(Propositions 9–14). Frequently, the convener organization is the initial supplier of resources to the coalition supplying staff and financial support.

The maintenance stage involves sustaining member involvement and creating collaborative synergy (Proposition 15), mobilizing and pooling member and external resources (Proposition 16), and comprehensive strategies to identify and adapt evidence-based interventions that are appropriate for the local context and that have the greatest chance of leading to the desired health or social outcomes. Completing the cycle involves acquisition of resources, combined with engaged coalition members and a comprehensive and multi-level planning and implementation process, which leads to changes in community policies, practices and environments (Propositions 17–18). A successful maintenance stage is a precursor to the final stage of coalition development which is institutionalization. In the institutionalization stage, if resources have been adequately mobilized and strategies effectively address an ongoing need, coalition strategies may become established in a community and demonstrated through improvement in health/social outcomes (Proposition 19–20).

Progress in maintenance and institutionalization stages can potentially increase the capacity of local organizations to apply these skills and resources to address additional issues that resonate within the community (Proposition 21). Butterfoss indicates that not every organization will experience every proposition and construct. For example, some coalitions never reach the institutionalization state. Rather they will remain in maintenance or be cycling between maintenance and formation stages as they deal with changing community contexts, loss of members, and other issues.

Much of the literature on the involvement of grassroots coalitions in health disparities (including CCAT) fit what Wayne Parsons' (1995) labels the natural history of social problems.

Social problems occur in three distinct non-linear stages: awareness, policy determination, and reform. During the awareness stage, equality and quality in health care services and outcomes are threatened. In the policy determination stage, debates on the best policy options result in a decision to include grassroots contributions as a part of the strategies aimed at eliminating disparities. During the reform stage, policies are put into action. Action research theorists support this study of the role of organizational processes and resources of rural grassroots coalitions in eliminating health disparities that affect their community. Coalitions are defined as "flexible trans-structural organizations made of volunteers that have a greater collective strength or voice than do individuals or individual organizations" (Roberts, 2004). These organizational structures may consist of individuals or groups at local, county, state, national or international levels (Childress, 2005; Chinman, Anderson, Imm, Wandersman, & Goodman, 1996; Murnighan, 1978; Phillips 2000; Roberts, 2004; Stevenson, Pearce, & Porter, 1985; Weible, Sabatier, & Lubell, 2004).

Parsons' natural history of the development of social problems can be applied to research focused on the involvement of grassroots coalitions in addressing health disparities. However, the reform stage, in which policies are put into action, is non-linear. The motivation of grassroots organizations to become active participants in the reform stage is the core function of the rural coalition. It is this stage that requires participation by multiple levels of the community and government.

The Schambert-Hollings "survival and catastrophe" life cycle supports the current approach to action research, because it challenges people to encourage healthy renewal in the face of a potential catastrophic collapse of existing systems caused by perpetual disparities.

Limited resources induce a change in behavior and practices at all societal levels, which is needed in order to maintain human sustainability as long as possible (Homer-Dixon, 2007).

Rose's (1993) lesson drawing theory allows generalization from experiences in global areas of limited resources. This demonstrates that active participation by community residents, as well as organizations which comprise a coalition, produces positive changes in behavior. Information gathering, such as in depth inquires, community norms studies, and community vetting is used to identify the transferable behaviors and enabling factors that account for a good outcome (Marsh, Schroeder, Dearden, Sternin & Sternin, 2004).

The next chapter will describe the research methodology employed in the study and describe how Community Coalition Action Theory will be used in the analysis of four health care focused community coalitions. It also identifies the major data sources that will be use in the analysis.

CHAPTER III. METHODOLOGY

Design of Study

This chapter examines the methods and procedures used in collecting, analyzing, and interpreting the data for this study. The discussion of the methodology includes (a) a statement of the research questions, (b) information on the population, (c) the rationale for the section of the population used in this study, (d) methods of data collection, and (e) the sampling techniques.

Research Questions

The major research questions that will guide the study are:

1. What is a "health disparity?"
2. How useful is Community Coalition Action Theory (CCAT) for guiding research on community coalitions in the rural context and for assessing a coalition's effectiveness?
3. If CCAT is a useful tool, it should lead to answers to the following questions.
    a. How do rural grassroots coalitions identify access and mobilize resources to eliminate health disparities in their communities?
    b. Do founding documents, organizational structure, budget and service provision strategies developed by the coalitions link to the elimination of health disparities?
    c. What are the outcomes of the evaluation process used by the coalitions, subsequent responses, and their impacts on organizational longevity?

d. Which of the four coalitions as they are now organized and operating are most likely to succeed in their goals? Why?

Information on Population

CCAT indicates that specific factors in the community may enhance or inhibit formation coalition function and influence how the coalition moves through its stages of development. One prime factor identified was history of collaboration. Other factors included politics, social capital, economic situation, trust between community sectors and organizations as well as community readiness.

Community Context

The study focuses on four grassroots coalitions located in a single county situated in the Black Belt (BB) region of the southeastern United States. All four coalitions seek to eliminate health care disparities impacting citizens of the county. The Black Belt region is one of impoverishment. Due to promises of anonymity given those interviewed and surveyed for the study, the county name and the names of the coalitions have been masked in the discussions that follow.

The county included in this study has a rich history of innovation and the ability of its people to overcome seemingly insurmountable obstacles. However, for the past two or three decades, many earlier gains have been lost and the county has seen a decline economically as well as in primary and secondary education. The county is one of eighteen Black Belt Counties in one southern state. Further, this county is just one of more than 600 counties found in parts of Virginia, the Carolinas, Georgia, Florida, Alabama, Mississippi, Tennessee, Louisiana, Arkansas, and Texas that contain greater levels of poverty than the Northeast, Midwest, or the Western regions of our nation (Morris & Wimberley, 1997).

The county has as its county seat a city with strong historical legacy. Due to this legacy the sample county particularly at the county seat has a higher number of college educated individuals than many of the surrounding areas in the county and in surrounding Black Belt counties. In addition the strong historical legacy often results in equating the county with the county seat. A neighboring Black Belt county about forty miles away contains the state capital. For the sample county, there are three major employers consisting of the educational system K–12, one Historically Black College or University, and one federal health care facility. Many professionals that work in the county at the health care facility and the university choose not to live in the county. As a result they do not contribute to the property tax collections. Because of state law, there is no county or city income tax.

This sample county was chosen due to accessibility. This researcher works in the health care field and has contacts within a variety of health related groups that work within the county.

Work being done by the rural grass roots coalitions in the Black Belt of the United States, mirrors countless efforts worldwide among indigent and third world populations seeking to improve the quality of life and access to much needed health care services for their community. This study which focuses on the processes employed by these four coalitions as they identify and access resources for sustainability will give voice and insight to the processes that may enhance a more fruitful journey through the stages of formation, maintenance and institutionalization.

Sample Population: Four Rural Grass Roots Coalitions

The four rural grass roots coalitions in this study describe themselves as being self-organized community groups which identify their services as having a health-related focus. The shareholders of these coalitions consist of individuals with many characteristics of the priority population described in the NHDR. They reside in rural communities, with a population that is

predominantly African American, low income, elderly, and women and children with special, chronic and catastrophic healthcare needs. For example, their clients suffer from heart disease, cancer, stroke, chronic lower respiratory disease, diabetes and Alzheimer's disease at rates higher than the general population. They are often disabled, cannot work, and are in need of long-term health care. Many of the individuals require end-of-life care with limited access to medical services. Many of the illnesses are long term or chronic and affect populations who live in persistent poverty to a greater degree than affluent populations. The residents of the Black Belt county also share common traits with at-risk or priority populations described by the national health care disparity report. Table 2 presents the demographic and health disparity information for the county, the state, and the Black Belt region of the state. It shows the county to be similar to the other Black Belt counties within the state and at a disadvantage when compared to the state as a whole.

Table 2

Sample Black Belt County Demographics

	Sample Black Belt County	State—2007–2008	Average of Black Belt Counties in State
Percent non-White,	82.8	29.1	58.11
Percent White	15.3	68.4	40.59
Median household income	27,011	40,596	29,109
Percent persons below poverty	29.6	16.6	26.68
Percent Medicaid births	67.3	49.5	65.6
Divorce rate	1.7	4.4	3.08
Marriage rate	4.5	8.7	8.2

(table continues)

Table 2 (continued)

	Sample Black Belt County	State— 2007–2008	Average of Black Belt Counties in State
Life expectancy at birth	73.2	75.3	73.9
Number/percent under age 5, 2007	18.7	23.8	24.6
Percent under age 18	21.7	24.3	24.8
Percent of people 25 years and over who have completed a bachelors degree or higher, 2000 & 2008	22.8	13.3	21.5
Percent under age 20	27.9	26.9	27.5
Percent 65+	15.2	13.5	14.6
Death rate from heart disease	309.6	259.4	322.6
Death rate from cancer	269.2	217.8	242.3
Death rate from stroke	71.8	60.4	69.7
Death rate from chronic lower respiratory disease	35.9	58.4	48.6
Death rate from Diabetes	26.9	29.6	36.9
Rate of physicians per 10,000 population	4.5	19	7
Rate of licensed hospital beds	90.4	59	86.3
Rate of licensed nursing home beds	200	27,299	232

Sources: 2009 [State Name] Population Data Sheet and 2010 [State Name] Health Data Sheet and Census Information, prepared by the Center for Demographic Research.

2009 [State Name] Kids Count Data Book, U.S. Census Bureau, Census 2000 Summary File 3, and U.S. Census Bureau, 2006–2008 American Community Survey.

Selection of the Coalitions

The oldest of the four coalitions provided services of education of a preventative nature and participated in many community functions. It was selected because of its high visibility in

the community. Inquiry was made of several members of this coalition and other health care informants knowledgeable of health related activities in the county. Each coalition selected for study was referred or mentioned by several individuals — either these initial contacts or those individuals they referred me to who represented organizations that were members of the coalitions. The four coalitions selected in this manner will be referred to as Black Belt Community Coalition, Black Belt Cancer Coalition, Black Belt Parish Nurses Coalition, and the Black Belt Diabetes Coalition.

Methods of Data Collection

Prior to the collection of data for this study, permission was obtained from the Auburn University Institutional Review Board or IRB (Appendix A) and directors from the coalitions were contacted. Data for this research was collected through face-to-face interviews with the four coalition directors or their designees to request permission to secure additional data for the study. Directors were asked for permission to address a coalition meeting at which the researcher requested that those present answer a short survey and such meetings were scheduled. During the discussions with the directors, they were asked to supply the following information about their organization — founding documents, membership information, orientation materials (e.g., electronic information and/or training materials, formal classes, written literature), and the minutes for at least the three meetings occurring after initial administration of the survey instrument. The minutes were used to ascertain a description of current activities of the coalition. A review of orientation materials supplied by the coalition leadership were used to determine what each coalition considered essential new knowledge for each new coalition member to have in order for them to make adjustments and share in the mission of the coalition.

Initial meetings of the four coalitions were scheduled. Three of the four coalitions had face-to-face meetings, whereas, the fourth coalition held teleconferenced meetings. Attendance at the initial meetings ranged from 5–12 participants. The researcher remained in the room while participants completed the survey. Meetings were not tape recorded; however, notes were taken if questions or discussions were generated.

The researcher requested agenda placement for a second meeting during which the survey tool might be administered and collected. The goal was to administer and collect the survey on the same day. Because coalitions only had monthly and quarterly meetings, those present at the first meeting requested that the survey tool be left with the coalition leader for distribution or e-mailed to other participants. Permission was requested to be able to contact coalition members in order to see if survey tools had been received within seven days. Surveys were delivered by the coalition leadership via electronic mail, regular mail with self-stamped addressed return envelopes, or hand delivered.

Each coalition received the survey printed on different colored paper. This color coding was used as the means to differentiate survey responses between coalitions. Participants in this IRB-approved study were informed of their rights as research participants. All surveys were stored in a secured location and kept confidential.

In all fifty-one printed or electronic surveys were distributed to potential respondents. Thirty respondents (59 %) provided useable responses and are included in the analysis. There was some overlap in coalition memberships, and one respondent was a member of all four coalitions.

The survey instrument (Appendix B) was designed to assess resources to promote sustainability. The survey questions were based on the Baldridge necessary criteria for quality

performance (Baldridge, 2008). Questions were grouped into seven areas of focus: organizational structure, budget, stakeholders, and relationship to organizations outside of the coalition, relationship to government, new members, and outcomes. These areas were addressed using a combination of nominal, categorical, ranking, and narrative items.

Organizational structure questions assessed coalition member knowledge of processes and resources from the perspective of the organizations foundational tenants, purpose, goal, and mission. Budget questions assessed financial knowledge of processes and resources using questions related to funding and tax status. Stakeholder questions identified the knowledge of processes, resources, and needs of internal and external constituents. The survey also included questions related to the processes and resources used to maintain sustainability and obtain political voice via relationships with organizations outside of the coalition. The survey included two questions related to the knowledge of processes of relationships to governmental/political organizations. New member questions assessed organizational method and processes for matching potential resources with existing need. Questions related to outcomes and evaluation assessed whether resources had been effectively used to affect changed behavior.

Finally, an Internet search was conducted for information on each coalition and its work including media coverage. The variety of data collected allowed for triangulation of sources during data analysis.

Analysis of Data

Microsoft Excel version 2003 was used to manage and analyze the data collected. Analysis of data gathered used the CCAT as a guide, identifying the cycling and or transition through the three stages, while simultaneously applying the constructs and propositions. Table 3

presents in summary form the main indicators used to connect the data collected to the CCAT materials. The propositions listed are taken from Butterfoss and Keigler's 2009 work.

