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UNDERSTANDING MEMBER ENGAGEMENT THROUGH PARTICIPATION AND COMMITMENT IN A COMMUNITY-BASED HEALTH COALITION, 1994-2008: A MIXED-METHODOLOGICAL STUDY

by

Christopher Scott Holliday

Under the direction of James G. Emshoff

ABSTRACT

Community coalitions are prime vehicles for fostering social support within communities and prominent mechanisms for building local capacities to address health and social concerns. However, sustaining these entities beyond initial efforts and funding is difficult. What has kept members participating in and committed to the work of the Clarkston (Georgia) Health Collaborative, a community coalition, nearly 15 years after its inception? Prior research has examined several variables that predict overall participation and commitment in community-based coalitions, however, the literature has largely focused on coalitions that are topic driven (e.g., diabetes, gang violence, drugs, or obesity). These studies fail to identify those factors that are important in sustaining efforts in non-topic-based (i.e., there is no singular focus, but topics are community generated and vary), non-grant-funded community coalitions.

This cross-sectional study examines member engagement as a sustaining factor of coalitions. Members of the Clarkston Health Collaborative (N = 93), ages 21 to 70 years and representing various sectors of the community, as well as racial and ethnic backgrounds, were surveyed as part of a coalition assessment in 2007 and 2008 in Clarkston, Georgia. Predictors that influence their participation and commitment, key components of engagement, are analyzed. These components were: leadership, social resources, sense of community, empowerment,

member satisfaction, communication, decision making, and participation benefits. Based on the review of the literature, specific mediating relationships are hypothesized. A mixed-methods approach is employed, including path analysis that tests how well process models fit the coalition data, as well as key informant interviews by coalition members.

Toward a conceptual model of engagement, findings supported the hypothesis that effective leadership increases member participation through increased social resources. Findings also supported the hypotheses that shared decision making and effective leadership increases member commitment through increased member satisfaction. Clear communication and sense of community were also factors that contributed to increased participation and commitment.

These findings have implications for intervention, policy, and research, including a need for interventions that recognize the contexts of influence that foster member engagement in community-based coalitions. In addition, insight is gained for the planning and implementation of other coalitions to help ensure coalition sustainability.

INDEX WORDS: Coalition, Community, Sustainability, Leadership, Social Resources, Sense of Community, Empowerment, Member Satisfaction, Communication, Decision Making, Participation Benefits

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by

Christopher Scott Holliday

A Dissertation Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy

in the College of Arts and Sciences

Georgia State University

2008

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by

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August 2008

DEDICATION

I would like to dedicate this manuscript to my family, who supported me throughout my life and who helped shape me to become who I am today. I would also like to dedicate this work to the memory of my grandfather, Luther H. Holliday, Sr., my uncle Jerome Holliday, Sr., and my aunt Mable Miliner. Each uniquely influenced my growth as a son, as a father, and as a man of God.

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A special thank you goes to my dissertation chair, Dr. James Emshoff, who believed in me and trusted my ability to deal judiciously with this critical research and for teaching me the principles of Community Psychology. As well, special thanks to my supportive dissertation committee, Dr. John Peterson, who always demonstrated sound judgment, Dr. Sarah Cook, who patiently helped me to make sense of statistical challenges, Dr. Marci Culley, who helped me to appreciate and honor the added richness of the qualitative method, and Dr. Bethann Cottrell, my mentor and friend, and the reason this research is even possible.

Lastly, immense gratitude goes to my behind-the-scenes angels: Dr. Mayowa Obasaju, my writing partner and super-student, Dr. Jerris Raiford, the gold standard, Dr. Leslie Jackson, a source of inspiration, Dr. Jim Griffin for directing me to Community Psychology, Dr. H. Earl "Doc" Holliday, my uncle, for paving the way, and to Dr. Beth Ruddiman for helping to make it all come together! Most importantly, thank you to the residents of the City of Clarkston and the members of the Clarkston Health Collaborative for their commitment and participation for nearly 15 years of grassroots community mobilization. The sky is the limit when community cares.

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LIST OF ABBREVIATIONS

CCAT	Community Coalition Action Theory
CFI	Comparative Fit Index
CHC	Clarkston Health Collaborative
CI	Confidence Intervals
CITI	Collaborative IRB Training Initiative
COR	Conservation of Resources
DV	Dependent Variable
EM	Expectation Maximization
HMR	Hierarchical Multiple Regression
IRB	Institutional Review Board
IV	Independent Variable
MLE	Maximum Likelihood Estimation
MV	Mediator Variable
MVA	Missing Value Analysis
OLS	Ordinary Least Squares
PI	Principal Investigator
RMSEA	Root Mean Square Error of Approximation
SOC	Sense of Community
SRMR	Standardized Root Mean Square Residual

INTRODUCTION

We live in an age of increasing individualism, a time when a decrease in civic engagement or people's connections with the life of their communities, and an erosion of social capital are being increasingly reported (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985, 1991; Edwards, 2004; Putnam, 1993, 1995). Yet, there are ongoing processes of community association, community organizing, community mobilization, and community conversations where regular, collaborative exchange among neighbors, elected officials, agencies, businesses, faith institutions, and various other segments of the community is occurring. These collaborative exchanges are taking place in an effort to produce a better, healthier environment, community, or setting. In fact, it was Americans' propensity to organize in associations to address local issues that prompted Alexis de Tocqueville, in his 1835 book *Democracy in America*, to describe this unique phenomenon. He remarks:

> "Americans of all ages, all stations in life, and all types of disposition are forever forming associations. There are not only commercial and industrial associations in which all take part, but others of a thousand different types–religious, moral, serious, futile, very general and very limited, immensely large and very minute. At the head of any new undertaking, where in France you would find the government or in England some territorial magnate, in the United States you are sure to find an association" (DeTocqueville, 1945).

Since the time of de Tocqueville, several modern masters of community organizing and mobilization from around the world have emerged as beacons of social justice, where last names speak volumes for social change, including Alinsky, King, Gandhi, Horton, Freire, Douglass, Bhutto, Biko, and Chavez. Their skill at organizing communities and groups often led to large scale, collective action and social movements. These social movements mounted challenges through direct, oft times disruptive action against elites, authorities, other groups, or cultural

codes (Tarrow, 1994). The pervasive sentiment in all cases was that the end result (i.e., social change) justified the means (i.e., mobilizing community) (Alinsky, 1971). De Tocqueville (1945) noted that better use has been made of association and this powerful instrument of action has been applied for more varied aims in America than anywhere else in the world.

While these are examples of national and international organizers whose efforts and effects are renown, there are an increasing number of equally effective efforts that are occurring at the grassroots level in communities around the U.S. As noted by De Tocqueville, these efforts have been around for some time. However, due to a rise in recent years in the