Table 3

Major Indicators for CCAT Propositions and Associated Data Sources

Major Category of Coalition Examination and Related Proposition(s)	**Indicators Associated with Coalition Effectiveness**	**Data Sources**
	FORMATION STAGE	
Lead Agency/Convener Group		
Coalitions form when a lead agency or convening group responds to an opportunity, threat or mandate.	Founding documents should identify: 1. issue/threat/ opportunity/mandate (e.g., law; grant requirements) that lead to coalition formation; 2. convening agency, group or individual	Founding documents Community knowledge
	Members should have knowledge of: 1. founding issue, threat, or opportunity; 2. convening agency, group or individual	Survey Q. 1C
Coalition formation is more likely when the convening group provides technical assistance, financial or material support, credibility and valuable networks/contacts.	Type of convener supplied resources at initial	For all indicators:
	Convener locale – external or internal to local community	Founding documents Community knowledge
	Convener tie to local networks/contact	Founding documents Community knowledge
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.	Early members represent key community organizations, especially individuals associated with local government, local media, professional groups, and faith-based organizations.	Founding documents List of membership Orientation documents
Coalition formation usually begins by recruiting a core group of people who are committed to resolve the health or social issue.	A core group of active participants can be identified shortly after coalition forms and most of the core is locally based.	Founding documents Membership list Orientation documents.

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	Indicators Associated with Coalition Effectiveness	Data Sources
Coalition Membership		
Coalition formation usually begins by recruiting a core group of people who are committed to resolve the health or social issue.	A core group of active participants can be identified shortly after coalition forms and most of the core is locally based.	Founding documents Membership list Orientation documents.
	Core group identification with the issue predates coalition formation.	Founding documents Membership list Community knowledge
More effective coalitions result when the core group expands to include a broader constituency of participants who represent diverse interest groups, agencies, organizations and institutions.	Membership expanded after founding.	Founding documents Membership list Community knowledge Survey Q. 4A
	New members include non locals (at least state and regional groups)	Founding documents Membership list Community knowledge Survey Q. 4A
	Coalition members can identify stakeholders	Survey Qs. 3A; 4A; 5A,B; 6A
	Expanded membership should result in expansion of efforts and resources directed toward original objections; little, if any, internal dissonance related to expansion	Community knowledge Founding documents Minutes Survey Qs. 7A,B
Operations and Processes		
Open and frequent communication among staff and members helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely.	Staff maintains contact with: coalition leadership; member organizations' leadership; general membership	Minutes Survey Q.7B Orientation materials
	Evidence of both oral and written communications	Minutes

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	Indicators Associated with Coalition Effectiveness	Data Sources
Shared and formalized decision-making processes help to create a positive climate, ensure benefits outweigh costs, and make collaborative synergy more likely.	Coalition has and members are aware of: • Written bylaws • Formal budget • Written job descriptions for staff • Regularly scheduled meetings • Meeting minutes that are distributed to all members • Orientation materials for new members • Work groups or committees	Minutes Founding documents Orientation documents Survey Qs: 2; 4C,D,E
	Little, if any, internal dissonance	Minutes Community knowledge Survey Qs 7A,B
Conflict management helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely.	Conflict management indicators include: • Written bylaws • Formal leadership structure for the coalition. • Written staff job descriptions • Formal budget • Regularly scheduled meetings • Meeting minutes that are distributed to all members • Staff reports of activities/ action at coalition meetings	Founding documents Minutes Survey Qs: 6; 7A,B,C Founding documents Minutes Survey Qs: 6; 7A,B,C Minutes
	Benefits of participation must outweigh costs: Regularly held meetings	Minutes Founding documents Survey Qs 1C,D
	Communication of coalition actions/decisions to members	Orientation documents Survey Q 1C,D
	Training/orientation sessions for new coalition members.	Orientation documents Survey Q 7A Survey Q 7A Minutes Founding documents

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	Indicators Associated with Coalition Effectiveness	Data Sources
	Updated training/orientation sessions for current members Leadership training available to member organization representatives to coalition	Survey Qs. 3B; 7B
	Members believe: they can contribute to group decision-making process; their views can be expressed, will be listened to; the coalition is achieving its goals	Survey Q 7B
	Actions making meeting attendance easier for members (e.g., transportation, mentors, meeting location, meeting time, letters of appreciation to members and/or groups they represent)	Orientation materials Founding documents Community knowledge
		Community knowledge
		Attendance levels at coalition sponsored community events Event evaluations Media coverage Community knowledge
	Positive coalition reputation/ image in community, among members, organizations, media, local and state agencies relevant to coalition operations	Orientation documents Community knowledge
	Positive relationships among members/positive climate: Membership retention levels Member attendance at coalition meetings	Minutes Community knowledge
Leadership and Staffing		
Strong leadership improves coalition function and makes collaborative synergy more likely through member engagement and pooling of resources.	Identifiable coalition leadership separate from staff	Minutes Community knowledge

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	**Indicators Associated with Coalition Effectiveness**	**Data Sources**
	Access to leadership positions is or is perceived to be open, not closed	Minutes Community knowledge Survey Q. 7A,B
	Leaders and staff described in positive terms	Survey Q. 7A,B
Paid staff collaborative synergy more likely through member engagement and pooling of resources.	Existence of coalition staff	For all indicators:
	Size of staff and whether full-time or part-time	Founding documents Orientation materials Community knowledge Media coverage Survey Q. 2B
	Source of staff funding – convener group or individual; groups of members; coalition funds/budget	
	Staff responsible to coalition and its leadership v. member organization/individual	
	Staff training/background Also above indicators related to ensuring benefits of membership outweigh costs.	
Structure		
Formalized rules, roles, structures and procedures make collaborative synergy more likely through member engagement and pooling of resources.	Coalition has: • Mission Statement • Vision Statement • Written bylaws • Formal budget • Written job descriptions for staff • Regularly scheduled meetings • Meeting minutes that are distributed to all members • Orientation materials for new members • Work groups or committees	For all indicators Founding documents Orientation materials Survey Qs. 1 B, 2; 6
Member Engagement		
Satisfied and committed members will participate more fully in the work of the coalition.	See above indicators and data sources related to ensuring membership benefits outweigh costs.	

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	Indicators Associated with Coalition Effectiveness	Data Sources
Pooled Member and External Resources		
The synergistic pooling of members and resources prompts comprehensive assessment, planning and implementation of strategies.	See indicators and data sources under Operations, Leadership and Staffing, and Structure.	
Assessment and Planning		
Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur.	See indicators and data sources under "Pooled Member and External Resources"	
Implementation		
Coalitions are more likely to create change in community policies, practices and environment when they direct interventions at multiple levels.	Group contacts and activities tie into regional, state, and/or national levels and multiple types of organizations	Founding documents Membership list. Community knowledge Media coverage Survey Qs. 4, 5, 7A,E
	Sponsored events/activities include regional, state, and/or national levels	Community knowledge Media coverage Survey Qs. 7A,E
Community Change Outcomes		
Coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes.	Coalition collects and analyzes data on outcomes; evaluates outcome data & reports results	Survey Q. 7
	Sponsorship of events and activities that may contribute to a lessening of health disparities	Community knowledge Minutes Internet Media coverage
	Involvement local, state and/or national government agencies, academic and professional groups in sponsored events and activities	Community knowledge Minutes Internet Media coverage

(table continues)

Table 3 (continued)

Major Category of Coalition Examination and Related Proposition(s)	Indicators Associated with Coalition Effectiveness	Data Sources
Health/Social Outcomes		
The ultimate indicator of coalition effectiveness is the improvement in health and social outcomes.	Health disparities decline	Department of Public Health demographic and health disparity data Survey Q. 7F
Community Capacity		
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.	Reputation of the coalition in the community	Community knowledge Media coverage Membership list growth
	Reputation of the coalition among its members	Willingness to serve on coalition committees Attendance of coalition leadership and members at coalition sponsored events Survey Qs. 7A,B,C

Sources: The constructs and propositions are from Butterfoss and Keigler (2009) while the "Indicators" column is partially based on Butterfoss (2006a).

The community context proposition (Propositions #3) is not listed in the table because the four coalitions studied operate within the same county and seek to eliminate health care disparities. Variations in coalition ties to professional and political organizations and multi-level interactions will be picked up through propositions related to Coalition Membership, Structure, and Implementation. Analysis of Propositions #1 and #2 requires examination of the all the propositions covered in Table 3. These propositions stress that coalitions go through stages of development and recycle through the stages as new circumstances warrant.

In the Data Sources column community knowledge represents the information gleaned from the key health care informants used to identify the coalitions as well as the researcher's experience in the area.

Chapter IV will present analysis results. It will begin with an introduction to the coalitions. Then, Community Coalition Action Theory constructs and propositions will be used to organize the analysis results, moving from the Formation, Maintenance and Institutionalization Stages of the theory.

CHAPTER IV. ANALYSIS OF RURAL GRASS ROOTS COALITIONS

This chapter examines each of the four coalitions in the study using the Community Coalition Action Theory (CCAT). Each coalition is examined in terms of the three main stages outlined in CCAT: the formulation stage; the maintenance stage; and the institutionalization stage. Not only will the background and history of each coalition be covered along with the community environment, an attempt will be made to determine whether the coalitions have moved through the three stages outlined by CCAT, show any evidence of cycling between the stages and/or adapting to changes in the environment, and attempt to determine how the structure, operations and processes used have impacted the ability of the coalition to reach its goals. Finally, the chapter will summarize the findings by comparing the major findings for the four coalitions.

The Diabetes Coalition

In the context of this impoverished Black Belt community, the demographics of the constituents of the Diabetes Coalition, which center on end organ effects of this chronic illness (see Table 2 in Chapter 3), may at first glance appear to be low when compared to the figures for the state as a whole and the averages for the other Black Belt counties in the state, but one must remember that the state statistics are consistently among the worst in the nation. The county's death rate per 100,000 of the population from diabetes is 26.9 (lower than that of the state or other Black Belt counties). The death rate from heart disease is 309.6 per 100,000 (higher than the state average but lower that the average of the combined Black Belt). The death rate from

stroke is 71.8 per 100,000 which exceeds that of the state or other Black Belt counties. The death rate from chronic lower respiratory disease is 35.9 per 100,000 of the population (lower than that of the state or other Black Belt counties).

Community Context and the Formation Stage

CCAT considers the convener role during the Formation Stage crucial to the future development of a coalition. The convener's position relative to the community, initial groups it contacts to join the coalition and the resources it commits to the coalition are all important factors in its development. Formation of the Diabetes Coalition occurred in 2004 after a conference at the local university that was jointly sponsored by the federal Centers for Disease Control (CDC) and the State Department of Public Health.

The Diabetes Coalition's relationship with its convener, the CDC, guaranteed it financial support, credibility, with name recognition as well as networks/contacts. In addition the convener group provided support in the form of a preexisting structure. According to the coalition web site and interviews with key contacts, the initial relationship was based on grant funding and was time limited with the decision to continue or terminate the relationship to be made at a later date. According the web site page that serves as the coalition's orientation materials, the Diabetes Coalition represents one of 40 communities across the state that participates in the U. S. Department of Health and Human Services' (DHHS) Healthy Steps Program to implement chronic disease prevention efforts focused on reducing the burden of diabetes, overweight, obesity, and asthma, as well as addressing three related risk factors — physical inactivity, poor nutrition, and tobacco use. As the convener group, the CDC provided goals, guidance and expectations. Further, the convener introduced the local Diabetes Coalition to similar organizations in the region.

According to CCAT, the convener group should bring into the coalition well respected organizations and individuals with a thorough understanding of the community and its environment and an interest in solving the problem which the coalition was founded to address. These community gatekeepers can shortcut the process of developing credibility and trust in the community and quickly expand the coalition's network of supporters.

The Diabetes Coalition was born when members of the Area Health Care Educational Consortium attended the CDC/State Health Department conference and volunteered when requests were made by the sponsors for individuals or groups to work to establish and sustain educational and prevention measures related to health disparities. The web site of the Area Health Educational Consortium reflects a variety of multilevel collaborative relationships which would lend support to identifying the educational consortium as a gatekeeper which thoroughly understands the community. The educational consortium's services, projects and employees demonstrate a diverse involvement in the Black Belt county and regional health education activities which may or may not be diabetes-related. Current projects include involvement in the Rural Health Education Network (RHEN), Model SHEC (State Health Education Consortium), Health College Connection Program, Black Belt Medical Reserve Corps, HIV/AIDS Awareness, Learn and Serve program, Delta Rural Access Program, Steps to a Healthier State, River Region (the diabetes component), Citizen Corps Councils, Reach US (Racial and Ethnic Approaches to Community Health Across the United States), Community Training Center (CTC), and Preparedness and Catastrophic Event Response (PACER). The reach of the consortium is extensive, making networking an easier task for the Diabetes Coalition.

The membership list provided by the Diabetes Coalition contains a coalition membership of 12 organizations. The membership list is diverse and multi-sectoral beginning with the local

Area Health Care Education Consortium. Other members are the Employee Educational Systems for a federal health care facility; health and wellness organizations representing two adjoining counties; a diabetes association representing the southeastern region of the state; the State Department of Public Health; professional groups representing multiple disciplines such as pharmacy, nursing, social work, and nutrition; and state versions of the Healthier Steps programs.

The organizations responding to the social problem identified by the convener group represent diverse interest groups, agencies, organizations and institutions which seemingly are approaching diabetes through different strategies in their environments. They represent local, intra-state, regional, and state levels, as well as governmental and nonprofit organizations. Governmental officials at the local and county levels are identified as part of the coalition. Based upon CCAT's stages of Institutionalization, specifically propositions relating to community-change outcomes, involvement of local, state and/or national governmental agencies increase capacity and improve health/social outcomes. One out of seven respondents answering Question 7A, dealing with needed organizational improvements, indicated that the coalition's political network needed to be improved.

During the formation process, CCAT states that coalitions must create a series of founding documents that include mission and vision statements. These and other documents such as orientation materials, bylaws, and budgets guide the organization, facilitate recruitment, and contribute to creating a smoothly running operation that manages conflict and helps to establish a cooperative membership. They assist in creating the synergy considered by CCAT as essential for achieving coalition goals. As discussed above, when the Centers for Disease Control (CDC) helped to organize the Diabetes Coalition, it provided the initial mission based on

the Healthy Steps Program, guided a structure by introducing the coalition to similarly created coalitions in the region, and supplied funding. From that point, the coalition assumed responsibility for its operation.

As part of the survey, Question 1C asked respondents if the organization (the coalition) has brochures or literature describing the organization, its mission, vision, values and goals. Six of the seven participants from the Diabetes Coalition indicated that these documents exist. One individual, however, indicated "no, not to his/her knowledge." In survey questions which followed focusing on coalition processes, one individual usually served as an outlier with similar responses. This could be due to frequency of attendance or depth of involvement with coalition meetings. Two of the seven respondents to the survey indicated in response to Questions 7A that an area in need of improvement organizationally was "Literature describing the organization inclusive of statement of mission, vision, values, and goals."

The coalition has standardized the communication process. Communication in the form of teleconferenced meetings occurs monthly. Minutes of the meetings are taken and then disseminated by email to the participating members for review, approval or modification. This is a standard part of the decision making process.

The decision making processes should create a positive climate, manage conflict, and facilitate a collaborative synergy. The coalition's major activities are discussed and acted upon at the monthly meeting. Another indication of the nature of decision making is the response to survey Question 1D, which asks, "How are decisions made regarding issues or projects that require action or response from the coalition?" The seven Diabetes Coalition respondents generated eleven responses. Two members indicated that decisions were data based; one indicated written request, and four indicated decisions were influenced by professional

organizations, while two indicated national/governmental organization. The two responses to the category “other,” included meetings with executive director, who is a member of a coalition member organization. Also, board approval is another method of decision making. Overall, the responses suggest input from member organizations and analyses of data are considered by the coalition in its decision-making process.

Further support for a positive decision-making climate comes from responses to Question 7A, which asked, “Organizationally what would you identify as the area needing most improvement?” None of the seven respondents identified the following as in need of improvement by the organization: decision making regarding issues or projects that require action or response by the coalition, stakeholder identification, diversity of services provided to stakeholders, and new member selection. This may suggest that the coalition members fully trust the leadership's ability to make wise and prudent decisions.

Question 1B addresses operations, processes and conflict management through the establishment of an organizational chart. Four of the seven respondents indicated that the organization did have an organizational chart. One individual stated not to his/her knowledge; two other members chose not to respond. This variance in response may be attributed to the non respondents not seeing a written flow chart labeled or describing an organizational chart. Electronic orientation materials describe an organizational structure without providing a tree diagram. Individuals knowledgeable of the coalition’s grant origins and details may have responded in the affirmative. With a focus on working to resolve a health disparity, conflict may not be a priority or concern. Similarly, the length of time respondents have been involved with the coalition as well as their commitment or interest in learning the details of founding

documents may affect the depth of their knowledge or operational processes which minimize conflict and enhance collaborative synergy.

Pooling of resources has been identified by each coalition as something that occurs periodically especially for county and community events such as health fairs. Question 7C asked participants to provide two examples of success stories. Success stories, as a resource for organizational longevity, are subjective evaluations of a coalition's work or performance. They contribute to the flow of information and reflect the impacts of attitudes and services and to some degree, shareholder control or involvement. Respondents from the Diabetes Coalition described the annual diabetes conference as a success story. Other responses included wellness case management, health fairs, and the identification of perspective supporters of the diabetes conference.

Paid staff, according to CCAT, can play an important role in creating collaborative synergy by engaging members and pooling resources. The Diabetes Coalition itself does not have paid staff. However, it benefits from the staff of the Area Health Educational Consortium. Area Health Educational Consortium staff members are instrumental in coordinating coalition meetings, as well as arrangements agreed upon by the coalition related to the annual educational activity and other health related events. As a component of the Area Health Care Education Consortium and by indication in the orientation website, the staff of professionals have successfully worked with the process of application for and overseeing of grant funding for a variety of health education related affiliates, including the Diabetes Coalition. With such a successful history of grant management, the leadership and staff of this coalition are knowledgeable of the collaboration and pooling of resources which appeal to funding sources.

CCAT considers collaboration and synergy to be related to formalized rules, roles, structures, and procedures. The formalized rules, roles, structure and procedures include founding documents such as mission and vision statements. The orientation materials for the coalition indicate a mission to implement chronic disease prevention efforts focused on reducing the burden of diabetes, overweight, obesity, and asthma, as well as addressing three related risk factors — physical inactivity, poor nutrition and tobacco use. Survey Question 4D focuses on how well the mission, vision, values and goals of the organization correlate with that of the city and county. Five of the six respondents to this question indicated that in their opinion, these founding documents correlated highly or moderately to that of the city or county. One individual responded “unknown”.

Another of the formalized structures to improve collaborative functioning, enhance member engagement, and pooling of resources is the budget which was addressed in survey Question 2, parts A-C. With six participants responding, annual budget estimates ranged from $6–15,000. When responding to the sources of the operating funds, five respondents indicated grants as the principal source of funding. Other sources of funding identified included religious organizations, government agencies, and fund raisers. Narrative responses to the category "other" indicated board member agency contributions as a principal funding source. There was total agreement regarding the tax exempt status of this coalition. However, the length of time this status has been in place varied. Reasons for variation related to the annual budget estimates could relate to the degree of communication and, therefore, the coalition members’ knowledge of the amount of grant funding for the program. Each coalition member responding to the CDC grant may have received a predetermine amount based on established criteria. Or, through the process of self selection of the respondents, the amount may not have been communicated to

those responding to the survey. Knowledge might also be related to length of involvement with the coalition.

The large number of responses indicating that grants are the source of greatest funding would indicate that all coalition members are in a similar situation. Thus, they are together because each responded to a similar issue appeal. The one narrative response describing funding from board member agencies may serve to inspire other coalition member organizations in ways to diversify funding and or select board members. In organizing coalitions or other not for profit organizations, board members should be selected who can contribute resources to the vision and mission of the coalition, including funding.

Considering collaborative synergy from the perspective of member engagement, survey Question 6 examined new members and criteria for member selection. Only two of the six respondents who answered, "Are there criteria for new member selection?" answered "Yes" that the coalition did have criteria for new member selection; the other four said "No." The two who responded to the second part of the question dealing with the extent to which organization needs are considered with regard to applicant organization, gave different criteria which were location and fit with organization mission. It was interesting that only two of the six respondents were able to indicate any criteria. This could reflect the degree of communication and/or the level of participation and or attendance for those choosing to respond to the survey. The concern for new member criteria may not often arise if the membership is somewhat closed, and if the current members have been with the coalition since its beginning.

Maintenance Stage

The commitment and satisfaction of the members that participate in the work of the coalition is evidenced by their repeated availability to participate in the planning of present and

future events. Minutes indicate that each organization or sector of the coalition, which has a particular interest in the topic of the event, makes a contribution to the planning process.

Repeated educational events focusing on diabetes are planned annually. There is a recycling of the degree of planning participation that occurs for each yearly event. This is a primary example of the synergistic pooling of member and external resources.

The assessment and planning that occurs in the Diabetes Coalition appears to be associated with the educational activities, not assessment of the coalition and its operations. This information is queried in the survey Question 7, parts D-F. Part D1asks, "How is progress toward the statement of mission, vision, value, goal of the organization measured or evaluated?", while D2 focuses on Frequency, D3 on how has the result of measurement or evaluation been used in the past, 7E on types of data collected for each activity, and 7F on the types of data collected on the constituents. The respondents indicated that written evaluation or determination of effectiveness of strategies is done after each of the annual conferences. The evaluations are generated from the participants as well as from the providers of the services. Other indicators of success identified were electronic data based indicators, anecdotal reports and participation/ attendance to events. Tracking of numbers served or in attendance or other means of recording volume or numbers of persons touched is a good indication of effectiveness. Whether the number of participants increases or decreases as well as their characteristics has the potential to be extremely revealing. This demographic data can also be entered into an electronic data base and serve as a basis for comparison of constituents outside of this coalition's geographic area. The majority of participants indicated that the frequency of the evaluation was annually. In a seldom occurring total agreement, respondents indicated that the evaluations were used to provide better services and as a basis for future planning, meetings, and additional services.

Only one respondent indicated that the evaluations or indication of strategy effectiveness were used for grant retention. The significance of the quantifying effectiveness of strategies for funding purposes should not be a new concept for coalition members, particularly since the 1980s introduction of Diagnostic Related Groups (DRGs) into the health care arena.

Community Coalition Action Theory argues that coalitions must direct their interventions at multiple levels in order to accomplish change in the community. The Diabetes Coalition's membership consists of organizations from a variety of local, state and national levels. The criteria for membership have been described by survey respondents as location and fit with mission. Meeting minutes and electronic communications identify multi-sectoral members beginning with the local Area Health Education Consortium; Educational Systems for a federal health care facility; health and wellness organizations representing two adjoining counties; state level diabetes association' and the State Department of Public Health.

Survey Question 4 inquires regarding the coalition's relationship to organizations outside of the coalition, and Question 5 into its relationships to government. Also, three of the seven participants indicated that organizations outside of the coalition with which there are relationships included another area educational consortium and Disabled American Veterans. The external relationships are further described as health focused and educational organizations or entities. Four of the five respondents indicated that data are shared with external organizations. Three of the six participants indicated that affiliation with the external organization influenced the coalition's statement of mission, vision, values, and goals. Two of the six participants indicated that the organization does have benchmarks for member organizations. The benchmarks described include the annual conference which provides education to patients and professionals and services provided such as wellness case management. Services are tracked through the state information network with comparisons made with others

participating in Steps to A Healthier State program and with activities that are tracked by a risk factor survey. The response of two of the six participants to the benchmark segment suggests that the use of the term benchmark may have been unclear. The question asked about benchmarks outside of the organization. Quantifying and tracking of services provide the coalition with both internal and external benchmarks.

Institutionalization Stage

The final three propositions (19 through 21) in Community Coalition Acton Theory focus on changing community outcomes with improvements in outcomes the "ultimate indicator" of coalition effectiveness. Building community capacity to deal with problems other than those the coalition was originally founded to deal with is another indicator of success and institutionalization. Time is a factor in the change described. Change in behaviors and practices within the environment occur slowly. This coalition pools resources and collaborates with other coalitions in area health fairs, community education to provide at the very basic layman level alternative approaches to less healthy practices that may be culturally ingrained.

Other than the evaluations of the educational activities provided, and numbers in attendance or numbers served, no data are gathered by the Diabetes Coalition that ties directly to documentation that there have been improvements in health and social outcomes as a result of these activities. Survey Question7F, which is based on data from the National Healthcare Disparity Report, indicates that this coalition does collect data on the illness or disease state, race/ethnicity, income, living status, contact information, gender, age, education, and health insurance as part of the planning process for its annual conference. No data are collected on employment status.

This coalition has been successful in garnering funds and forming collaborative relationships on multiple community sectors. These relationships are a form of social capital that may be applied to other health and social issues. The coalition can learn transtructurally from its members and act to build firmer relationships, build stronger data bases, and benchmark internally.

The stage that this coalition is in based on CCAT is maintenance which focuses heavily on the development of collaborative synergy. The Diabetes Coalition has cycled through the formation stage in that it had a convener group which provided social support, financial support and structural guidelines. There are no imminent threats from the environment for this coalition. External funding from the CDC is still in effect, but alternative long term funding is not clearly established. Based on available data and feed back from community participants, the coalition appears to be changing behavior and assisting in the reduction of health related and diabetic problems by increasing awareness and providing alternatives. However, clear evidence of impacts on health care disparities needs to be established and the coalition needs to involve more diverse and multi-sectoral participants in the decision making processes of the coalition in this county, particularly in the area of funding.

The Black Belt Cancer Coalition

Community Context and the Formation Stage

Demographics of the constituents of this Cancer Coalition for this Black Belt county reflect a death rate from cancer of 269.2 per 100,000 population, which exceeds that of both the state (217.8 per 100,000 population) and the averaged rate of the Black Belt counties in the state (242.3 per 100,000 population). (See Table 2, Chapter 3.)

This coalition has no convener group. Instead, this coalition was convened by an individual who responded to repeated requests for technical assistance in the area of oncology and related health care. The Cancer Coalition began through the initiative of one individual associated with a grassroots cancer center that provided health education on breast self examination and preventive measures such as mammograms. This individual was a life long resident of the community, and a health care professional for many years. Her passion for this area of health care resulted from a commitment to serve others.

The initial impetus evolved from repeated collaborations with community members with common interests in specific health related issues, service provision and resource availability. Since this coalition was established in response to internal community/county needs, there was no formal convening agency. The initial organizations which formed the core group were recruited from local organizations, two of which originated from home grown entities. Others included in the original nine organizations were one Greek professional organization, three educational organizations, and two disease focused organizations. Expanded membership grew to seventeen which included health focused organizational representatives on the local, county, and state levels. Also included were diverse spiritual/religious alliances. National representation is indirect due to state organizations representing larger national groups, as well as individual professional memberships connecting to national groups.

Organizations in the Cancer Coalition collaborate to organize, implement, and evaluate community wide action plans which are designed to target a reduction in cancer-related health care disparities. These action plans are implemented via education promoting healthy lifestyles, cancer prevention, and control. The Cancer Coalition was the first county-based organization to

raise awareness about processes related to resources, goal attainment, community advancement, and sustainability for rural grassroots coalitions.

As indicated earlier, this coalition evolved from the community gatekeepers with good repute and a thorough understanding of the community. With this creditability among lay and professional segments of the community, this coalition has been approached by external conveners to participate in grantsmanship. This coalition has provided support and access to coalition resources. Historically, these relationships have been short lived and not perceived by coalition members as mutually beneficial.

During the formation process, CCAT states that coalitions must create a series of founding documents that include mission and vision statements. These and other documents such as orientation materials, by laws and budgets guide the organization, facilitate recruitment, contribute to creating a smoothly running operation that manages conflict and helps to establish a cooperative membership. Orientation materials consisted of literature describing the mission of the Black Belt Cancer Coalition as well as its member organizations. Question 1C which ask if the organization has brochures or literature describing the organization, yielded seven yes responses from this coalition and one response of "no."

One concern voiced by the primary contact was the desire to establish formal documents such as an organizational chart. Readily available was a draft statement of mission, purpose, and objectives. Also voiced was a desire to have this component of the health care organization to become 501(c)(3). Many of the member organizations have attained this status.

The Cancer Coalition is a diverse collaborative assembly of public, private, health and community organizations. Each of these organizations works to fulfill a mutual purpose, which is multifaceted.

The mission of the Cancer Coalition is to reduce cancer-related health disparities affecting African Americans by promoting cancer prevention activities and healthy lifestyles. Activities designed to reduce cancer-related health disparities include: developing, implementing and evaluating a community-wide action plan that incorporates public, private, health and community resources in cancer control activities (BBCC internal notes October 3, 2006). This coalition participated in "Paint the Town Pink," which is a celebration of October Cancer Awareness month, the Relay for Life, and the city/county proclamation activities.

Communication Processes and Meeting Minutes

The primary contact for this coalition stated that between 2003 and 2006, the coalition met on a quarterly basis. Beginning in 2007 and 2008, meetings were less frequent and are currently called on an "as needed basis." The main focus of these called meetings is participation in events. During the meetings an event is proposed by a group within the coalition. The coalition decides the degree to which it will be involved, whether involvement is participatory, sponsorship or a combination. Participation in an event is offered to the membership by the coalition board, and the individual coalition members indicate the extent to which they will participate. These and other business decisions of the coalition are made as needed by teleconference.

Survey Question 1D dealing with decision making received a diverse set of responses indicating that decisions were influenced by professional organizations (four responses), national or governmental organizations (two responses) or data based (two responses). Operations, processes, lines of authority and conflict management should be reflected in an organization's organizational chart. All six respondents to Question 1B (the existence of organizational chart) indicated that there was an organizational chart.

One example of conflict management that has not helped to create a positive climate resulted on more than one occasion when this coalition and its member organizations were approached by potential funding sources. Likewise, an organization having applied for grant funding or having received grant funding needed data which the coalition had or manpower resources or networks with which the coalition members were familiar. The coalition entered into what it considered a mutually beneficial agreement and provided the external group with the assistance requested. The external organization did not share the funding as agreed. This violated the coalition's sense of trust and created conflict and mistrust of external funding. In essence, groups on local, county and state levels have benefited from the assistance provided by the coalition. However, in this instance the coalition did not benefit from its relationship with the funding sources. In fact, the coalition members felt was robbed of its resources.

Group dynamics changed in this coalition due to leadership styles. The founder and convener exhibited a laissez-faire type leadership style that is characterized by leaders who give group subordinates total freedom to make their own decision. Laissez-faire leaders are effective when leading individuals who are highly skilled, experienced and educated. They are basically leaders who do not provide leadership or direction (Lunenburg & Ornstein, 1991). This laissez-faire leader can also be considered a servant leader, in that her passion in this area of work has resulted from a choice to serve first and then lead as a way of expanding service. Servant leaders are servants first with the object of making sure that other people's highest priority needs are being served (Lisao, 2006). The conflicting leadership style appeared to be more intrusive and transformational. The transformational approach to leadership acknowledges that within an organization, there can be many leaders who share the same goals and who can be empowered to make certain decisions. Transformational leadership involves the use of charisma to motivate

followers to buy into and share the leader's vision to the extent that individual interest are set aside for the interest of the organization (Sousa, 2003).

In spite of the many obstacles, the Cancer Coalition continues to survive. Factors essential in its survival are: (1) increased caution and protectiveness of data and other resources, (2) the shared and painful bond resulting from the negative experiences with outside funding sources which resulted in increased collaborative synergy, (3) continued focus on its mission and the needs of constituents, and (4) multisectoral political ties that have maintained communication among groups with which prior tensions have been experienced related to perceived inequities in data sharing and funding agreements (Construct 3, Community Context, Proposition 3; Construct 4, Proposition 6).

The assessment and planning that occurs are associated with the educational activities sponsored by the coalition. This information is queried in the survey Question 7D-F. Question 7D1 asks how progress toward the statement of mission, vision, value, and goal of the organization is measured or evaluated. The responses indicated that these areas were measured through evaluations, measurable outcomes, data collected and number of individuals touched. Question D2 asks about the frequency of measurement of progress toward the statement of mission, vision, value, and goals. The frequency varied. Two respondents indicated that members/constituents could contact the coalition at any time, and following activities or programs of the coalition. Two respondents indicated the frequency to be monthly and two indicated quarterly.

Question D3 asked how results of measurement or evaluation have been used in the past. Results of the assessments were, according to respondents, used to provide better services (two responses), planning, or meeting additional services (two responses), and to retain grant funding

(one response). Question 7E asked what types of data are collected for each activity. The types of data collected were both summative and formative. The top three responses were date (seven responses), target audience (seven responses), and evaluation (six responses). Question 7F asked about the types of data collected on the constituents. Types of data collected on constituents included race/ethnicity (six responses), age (five responses), and education (five responses),

Question 3A-C focused on stakeholders. Responses to Question 3A which asked who are the organization's primary stakeholders yielded five respondents describing survivors, current recipients of services, those needing services and the community, and five respondents indicating organizations represented and partners. Question 3B which focused on how stakeholders make their needs known resulted in the following answers: through verbal request (seven responses), written request (six responses), and request for proposals (three responses). Responses to Question 3C indicated that services requested by constituents if funds were available were: health services (six responses), personal care services (five responses), and community skills/affiliations (five responses).

The leadership of this Cancer Coalition is described as laissez-faire, and is characterized as a leader who gives group subordinates total freedom to make their own decisions. The problems discussed below are: (1) the coalition lives from paycheck to paycheck without reserves, (2) leadership growth and strength have come as the result of lessons learned from mistakes, and (3) imperfect information. To solve the problems of the Cancer Coalition, the leadership and members are seeking internal and external funding. A moratorium has been declared on sharing data and any other fiscal and material resources. All of the Cancer Coalition members have remained in spite of the obstacles incurred. The Cancer Coalition member who

was the source of funding related conflict did not leave the organization. However, that person's participation is less frequent.

Coalition member's data are pooled from national and state initiatives that serve as the basis for the initiation of new projects in which community members participate. As it relates to collaborative and pooling of resources, the staff of this coalition is actually provided as in-kind services by the convening organization. This individual works for and is paid by the founding organization. This part time paid staff member serves as a central contact person, arranging meetings, relaying messages, and generally coordinating meetings and functions for the coalition members. This staff is knowledgeable of the local organizations and functioning and has been in place throughout the existence of the Cancer Coalition.

Maintenance Stage

Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur. The initial efforts of the Cancer Coalition have grown as has that of the national cancer association. The Cancer Coalition adopts independent events ("Painting the Town Pink"), as well as some national events ("Cancer Relay for Life"). "Painting the Town Pink" and an annual fund raiser are local events. When the town is painted pink, light posts in the city square of the county's largest city and the businesses surrounding the square are decorated or display pink bows for the month of October. The event ends in a local fund raiser published in the local newspaper. Donations are solicited for the benefit of the work of the cancer coalition. The collaborative actions of this coalition have also spread to a spring-time "Relay for Life," a walk-a-thon, which is held on the athletic field of the local high school and attended by a variety of Greek organizations, church groups, other social groups, the general

public, and cancer survivors from the county and surrounding areas. The walk-a-thon is a fund raising and educational event.

The organizations that are members of the coalition collaborate to organize, implement, and evaluate community wide action plans. These action plans may be produced individually or collaboratively through shared resources. The action plans are designed to target reduction in cancer related healthcare disparities. The vehicle through which most of the action plans are implemented is through the provision of education, which promotes healthy lifestyles, cancer prevention, and control. One method of comprehensiveness of assessment, planning and implementation is via data related to evaluation or effectiveness (Question 4B). CCAT argues that coalitions must direct their interventions at multiple levels in order to accomplish change in the community. The Cancer Coalition's membership consists of organizations from a variety of local, state and national levels. These multi-sectoral organizations interact in response to a mixture of national level proposals dealing with cancer prevention and other related issues. The criteria of membership have been described by survey respondents to Question 6A as knowledge, licensure, skills (two responses); service orientation (two responses); and need (one response).

Survey Question 4A inquired whether the coalition had a relationship with organizations outside of the coalition. Four respondents reported in the affirmative and four in the negative. In response to Question 4B, four respondents indicated that the organization does share data with external organizations. Two responded that it did not. The variance in responses to these questions suggests differences in perceptions of the Cancer Coalition members based upon their understanding of how the organization is functioning.

Institutionalization Stage

CCAT explains that coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes. The Cancer Coalition has consistently worked with individuals and groups to provide cancer education and awareness activities.

According to CCAT, by participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues. The Cancer Coalition offers opportunities for volunteerism through participation in activities such as health fairs, relays, fund raising and other health related activities. Linkages between organizations mean a cooperative relationship that strengthens each member organization synergistically. Membership in the coalition is mutually beneficial to the member as well as the organization.

The Cancer Coalition is in the institutional stage based on Constructs 19–21 which examine community change outcomes, health/social outcomes, and community capacity. Community change has taken place through annual events described such as painting the town pink, fund raisers, and relay for life. Changes to community policies and practices have continued through city and county promotions and resolutions supporting these activities. Based upon the literature review in this study, there is no solid evidence of change in disparities. However, the impetus of change begins with awareness, knowledge, skills, and change in behavior along with cultural practices which these activities embrace.

Evidence of cycling is demonstrated with every successful appeal for funding and support which moves the coalition from the formation into the maintenance stage. With each coalition appearance in diverse cancer focused activities, member engagement is enhanced, and

collaborative synergy is demonstrated. Further cycling into institutionalization is evident with each annual city, county, state proclamation and increased numbers of participants to the spring and fall cancer related activities. Mainstream political and governmental officials are not involved in core works of this coalition. Justification for placing the coalition in the institutional stage is supported by Propositions 19–21 which focus on change in community practices and environments. These changes have occurred for several years as described during the fall and spring events, Painting the Town Pink and the Relay for Life. These activities are an important step toward improving health and social outcomes.

Threats identified by the Cancer Coalition in Question 3C, which asked about services requested by the constituency which cannot be provided are due to lack of adequate finances and qualified personnel (Construct 10, Proposition 17). Institutionalization (Propositions 19–21) deals with change in community policies, practices, improvements in health and social outcomes. Social capital in this stage can be applied to other health and social issues. From this perspective, the Cancer Coalition has entered into the institutionalization stage, although their finances have been in doubt since its inception and are not presently stable. Based on the available nutritional data, the Cancer Coalition is changing behavior in the African American community by promoting healthier diets, exercise and other cancer prevention activities and healthy lifestyles in this Black Belt county.

Black Belt Community Coalition

Community Context and the Formation Stage

CCAT considers the convener role during the Formation Stage crucial to the future development of a coalition. The convener's position relative to the community, initial groups contacted to join and the resources committed to the coalition are all important factors in its

development. The convener group for the Community Coalition was the local university that initially served as the lead benefactor. This coalition was established in January 2005, as a 501(c)(3) organization, in order to address comprehensive community needs in preventing substance abuse, drop out rates, and to enhance economic development (see Table 2, Chapter 3).

The Community Coalition relationship with its convener, the local university, provided a foundation for financial support, credibility, structure, networks and contacts. Because the convener group was local, the strategic approach might be considered inside out. For example, internal organizations identify and appeal to external conveners with similar interests to assist in the local battle to minimize social problems resulting from substance abuse and drop out rates. The convening group which was from within the county provided technical assistance in that it compiled a list of business professionals who shared an interest in community advancement giving the coalition a base from which to recruit. Financial assistance was provided for initial start up. Credibility was provided through indirect affiliation with the local university, as well as through this convener serving as gate keeper to access to networks, and contacts. The convener group brought into the coalition well respected organizations and individuals with a thorough understanding of the community and its involvement and an interest in solving the problems for which the coalition was created to solve. These community gate keepers can shortcut the process of developing credibility and trust in the community and quickly expand the coalition's network of supporters.

Coalition orientation materials included a list of community gate keepers. They are: Chamber of Commerce, educational organizations, local university, local board of education, Head Start, technical college, public library, faith-based organizations, financial institutions, and

government organizations. Other organizations include healthcare, city and county law enforcement organizations, legal entities, and media organizations.

The current mayor of the county's largest city was a part of the coalition. He served as the Associate Director for the Community Coalition. His role included: (1) participation in developing a strategic plan to guide the community planning process of the coalition; (2) helping to identify, assess, and inform the coalition of issues that affect its progress; and (3) working in conjunction with the coalition chair person to coordinate aspects of the coalition activities. In his current role as mayor of the city, he is not involved with coalition day to day operations. At best, his coalition role is now ceremonial; however, his continued focus on community economic development in his role as mayor is a focus which is shared with the coalition. In terms of political contacts there are no fiduciary benefits.

The Community Coalition concern with health issues stems from its desire to strengthen and develop an infrastructure for future development and community advancement. The health and social problems of concern is based on demographics reflective of poverty and high school drop out rates (Table 2, Chapter 3).

The coalition has had a paid staff since its inception. Certain positions have been continuous, although different individuals may have held those positions. CCAT describes essential leadership as necessary to improve coalition function and makes collaborative synergy more likely through member engagement and pooling of resources. Since the organization of the Community Coalition, it has demonstrated consistent leadership positions. The coalition has two paid staff members – a consultant/coordinator and an office assistant. The structure of the Community Coalition described on its website consists of an executive committee with the following elected and appointed positions: Chairman, First Vice Chair, Second Vice Chair,

Recording Secretary, Assistant to the Recording Secretary, Treasurer, Chaplin, Parliamentarian, District 1,2,3,4 Representatives, Black Belt County Board of Education Representative, and Black Belt City-County Chamber of Commerce Representative.

The coalition is a subsidiary of a larger state, regional, and national organization which has established guidelines that influence coalition functioning and reporting. The membership list provided by the Community Coalition contains a membership of over 100 organizations. The membership list is diverse and multi-sectoral as described in the executive committee.

Other structural guidance and decision making has been conducted through defined committees and requirements for committee participation. The web site requests applications or inquiries from individuals to match their professional work life with the needs of the identified committees. The coalition's organizational structure consists of the following committees: executive, membership, needs assessment, strategic planning, implementation, evaluation, and general membership. The website also posts minutes which describe functions of the committees and requests reports of committee progress.

Focusing on decision making and conflict management, survey Question 1B addresses operations, processes, and conflict management by the establishment of an organizational chart. Five of the seven participants affirmed the existence of an organizational chart. Two individuals responded "no." According to responses to survey Question 1D, decision making occurs in phases. Three participants described the process as one based on written requests. Two participants described the process as one influenced by professional, national/governmental organizations. Six participants described the process as one in which the coalition had to agree, and that all decisions were brought before the body, discussed, and approved or disapproved. The legalities of coalition decision making were determined by legal authority. The overall

responses indicate that there is a formalized shared decision making process which creates a positive climate.

This coalition is largely funded by grants from state and national organizations with matching funds provided by the county. However, some funds are provided through private contributions and in kind services. Diversity in funding strategies remains a concern. Question 7A focused on the self identification of areas needing improvement. Four of the respondents identified "diversity of funding sources." Diversity of services and new member selection were not considered areas needing improvement.

During the formation process, CCAT states that coalitions must create a series of founding documents that include mission and vision statements. These and other documents such as orientation materials, by-laws, and budgets guide the organizations, facilitate recruitment and contribute to creating a smoothly running operation that manages conflict and helps to establish a cooperative membership. They assist in creating the synergy considered by CCAT as essential for achieving coalition goals. The mission of the Community Coalition is to improve the mental and physical well-being of youth, young adults, and families by working collaboratively to develop, implement, monitor, evaluate a strategic plan, and use evidence-based prevention strategies. Coalition evaluation takes place after each major activity and the results are implemented to improve program development. The Community Coalition is committed to sustainability, promotion of diversity, inclusiveness, moral values and principles to effectively integrate, leverage, and manage resources to obtain maximum results. Survey Question 4D focuses on how well the mission, vision, values and goals of the organization correlate with that of the city and county. All respondents indicated a high level of correlation.

Question 1C asked respondents if the coalition had brochures or literature describing the organization, its mission, vision, values and goals. Five of the seven Community Coalition members responding, indicated knowledge of the literature described. One of the respondents indicated that work had just concluded on a logo.

Communication in the form of meetings occurs monthly. Minutes of the meetings are not restricted and are electronically placed on the internet for public information. Agenda items varied; however, prayer was a constant component. Previous minutes were reviewed and accepted. Updates were provided from executive committee meetings and varied partnership programs. Minutes included discussions of hiring needs, personnel selection processes, and timely submission of coalition reports. Strategies regarding sustaining specific projects beyond the grant cycle were included in discussions. Interests and needs for collaboration were documented from a variety of coalition members for their particular areas. Strategies were discussed regarding beneficial links with existing coalition partnership initiatives. Minutes contained reports and presentations from the coalition's participation in a national convention, as well as a web site promoting prevention and web seminar activities. The materials indicated that membership with this organization was a way to identify best practices from around the globe for a variety of concerns.

Minutes also provided a draft of environmental strategies for the period 2009–2011. Strategies included memos to county consumers and regulatory offices, city and county law enforcement offices, and plans to use media and telephone to educate the community on prevention awareness information. June, 2009, meeting minutes contained a variety of reports such as goals and history. A second component contained reports including a description of coalitions as well a best practice formats and digitalization of coalition functions.

Pooling of resources is described by CCAT as a method to increase member involvement and collaborative synergy. Pooling of resources has been described in response to Question 5B as appealing to government/political entities through an offering of coalition resources. Similarly in-kind services were provided in response to Question 2B, which inquired of the principle sources of operating funds. Further examples of pooling of resources were provided in response to Question 7C. This question dealt with success stories. Coalition members described success stories as assistance to Katrina evacuees, placement of a digital bill board, which advertised health related topics, mentoring programs, tutorials, extracurricular activities and related drug programs.

CCAT considers collaboration and synergy to be related to formalized rules, roles, structures and procedures. Another of the formalized structures to improve collaborative function, enhance member engagement and pooling of resources is the budget which was addressed in survey Question 2A-C. Question 2A inquired of an estimate of the coalition's annual budget. Responses were divided between the lowest selection and the highest. Four participants selected the largest amount, which was $51,000 or greater while four selected $5,000 or less. Question 2B asked for a percentage estimate of sources of operating funds. Grants received three responses. Government funding and the option "other" each received two responses. The category "other," contained explanations of in-kind donations which were responsible for 25% of the budget.

The Community Coalition functions as an independent organization with a structure, staff, decision making processes, communications and other elements. In fact, this coalition fulfills the constructs and propositions identified by CCAT.

Data to support the constructs and propositions of the formation stage, which cycle to the maintenance stage, are considered dynamic with no exact delineated (cut and dry) beginning and ending. However, more ingrained support for constructs and propositions are evidenced as cycling continues into the maintenance stage.

Maintenance Stage

Commitment and satisfaction are evidenced by increased member involvement and collaborative synergy. The number of members published by this organization indicates that at least 100 organizations are participating in the work of the coalition. Due to cycling of coalition member organizations, it is unlikely that all 100 members participate at one time. For example, in many instances organizations listed as members gave contact persons. When the researcher contacted the organization, that individual was no longer employed, and the replacement individual either had not been identified, or had not begun work with the coalition.

Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur. The Community Coalition website focused heavily on comprehensive assessment and planning. There is a published effort on the part of the Community Coalition to adopt best practice standards. The only other indication of this effort is the acknowledgement of benchmark organizations and the desire to emulate the practices of these organizations (Question 4D-E). Five of the seven respondents indicated that there were benchmarks for the member organizations. Explanations ranged from the implementation of a children's rhythm band to pre hurricane Katrina youth activities, including four cities.

The assessment and planning that occurs, is associated with the educational activities. This information is queried in the survey Question 7D-F. Question 7D1, asks how is progress toward the statement of mission, vision, value, goal of the organization measured or evaluated?

The responses indicated that member comments and responses are instrumental in determining progress toward strategic goals, as are anecdotal reports and the number of constituents served. Question D2 asks about the frequency. The frequency was primarily monthly (supposedly with meetings). Question D3 asks how has the results of measurement or evaluation been used in the past. Results of the assessments were used to provide better services, planning, or meetings; additional services; to retain grant funding and general record keeping; and reporting. Question 7E asks what types of data are collected for each activity. Responses included date, description of activity or service, planning committee. Question 7F asks about the types of data collected on the constituents. Types of data collected included race/ethnicity, income, living status, gender, age, education, and health insurance.

Question 3A-C focuses on stakeholders. Responses to Question 3A indicated that primary stakeholders are local business and faith-based leaders, as well as the local board of education, local university, private local school, county commission, and retired board members. These retired board members are individuals who are retired from their jobs or professions, and some are still on the board. Question 3B indicated that stakeholders make their needs known through written requests, verbal requests, requests for proposals, mandates issued by professional/governmental organizations, and internal observation of demographic trends. Responses to Question 3C indicated that services requested by constituents were community skills and affiliation, transportation, and supervision. However, the resources for these services were not available.

CCAT argues that coalitions must direct their interventions at multiple levels in order to accomplish change in the community. The Community Coalition's membership consists of organizations from a variety of local, state and national levels. Question 6A, which focuses on

new members, asks are there criteria for new member selection. Respondents indicated need, board, and location as criteria. Applications are submitted to the chairperson, and applications are reviewed and referred to the board for approval or non approval.

Survey Question 4A inquired regarding the coalition's relationship to organizations outside of the coalition. In response to Question 4A which asks if this coalition part of any other local, state or national, professional or governmental organization, three of the respondents reported in the affirmative while three reported in the negative. This means that 50% do not understand the coalition's relationships to outside organizations. Question 4B further inquires if data are shared with these external organizations on local, state or national, professional or governmental levels. Of the respondents to Question 4B, one indicated "Yes", the coalition shared data with external organizations, while three indicated it did not share data with external organizations. This means that 25% of the respondents were knowledgeable of the external data sharing while 75% were not knowledgeable of the external data sharing.

Coalitions are more likely to increase capacity and create change in community policies, practices and environments when they direct interventions at multiple levels (Construct 11, Proposition 18). A first step in impacting public policy was described during an interview with the Community Coalition. Described during the interview was a combined collaborative effort with a neighboring non Black Belt county during which an initiative was presented on behalf of the two participating counties to the state beverage commission. The contents of this initiative at the county level have the potential to coincide with similar state and national initiatives related to the underage use of alcohol and tobacco.

Institutionalization Stage

CCAT explains that coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes both of which represent characteristics of institutionalization. The Community Coalition has consistently worked with youths in mentoring and anti-drug education. The website cites studies published in 2002, which served as a baseline for monitoring changes in underage smoking and drug use from a variety of databases. Survey Question 7F deals with the types of data collected on the constituents served by the coalition. Respondents identified data in three categories — gender, age, and education.

CCAT states that the ultimate indicator of coalition effectiveness is the improvement in health and social outcomes. The best indicator of coalition effectiveness is described by the coalition members in Question 7C, which is a self-report of coalition success stories. The success stories were collapsed into categories such as community outreach which includes support, health fairs, educational/mentoring, and fund raisers. The Community Coalition advocated education through digital bill boards. Educational materials publicized on the bill board describe health activities, mentoring programs, and community and coalition activities.

Another indicator of environmental change and community capacity is the coalition respondents' self report of strengths in Question 7B. Respondents described their greatest strengths as leadership and community buy in, both of which lead to capacity building and adaptability. When seeking to develop strategies for environmental change and community capacity, a starting point would be the following three items: transportation, community skills and affiliations, and health services, which were provided in response to Question 3C.

According to CCAT, by participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues. The Community Coalition offers opportunities for civic participation through its mentoring program, anti-drug participation, and educational activities. Participation is through workshops, seminars, training programs, and individual and group counseling. Linkages between organizations mean a cooperative relationship that strengthens each member organization synergistically. Membership in the coalition is mutually beneficial to the member as well as the organization. However, emphasis must continue to be on innovation and change.

The Community Coalition is in the early institutional stage based on Propositions 19–21 which examine community change outcomes, health/social outcomes, and community capacity. Community change has taken place through the mentoring programs. The mentoring programs have enhanced school attendance and decreased drop out rates. Changes to community policies and practices have continued through collaboration with a neighboring county to present an initiative to the state beverage commission, a first step in impacting public policy. The contents of this initiative at the county level have the potential to coincide with similar state and national initiatives related to the under age consumption of alcohol and tobacco. A proposal for this initiative was written and submitted to the state beverage commission for the purpose of funding educational activities relative to the dangers of youth consuming alcoholic beverages and tobacco products. This proposal was never funded.

Evidence of cycling between CCAT stages exists. Evidence is demonstrated through the history which reflects that the organization's formation began with a structure. Further, that the membership grew from the initial group of businessmen to include now at least 100

organizations. Also, cycling focuses on transition into the maintenance stage with member engagement through committee participation and planning of future events.

Threats are identified by the Community Coalition respondents to Question 3C, which asks about services requested by the constituency which cannot be provided due to lack of adequate finances and qualified personnel (Construct 10, Proposition 17). Based on the available demographic material (Table 2), it appears that the coalition is changing behavior and reducing the drug abuse and school drop out rates. Through affiliation with educational organizations and law enforcement, this coalition provides mentoring directly to the youth in the county. These mentoring services directly impact the youths in their daily and educational lives. While this may not be validated by the coalition activities and by internal coalition evaluations, statistics from the state department of education indicate drop out rates have decreased.

The Black Belt Parish Nurse Coalition

The Black Belt Parish Nurse Coalition's work is not focused on a specific disease state. Rather its focus is on the congregations in churches. Church members encompass all age groups and may present with any number of health concerns. Included in their health concerns are chronic illnesses such as heart disease, in which case this black belt community's rate is higher than the state, but lower than that of other Black Belt counties; cancer and stroke rates which are higher than the state or other black belt counties; respiratory disease; and Alzheimer's and diabetes are lower than that of the state or Black Belt county average (see Table 2, Chapter 3).

CCAT states that coalitions form when a lead agency or convening group responds to an opportunity, threat or mandate. For years, the concept of Parish Nursing floated around health care circles. Then, the more formal organization appeared in a newspaper article (State Nurses Association Publication, 2005, p.7), which described how nurses in local churches were

becoming involved in a ministry with the population being the members of their respective congregations.

The convener of the coalition was the initial contact person who endorsed the possibility of the Parish Nurse Coalition participating in this research. However, due to her unexpected death, a new primary contact has been established.

With fifty years of professional service and a background in research, the convener had a diverse healthcare background and exhibited an entrepreneurial managerial spirit. The convener became a part of a national organization for Parish Nursing, which had established guidelines, but allowed local flexibility. Thus, the convener initiated the coalition from inside the community but accessed external funding. She was connected to a local 501(c)(3) business that then sponsored a chapter of the Parish Nurse Coalition in this rural Black Belt community (Interview with convener, August, 2006).

CCAT proposes that coalition formation is more likely when the convening group provides technical assistance, financial or material support, credibility and valuable networks/ contacts. The Parish Nurse convening group offered credibility and the potential for networks and contacts. Actual support was provided in the form of initial grant funding, orientation materials, and thus some structure. Parish Nurse groups in other counties or states played a role in the start up by providing guidance and structural consultation.

The initial convener identified members of the nursing profession that attended her church and sought to recruit them into Parish Nursing. Nurses in other churches were recruited by the convening group. Expanded membership now includes nurses in nine different churches representing five and denominations. When the nurses in the respective congregations agreed to

participate, the pastors and governing bodies of the churches were approached to acknowledge the parish nurses as a health and wellness ministry within their church.

There are state, national and international components of this organization that share common bonds through vision, mission, and structure. The following is a typical description of the Parish Nurse concept:

> This coalition is rooted in the Judeo-Christian tradition, and is focused on the basic assumption that care for self and others is an expression of God's love. The mission of the International Parish Nurse organization is to foster physical, emotional, spiritual, and social harmony which leads to healthy and healing relationships with God, family, faith communities, and culture. (Deaconess Parish Nurse Ministries, 2009)

CCAT acknowledges that 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. The Parish Nurse networks and contacts are from within the local county. Members have external professional and personal relationships in that many of them have been classmates, coworkers and/or participated in many professional organizations together over time. The gatekeepers in this instance are nurses who are members of the respective churches and knowledgeable of the congregations of which they are members. The coalition members have the trust of those within their congregation. This trust is a key factor because the Parish Nurse works with members of his/her own congregation.

CCAT indicates that coalition formation usually begins by recruiting a core group of people who are committed to resolve the health or social issue. Membership in this coalition is restricted to those in professional nursing. However, other members may include health professionals in congregations of the churches and their multiple levels.

Open and frequent communication among staff and members helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely, according to CCAT. This coalition has no paid staff. All work is done by volunteers from within the coalition. Communication is both formal and informal.

Meeting minutes focused on the process of developing by laws and status updates on efforts to obtain a not for profit status. Strategic options were discussed to obtain funding for the application related to the not for profit status. A portion of the October 2009 minutes addressed participation in community functions (e.g., health fairs). A critique of county wide health fairs in which coalition members participated focused on variables such as weather, timing, advertisement, and conflict with other events. Further discussion focused on services requested during the fair which were not available due to malfunctioning equipment or unfamiliarity with a particular device. However, it was determined that over all participation in the health fair was a positive experience for the constituents who received services, as well as for the providers of the services. Education programs planned include a repeat performance of a workshop targeting teenage Christian relationships. Other topics considered were diabetic workshops focusing on involving children in cooking, food safety and preparation. Data do not reflect the any other coalition involvement except for Parish Nursing in this activity. The implication is that the Parish Nurse Coalition did recognize an opportunity to collaborate with an external organization. This workshop was to be held in February, 2009, in conjunction with Greek organizations, health care providers, and the Boy Scouts. Cervical cancer education is considered as a topic to be presented at one of the churches.

Minutes for the month of March, 2009 provided a list of topics such as human slavery, with a target audience of young girls and boys; the process of committing a client for mental

health treatment; and HIV/AIDS education, with a target audience of junior high to college aged students. The target audiences are within the respective church congregations. The ideas for topics originated from within the congregations.

Other activities common to all Parish Nurse Coalition meetings were educational sessions presented by various coalition members. Educational sessions presented within the Parish Nurse meetings focused on areas of interest or challenges encountered by individual members in their respective parish practices. Educational sessions are voluntary and occur at least quarterly. Topics provided in previous meetings focused on communication, privacy/confidentiality, and transportation. Plans or consideration for inviting pharmaceutical representatives to coalition meetings to make educational presentations were discussed. The possibility of periodically inviting the nurses' pastors or ministers to meetings was discussed. Meeting minutes for the month of February, 2009, reflected an attempt to contact the Baptist Association in order to provide it with more information regarding Parish Nurses.

The addition of new members was addressed, with programs for orientation discussed as well as attendance at orientation classes. Discussion focused on standards of practice found in the orientation book. These standards indicate that no hands on activities are performed unless the parish nurse is working directly with a physician, in which case the congregation member must sign a consent form.

Minutes from the month of March, 2009 focused on nurse commissioning ceremonies. According to the minutes, highlights of the orientation class were discussed on November 3, 2009. An internet course for Parish Nurse program orientation is offered by Trinity Regional Health System. Course highlights include a history of the Parish Nurse program, church culture, leadership, accountability of practice, health issues across the lifespan, health education and

promotion, complimentary therapies, grief and end of life issues, medical ethics, spirituality over the life span, family dynamics, emotional wellness, spiritual wellness, and stress management.

An interesting demonstration of collaborative synergy occurred following the unexpected death of the initial convener and primary contact. This coalition was a subsidiary of a larger organization, which was incorporated. This larger health focused grass roots organization had a 501(c)(3) status. This organization provided psychological counseling for abandoned and abused young women. Unexpectedly, the primary contact and convener who established the coalition became acutely ill and died very early during this author's interaction with the coalition. Following the death of the convener, conflicts were noted among coalition members, because they did not know the facts or the status of the 501(c)(3) organization. Fortunately, the organizational structure contained a president and other officers, which allowed the coalition meetings to continue. At the time of the researcher's attendance at the coalition meetings, however, officers were being identified and duties delegated particularly as related to by laws required for obtaining a separate 501(c)(3) status. The current status of the 501(c)(3) was in progress. Because of the longevity of the personal and professional relationships of the members of this coalition, conflict is not an issue. Their longstanding personal and professional relationships create a positive climate making collaborative synergy more likely.

CCAT states that conflict management helps create a positive climate, ensures that benefits outweigh costs, and makes collaborative synergy more likely. Since this coalition is comprised of a professional group support by local churches with each professional working with her/his own church's parishioners, its growth and survival depends on the continued recruitment of nurses and churches. In order for the coalition to grow and survive, it must continue to seek and obtain diverse internal and external funding sources.

CCAT proposes that strong leadership improves coalition function and makes collaborative synergy more likely through member engagement and pooling of resources. The current lead contact is also the president of this coalition. For years this individual has maintained active memberships in many health care organizations at all levels, local, state, and national. This individual was able to maintain the coalition during the unexpected death of its convener and has continued to guide the coalition through the process of reorganization. Familiarity with the structural needs of such an organization, allowed the president to ask for and receive volunteers to participate on committees, develop by laws, and seek the requirements for 501(c) (3) status so that the nursing coalition can continue its work and mission.

Paid staff is viewed by CCAT as necessary to make collaborative synergy more likely through member engagement and pooling of resources. The Parish Nurse Coalition has no paid staff. All work is performed by volunteers who are members of the organization. One coalition member provides the usual meeting place in her local church which is centrally located in the county.

Formalized rules, roles, structures and procedures improve collaborative functioning and make collaborative synergy more likely through member engagement and pooling of resources, according to CCAT. The coalition is rooted in the Judeo-Christian tradition, and its mission is consistent with the basic assumptions of many faiths that care for self and others are expressions of God's love. The mission of the International Parish Nurse organization is to foster physical, emotional, spiritual, and social harmony leading to healthy and healing relationships with God, family, faith communities, culture and creation of Registered Nurses serving in similar capacities within other faith traditions have also established similar ministries (Deaconess Parish Nurse Ministries, 2009).

Responses to survey Question 1B indicate that one-half of the participants believed that there was an organizational structure in place while the remaining half did not. All six respondents agreed that basic founding documents existed. Respondents indicated that decisions about needed actions were made based on a combination of data (two responses), written request (five responses), and community needs (three responses).

Parish Nursing interactions with their congregations are primarily on church premises. However, some home visits are made in conjunction with ministers or other church ministries, no medical health care services are provided.

Maintenance Stage

Successful implementation of effective strategies is more likely when comprehensive assessment and planning occur. The Parish Nurse Coalition's assessment and planning processes focus on coalition constituents. Services or activities are primarily restricted to their internal groups rather than the county population as a whole. There is some indication through minutes of involvement with Greek organizations and with other health professionals. Many of the nurses are members of sororities in addition to the Parish Nursing coalition. However, coalition participation in health fairs and other civic/political activities is by invitation from other groups rather than the coalition serving as host or initiator.

The coalition's member organizations (churches) collaborate to organize, implement, and evaluate community wide action plans. The Parish Nurse Coalition presents no evidence of complying with Proposition 17 except for their work on fulfilling requirements for 501 (c)(3) status. Another method to gauge the comprehensiveness of assessment, planning and implementation is via data related to evaluation or effectiveness (see Question 4B) which

addresses data sharing with external organizations. Four of the six respondents indicated such sharing occurs.

CCAT argues that coalitions must direct their interventions at multiple levels in order to accomplish change in the community. Though the Parish Nurse Coalition structural models are on state, national and international levels, the focus of the local coalition remains in the formation stage at the local level.

The criterion of membership has been described by survey respondents answering Question 6A as knowledge, licensure, skills (one response); service orientation (one response); and religious or faith based (one response). Survey Question 4A inquired regarding whether the coalition had relationships with organizations outside of the coalition. Three responded in the affirmative and three in the negative. This spilt in responses suggests that 50% of respondents are knowledgeable of external coalition relationship and the other 50% is not knowledgeable.

Institutionalization Stage

CCAT explains that coalitions that are able to change community policies, practices and environments are more likely to increase capacity and improve health/social outcomes. The Parish Nurse coalition is planting seeds among its youth memberships to affect positive change in behavior through educational activities described.

According to CCAT, by participating in successful coalitions, community members and organizations develop capacity and build social capital that can be applied to other health and social issues. The capacity of the Parish Nurse coalition to build social capital that can be applied to health and social issues lies within their mission and at this formative stage of development has yet to be realized.

The Parish Nurse Coalition is in the formation stage based on Constructs 3–4 and 12–14 which examine Lead Agency Convener Group, Coalition Membership, Community Change Outcomes, Health/Social Outcomes, and Community Capacity. The Parish Nurse Coalition shows no evidence of cycling. Threats identified by the Parish Nurse Coalition in Question 3C, which asks about services requested by the constituency which cannot be provided due to lack of adequate finances and qualified personnel yielded the highest three responses. They include six Parish Nurse Coalition responses identifying the need for health services; two identified transportation; one identified medications. This question correlates with (Construct 10, Proposition 17).

Summary

Four coalitions in this study were examined in terms of the three main stages (the formation stage; the maintenance stage; and the institutionalization stage) outlined in CCAT. The background and history of each coalition was examined along with the community environment.

Findings from the Diabetes Coalition indicated that it cycled from the formation stage to the maintenance stage, and recycles annually following their major annual educational events. Based upon CCAT this coalition fulfilled all requirements of a successful formation stage, in that it had an external lead agency/convener group that supplied funding, material support, credibility, and valuable network/contacts. Further the coalition membership includes a broad constituency of participants among whom there is open, frequent communication, shared and formalized decision making, and conflict management, all of which increase their collaborative synergy.

Findings from the Cancer Coalition indicated that it cycled from the formation stage to the maintenance stage and cycles into the institutionalization stage. This coalition began with an individual as an internal convener, and has had limited funding and resources through out its existence. Despite of challenges in the area of leadership, the services provided have impacted community practices and environment at multiple levels, which is an ultimate indicator of institutionalization and coalition effectiveness. Due to changes in community practices, social capital is being built that can be applied to other heath and social issues. Cycling continues through the maintenance stage with each successful grant obtained.

Findings from the Community Coalition indicated that it cycled from the formation stage to the maintenance stage, and recycles with membership turnover, or as new members are admitted into the coalition. Cycling has begun in the institutionalization stage. Based upon CCAT this coalition fulfilled all requirements of a successful formation stage, in that it had an internal lead agency/convener group that supplied funding, material support, credibility and valuable network/contacts. Further the coalition membership includes a broad constituency of participants among whom there is open and frequent communication, shared and formalized decision making and conflict management, all of which increase the collaborative synergy. The strong committee structure provides the opportunity for civic engagement.

Findings from the Parish Nurse Coalition indicated that it continues in the formation stage. It is in the process of restructuring following the death of its Convener, and lingering uncertainty for 501 (c)(3) status.

Chapter 5, Comparative Summary of Characteristics of the Four Coalitions Examined in Relation to Community Coalition Action Theory (CCAT), presents a complete listing of the

major findings (see Table 4). It will also evaluate the utility of CCAT as an analysis tool as well as make recommendations on how the coalitions might improve their operations.

CHAPTER V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The purposes of this study were to: (a) discover how rural community coalitions identify, access, and mobilize resources to eliminate health disparities in their community; (b) link founding documents, organizational structure, and budget with service provision strategies developed by these organizations; (c) determine the scope of approaches aimed at community advancement through interaction with various stakeholders; and (d) examine the outcome evaluation processes, subsequent responses, and their impacts on organizational longevity. Also, the study examined the utility of applying Community Coalition Action Theory (CCAT) to the analysis of the operations of rural community coalitions and utilized the results of the analysis to inform the coalitions studied of ways in which they might strengthen their coalitions and their work.

Summary of Findings

Relative to an analysis of the research done using Butterfoss and Kegler's Community Coalition Action Theory (CCAT), four coalitions located in a Black Belt county in the Southeastern region of the United States of America were examined. In application the theory proved useful to examine actual coalition behavior in the rural setting. It was an essential tool to uniformly identify areas of strengths and weaknesses of each coalition. Based on the data collected and determined by the constructs and propositions of CCAT, the four coalitions examined were shown to vary in the degree to which they correspond to the constructs and propositions of CCAT. In their respective stages of development, each of the coalitions is viable,

and each provides its constituents with needed strategies and techniques to reduce or eliminate health disparities in this rural Black Belt county.

Table 4 presents a comparative summary of the four coalitions relative to CCAT. It focuses on the specific structures and operations that CCAT constructions and propositions indicate must be in place in order to develop a successfully operating coalition.

Table 4

Comparative Summary of Characteristics of the Four Coalitions Examined in Relation to Community Coalition Action Theory (CCAT)

	Diabetes Coalition	Cancer Coalition	Community Coalition	Parish Nurses Coalition
Year Established	2004	2003	2005	2003
Current CCAT Stage of Development	Maintenance	Institutionalization	Early Institutional-ization	Formation
Evidence of Cycling	Yes. Following each annual educational activity.	Yes	Yes	No
Convener Internal or External (Internal preferred)	External; then, recruited internal convener	Internal; individual from grassroots cancer center	Internal group; local university	Internal; individual and the business with which she worked
Convener Recruited Local Gatekeepers	Yes	Yes	Yes	Yes
Convener Supplied Resources at Beginning	Grant money	Leadership	Financial support	Financial support
	Credibility	Credibility	Grant experience	Credibility
	Network/Contacts	Network/Contacts	Credibility	Network/ Contacts
	Goals	Goals	Network/ Contacts	Network/ Contacts
			Structure	Structure
Number of Members Organizations	12	17 (originally 9)	>100	18
General Expansion of Membership	Yes	Yes	Yes	Yes

Table 4 (continued)

	Diabetes Coalition	Cancer Coalition	Community Coalition	Parish Nurses Coalition
Membership Multilevel (Local, State, National, etc.)	Yes	Yes	Yes	Yes, but only indirectly through other Parish Nurses groups.
Membership Multi-Sector	Yes	Yes	Yes	No
Inclusion of Government Based Members	Yes	Yes	Yes	No
Criteria for New Members Exists	Yes	Yes	Yes	Yes
Organizational Chart	Yes, informal organizational chart exists.	Yes	Yes	No
Mission and/or Vision Statement	Yes	Yes	Yes	Yes
Bylaws	No	Yes	Yes	No, in progress
Orientation Materials	Yes	Yes	Yes	Yes
Regular Coalition Meetings	Yes. Teleconferenced.	Today: As needed; initially quarterly Teleconferenced	Yes	Yes
Minutes	Yes	Yes	Yes	Yes
Budget	Yes; members disagree on size	Yes, but amount not agreed upon	Yes	No, in progress
Not for Profit Status	No; however, the coalition is sponsored under another 501(c)(3) organization.	Being sought.	Yes	No, in progress
Major Funding Source	Grants	Grants	Grants	Affiliated churches and their members
Other Funding Sources	In-Kind Fund raisers	Private donors, organizational fund raisers, and Faith Based Institutions	In-Kind Government	Donations from faith based institutions, dues, private contributions
Funding Source Expansion	Needed	Needed	Needed	Needed

Table 4 (continued)

	Diabetes Coalition	Cancer Coalition	Community Coalition	Parish Nurses Coalition
Paid Staff	No; relies on local convener group's staff for coordinating activities	Yes, but paid by convener's organization	Yes	No
Staff Full-Time	No	No, part-time	No	No
Formal Committee Structure	Yes	No	Yes; seek to match member expertise & committee	No
Formal Leadership	Yes	No	Yes	Yes
Communication Processes	Open but tied mainly to activity planning	Open among members; less trustful of outside groups based on experience	Open but tied mainly to activity planning	Open
Major Focus of Assessment/ Planning Process	Evaluation of sponsored activities and demographics of attendees	Evaluation of sponsored activities and demographics of attendees	Best Practices; Evaluation of sponsored activities and demographics of attendees	Evaluation of sponsored activities and demographics of attendees;
				Responsive-ness to parish requests for programs
Evidence of Positive Member Synergy	Yes	Yes. Tested by crisis and survived.	Yes	Yes
Evidence of Member Commitment & Satisfaction	Yes	Yes.	Yes	Yes
Outcome Analysis of Impact on Health Disparities	No. Analysis of county statistics is not tied directly to clients served.	No. Analysis of county statistics is not tied directly to clients served.	Mixed	No
			Analysis of county statistics is not tied directly to clients served.	
			Benchmarking tied to comparison of member organization to similar group.	

Table 4 (continued)

	Diabetes Coalition	Cancer Coalition	Community Coalition	Parish Nurses Coalition
Improvements in Community Outcomes	Yes, only if one assumes increased participation in educational events results in change found in community statistics.	Yes, only if one assumes increased participation in educational events results in change found in community statistics.	Yes, only if one assumes increased participation in educational events results in change found in community statistics and if benchmarking an organization improves the community.	No
Capacity Building and Adaptability	No	Yes	Somewhat. Building community wide leadership and skills	No
Expansion into New Areas	No	Yes, but still cancer related.	Yes	No
Likely Future Problem Areas	Lack of funding diversity	Lack of funding diversity	Need to increase funding diversity	Lack of funding diversity
	Need to measure outcomes of own activities	Distrust of outside groups	Need to measure outcomes of own activities	Single sector dominance of coalition
		Need to measure outcomes of own activities		Numbers of county health care personnel living outside the county

Diabetes Coalition

The Diabetes Coalition is perceived to be in the Maintenance Stage of development (Propositions 1–18) identified by CCAT and summarized in Table 1. Therefore, it has the necessary attributes to sustain its mission, and make impacts within the community. However, it

must enhance its documented ability to change community policies, and demonstrate measurable improvements in health and social outcomes (Propositions 19–21).

Cancer Coalition

The Cancer Coalition is perceived to be in the Institutionalization Stage of development (Propositions 1–21). The Cancer Coalition did not begin with the necessary attributes as described in Proposition 4. Proposition 4 explains that a lead agency or convening group is needed. This coalition did not possess a lead agency as described in the Proposition 4, but it had only one rural grass roots entrepreneur who performed the duties and responsibilities of the convening group, with the exception of Proposition 5, providing financial or material support. Since inception it has struggled to and will continue to struggle in providing services to its constituents due to lack of funding and organizational challenges. This coalition must actively seek internal and external funding to actualize its mission and make additional impacts. Although this coalition is having some challenges as described in Propositions 4 and 5, relative to convener group and financial or material support, and conflict management as described in Proposition 11, it has been sustainable. The Cancer Coalition is aligned with Propositions 19–21, which describe community change outcomes polices and practices, improvement in health and social outcomes and an increase in social capital.

Community Coalition

The Community Coalition is perceived to be in the Institutionalization Stage of development (Propositions 1–18) as described by CCAT. Therefore, it has the necessary attributes to sustain its mission and make impacts within the community. Long term sustainability or institutionalization of the Community Coalition will require continued compliance with Propositions 19–21 which focus on documented change in community policies,

practices, increased capacity, and improved health/social outcomes. In addition there is a need for continued focus on benchmarking, as well as a quest for external and internal funding to support their vision and mission.

Parish Nurse Coalition

The Parish Nurse Coalition is perceived to be in the Formation Stage as evidenced by its current restructuring. This means that the coalition does not correspond to CCAT Propositions 8, 13, 14, 17, 18, or 20. Concomitant with their mission, this coalition can improve its performance in the community by seeking internal and external funding and a more diverse membership beyond the nursing professionals within the church.

Conclusion

Based on the review of literature examined in this study, a "health disparity" is defined as the following: Health disparities are defined as "differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific duration groups in the US" (Health Disparities Interest Group (HDIG), 2006). Disparities represent inequalities in the quality of life for segments of the population and are considered a national problem. They reflect inequities in the quality and delivery of services and affect healthcare at all points in the delivery process, at all sites of care, and for all medical conditions (National Healthcare Disparity Report (NHDR: Summary, 2004). Inequities can exist in both minority populations (e.g., African Americans and Hispanics) and geographically defined groups such as rural residents.

Each of the coalitions examined is addressing health care disparities by focusing on altering behaviours that contribute to higher incidence of specific diseases (e.g., cancer and diabetes) in the Black Belt county's largely African American rural population. To this end they

have concentrated primarily on educational efforts aimed at that population as well as the continuing education of health care professionals that serve the population. Through health fairs and other activities (e.g., home visits in the case of the Parish Nurses), they also provide basic screening and direct participants to other available screening. Though not quantifiable, basic community education and initial screening services have increased awareness. This increased awareness of actual and potential disease states has resulted in more constituents, both male and female, performing self screening as appropriate and requesting screening as a part of regular health care visits. Even the basic knowledge of risk factors are incrementally changing behaviour and influencing preventative actions within the community. Quantifiable follow up is needed for individuals identified through health fairs and community educational activities as experiencing a health disorder. Examples for quantifiable outcome measures could include documentation indicating: (1) Affected individual was referred for additional health care follow up, and (2) Call made to individual to determine if they followed up with private health care provider.

How useful is Community Coalition Action Theory (CCAT) for guiding research on community coalitions in the rural context and for assessing a coalition's effectiveness? Analysis of the data in this study, using Butterfoss and Kegler's Community Coalition Action Theory, suggests that CCAT is an effective tool to uniformly identify areas of strengths and weaknesses of each coalition. The propositions and their related constructs provide guidance on specific characteristics of a coalition to identify and evaluate as well as which of these lay the foundation for positive coalition growth and development. Based on the data collected as determined by the constructs and propositions, the coalitions studied were shown to vary in the degree to which they comply with the theory. In their respective stages of development, all four

coalitions are viable and to their constituents they provide needed strategies and techniques to reduce or eliminate health disparities in this rural Black Belt county.

If CCAT is a useful tool, it should lead to answers to the following questions.

e. How do rural grassroots coalitions identify access and mobilize resources to eliminate health disparities in their communities?

Coalition responses to Question 3A, which asked for a listing of the organizations primary stakeholders, indicated that except for the Parish Nurses, all coalitions had a diverse multidisciplinary group of stakeholders on multiple local, state and national levels. Stakeholders were identified from private businesses, faith-based groups, community members, educational arenas, governmental, professional and funding organizations. CCAT, Proposition 4, describes identifying, accessing, mobilization of resources, and the role of a convener group. Gatekeepers, who are trustworthy reputable members of the community, and who have knowledge of the needs of the community, are described in Proposition 6. A passion to resolve health or social issues is described in Proposition 7. The importance of a paid staff in promoting collaborative synergy and the significance of open and frequent communication is described in Proposition 9. The importance of leadership/decision making is described in Proposition10. The necessity to minimize conflicts is described in Proposition 11. The importance of the role of member involvement and engagement is described in Proposition 15. Synergistic pooling of resources to impact health and social problems at local and multiple levels is described in Propositions 16 and 18. Therefore CCAT is a useful tool for rural coalitions to identify access and mobilize resources to eliminate health disparities in their communities.

f. Do founding documents, organizational structure, budget and service provision strategies developed by the coalition's link to the elimination of health disparities?

According to CCAT, formalized rules structures and procedures make collaborative synergy more likely. An example of these rules, structures, and procedures, are founding documents such as mission, vision, goal statements, organizational charts, formal and informal, budget/funding sources, Proposition 14. These structures facilitate the comprehensive assessment, planning and pooling of resources on many levels, Proposition 16. Thus founding documents, organizational structure, budget and service provision strategies developed by the coalitions do link to the elimination of health disparities.

What are the outcomes of the evaluation process used by the coalitions, subsequent responses, and their impacts on organizational longevity? The outcomes of the evaluation process used by the coalitions, as indicated, in Question 7D3, which asked how has the results of measurements or evaluations been used in the past, indicate that feed back was used to provide better service for planning, meetings, additional services, assess need/effectiveness, funding and grant retention. According to CCAT, Proposition 17, successful implementation of effective strategies is more likely when comprehensive assessment and planning occur. Proposition 18 focuses on implementation to create change in community practices. Propositions 19–20 focus on improving health and social outcomes. Therefore, CCAT is a useful tool in determining the outcomes of the evaluation process used by the coalitions in this study.

The four coalitions participating in this study do cooperate with each other through availing resources and providing board based support during community health fairs. During the annual events such as educational activities or fund raising gala's each of the coalition's

memberships is highly visible. The coalitions in the study will benefit from greater cooperation in the areas of: (1) pooling resources to identify a broader base of funding, (2) transtructural communication between the coalitions focusing on health related developments, and (3) greater participation in the county's business meetings.

g. Which of the four coalitions as they are now organized and operating are most likely to succeed in their goals? Why?

Based upon the analysis of the four coalitions in this study the Community Coalition is most likely to succeed. This coalition, though in the early institutionalization stage, has complied to some degree with the CCAT propositions 1–21 for long term sustainability.

The Community Coalition is concerned with health issues stemming from its desire to strengthen and develop an infrastructure for future development and community advancement. The coalition is a subsidiary of a larger state, regional, and national organization, which have established guidelines that influence coalition functioning and reporting. Other structural guidance and decision making has been conducted through defined committees and requirements for committee participation. The Community Coalition is committed to sustainability, promotion of diversity, inclusiveness, moral values and principles to effectively integrate, leverage, and manage resources to obtain maximum results.

Minutes of coalition meetings also provided a draft of environmental strategies for the period 2009–2011. Strategies included memos to county consumers and regulatory offices, city and county law enforcement offices, and plans to use media and telephone to educate the community on prevention awareness information. The Community Coalition functions as an independent organization with a structure, staff, decision making processes, communications and other elements. The Community Coalition website focused heavily on comprehensive

assessment and planning. There is a published effort on the part of the Community Coalition to adopt best practice standards. There are opportunities for civic engagement and application of specific skills and training through committee participation.

Recommendations

The analyses of the four coalitions suggested areas of weakness and potential problems that each coalition might face. Based on these findings the following recommendations are offered.

Diabetic Coalition

The Diabetes Coalition should enhance documentation of its ability to change community policies and demonstrate measurable improvements in health and social outcomes. The coalition should benchmark internally to identify diverse funding from external sources and internal funding from members to support the vision and mission of the coalition.

Cancer Coalition

The Cancer Coalition should actively seek internal and external funding to actualize its mission and make additional impacts. Also, it is recommended that the Cancer Coalition administrative team participate in a conflict management resolution seminar to learn how to minimize conflict within the organization. Thirdly, the leadership and membership must develop written policies and procedures to eliminate data abuse and enhance trust with external organizations.

Community Coalition

The Community Coalition should continue to focus on benchmarking and collection of the necessary data to evaluate progress toward its mission and vision. The coalition should continue its quest for funding from external sources and internal funding from members to

support the vision and mission of the coalition. Without such efforts its heavy reliance on grants may serve to drain monies and personnel needed for the educational/preventive efforts

Parish Nurse Coalition

The Parish Nurse coalition should improve its performance in the community by seeking internal and external funding and a more diverse membership beyond the nursing professionals within the church. For example, survey Question 3C, describes services requested but unavailable to constituents due to a lack of resources. These services may be available through resources within the congregation and inclusion of these professionals in the work of the Parish Nurse Coalition would be an interdisciplinary approach to constituent needs. Some of the professions described in survey Question 3 include consultation with social workers, pharmacists, in home assistance, business professionals, lawyers, office workers, construction, repair and maintenance.

All Four Coalitions

Working together the four coalitions in this study should develop a uniform and sustainable database to collect and store social and demographic data to be used for the advancement of the coalitions and the county at large. As it stands now, they are largely duplicating efforts.

Other areas that the coalitions could collaboratively work toward are: (1) more comprehensive transtructural communication between the coalitions specifically related to health development, (2) joint planning for county wide activities, (3) altruistic approaches to constituent outcomes, and (4) greater participation in the county's business meetings.

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Appendix A

Institutional Review Board (IRB) Letter

INFORMATION LETTER
for participants in a survey of

Rural Grass Roots Coalitions:
A study of the relationship between resources and sustainability
in promoting community advancement through eliminating health disparities

(do not agree to participate unless an IRB approval stamp with current dates has been applied to this document.)

You are invited to participate in a research study to determine any significance or relationship of resources to sustainability from the perspective of founding documents, community advancement and organizational longevity. The study is being conducted by Hope R. Warren, Doctoral Student in the Auburn University at Montgomery Department of Political Science: Public Administration Public Policy. You were selected as a possible participant because, you represent an organization that is a member of a rural grass roots coalition responding to the challenge of sustainably eliminating health care disparities.

What will be involved if you participate? If you decide to participate in this research study, you will be asked to complete a 25 item survey based on your knowledge of the coalition processes in areas of organization; budget; stakeholders; relationship to organizations outside of the coalition; relationship to government; new members, and outcomes. Your total time commitment will not exceed one hour (60 minutes). We do not believe you will be subject to any risks or discomforts.

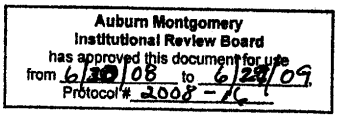
Are there any benefits to yourself or others? If you participate in this study, you can expect to benefit through an increased awareness of knowledge of issues held by and concerns important to representatives of coalition member organizations. Additionally the information provided may help others better understand the relationship between resources and sustainability in the work of rural grass roots coalitions. We/I cannot promise you that you will receive any or all of the benefits described.

Will you receive compensation for participating? You will not receive any payment or gifts for participating in this study.

Are there any costs? There are no costs to you as a participant in this study.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw, your data can be withdrawn as long as it is identifiable. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University at Montgomery, Department of Political Science. Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provided by:

- No interactions will be tape recorded.
- Hand written notes may be taken if survey completion generates questions or discussions. Anecdotal notes, if any, may be used during analysis of data from the respective group, but no individual names will be recorded, only the coalition name will be reflected on the notes.
- Voluntarily provided names, identifying data or contact information will be maintained in a locked fire proof file cabinet in the home of the researcher, until destroyed through shredding and deletion of electronic data after analysis.



- Any identifying information shared between the instructor and student will be hand delivered on hard copy. All electronic data is pass word protected.
- Surveys are color coded (pink, blue, and green, yellow) and each coalition will be referred to only by color of survey tool used. No coalition group will be made aware of the color form used by any other group.
- No personal names or names of individual organizations will be used during the reporting of the research results. The county is identified as being in the black belt region of the south eastern United States.
- Each coalition will receive the survey on a different colored paper. In the event that electronic medium is used, color coding of the electronic tool will apply to correspond with the color of the paper tool. All surveys will be maintained confidential, analysis of responses will be summarized.
- All surveys will be maintained confidential, results of analysis will be presented to each coalition as they apply to responses provided their respective membership compared to the combined responses of all coalitions.

Results of information collected through your participation will be used as basis for Dissertation work. It may also be used to fulfill an educational requirement such as publication in a professional journal, or presented at a professional meeting.

If you have any questions about this study, please contact Hope R. Warren, at 334-421-9052 and or (Dr Linda Dennard, phone# 334- 244-3646.

If you have questions about your rights as a research participant, you may contact the AUM, Office of Sponsored Programs: Debra Tomblin 334-244-3250.

Having read the information provided, you must decide if you want to participate in this research project. If you decide to participate, the data you provide will serve as your agreement to do so. This letter is yours to keep.

_____

Investigator's Name Date

Hope Warren

Print Name (Investigator)

Appendix B

Survey Instrument

[+] 7. Appendix C if data collection sheets, surveys, tests, or other recording instruments will be used for data collection. Be sure to mark each of the data collection instruments as they are identified in section #13, part c.

Rural Grass Roots Coalitions:
Tool to Survey
Assessment of Resources to Promote Sustainability

Date: _____

Name of Coalition:

_____

Name of Member Organization (that you represent):

_____

If I need to clarify certain points may I contact you? Yes [ ] No[ ]

Contact information:

Your Name_____

Title (if any):_____

Mailing address: _____

E-mail_____

Phone_____ Best time to call_____

Thank You
for consenting to participate in this survey

Directions: Please respond to each question by circling the number that best describes your coalition. The information that you provide will be held in strict confidence and reported with other responses in a summary form.

1. Organizational structure

A. How long has this organization existed? (please check one)

1	0-3 years;	4	11-15 years;
2	4-7 yrs;	5	16-20 years;
3	8-10 years;	6	21-26;
		7	27 years or more.

B. Does this organization have an organizational chart?(please check one)

1	Yes	2	No

C. Does this organization have brochures or literature describing the organization inclusive of statement of mission, vision, values, and goals?

1	Yes	2	NO

D. How are decisions made regarding issues or projects that require action or response by the coalition? (more than one may apply)

1	Data based	3	Professional organization
2	Written request	4	National/governmental organization
5	Other (specify)		

2. Budget

A. Please provide a rough estimate of this organizations annual budget?

1	0-$5,000;	5	21-30,000
2	6-10,000	6	31-40,000
3	11-15,000	6	41-50,000
4	16-20,000	8	51,000-or greater

B. Percentage wise, what are the principle sources of operating funds?

1	%_____Dues	5	%_____Government Agencies
2	%_____Grants	6	%_____Private contributions
3	%_____Religious Organizations	7	%_____Fund raisers
4	Other---specify		

C. Is the organization tax-exempt under the Federal Internal Revenue code

1	Yes	3	No		
2	How long _____		Plans for 501 (c) 3?		
		4	Yes	5	No

3. Stakeholders

A. Who are the organizations primary stake holders? Please list.

B. How do the stake holders make their needs known? Please list.

1	Written request	4	Mandate by Professional/Governmental organization
2	Verbal request	5	Internal observation of demographic trends
3	Request For Proposal		

Other (specify)

C. Please identify by category services requested by stakeholders/constituents which you would like to provide through this organization if the resources were available?

1	Health services	8	Transportation

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Protocol # 2008-16

	2	Medications	9	Operating equipment & repairing machinery
	3	Personal care services	10	Supervision
	4	Office skills	11	Sales
	5	Construction and repair	12	Security
	6	Maintenance	13	Community skills/affiliations;
	7	Food	14	Business interest /activities/ experiences
	Other (please specify)			

4. Relationship to organizations outside of the coalition

A. Is this coalition part of any other local, state or national; professional or governmental organizations?

1	Yes	2	No

If yes please provide names:

B. Is data shared with these organizations?

1	Yes	2	No

C. Has membership/affiliation with external organizations influenced the statement of mission, vision, values, and goals of this organization?

1	Yes	2	No

D. How does the statement of mission, vision, value, goal of this organization correlate with that of the city or county? Please indicate by selecting: 1= Highly; 2 = Moderately; 3 = Little; 4 = Not at All; 5 = Unknown

		Mission	Vision	Value	Goal
1	Highly				
2	Moderately				
3	Little				
4	Not at all				
5	Unknown				

D. Does this coalition have benchmark(s) for the member organizations?

1	Yes	2	No

Yes (if yes please specify)

5. Relationship to government

A. What governmental/political groups does this coalition network with or form relationships with. (Please list)

B. How does this coalition strategically approach or appeal to political entities. (Please describe)

6. New members

A. Are their criteria for new member selection?

1	Yes	2	No

What consideration is given to the organizational needs with respect to the applicant organization? (Please briefly describe)

7. Outcomes

A. Organizationally, what would you identify as the area needing most improvement? Please mark all that apply.

1	Literature describing the organization inclusive of statement of mission, vision, values, and goals	6	External benchmarking
2	Decision making regarding issues or projects that require action or response by the coalition	7	Political networks
3	Diversity of funding sources	8	New member selection
4	Stakeholder Identification	9	Measurement or evaluation
5	Diversity of services provided to stakeholders	10	Data collection

Other (specify)

B. Organizationally, What would you identify as the area of greatest strength?

C. Provide two examples of success stories.

1.

2.

D.

1 How is progress toward the statement of mission, vision, value, goal of this organization measured or evaluated?

2 At what frequency?

3 How has the results of measurements or evaluations been used in the past?

E. What types of data are collected on each activity or service of the coalition?

1	Date	6	Title or type of service	11	Cost/Budget to render or provide service
2	Description of activity or service	7	Target Audience	12	Evaluation
3	Planning committee or individuals approving	8	Description of need	13	Location
4	Instructors/activity leaders	9	Statement of Goal/Purpose	14	Roster with Number in Attendance or Par level
5	Qualifications of instructors/activity leaders	10	Measurable Objectives	15	Sponsors

Other (specify)

F. What types of data are collected on the constituents served by the coalition?

1	Illness or disease state	5	Gender
2	Race/ethnicity	6	Age
3	Income (negative/poor; near poor; middle income; high income)	7	Education (less than high school; high school graduate; at least some college
4	Living status (alone with family)	8	Health insurance (private; public; uninsured)
5	Contact information (address with zip code, telephone)	9	Employment status

	Other (specify)			
G.	At what point does your documentation support that data collection began? More than one may apply.			
	1	Within founding documents	4	Within 6-10 encounters
	2	With first official encounter	5	Data collection has not yet started
	3	Within 2 to 5 encounters	6	Unknown
	Other (specify)			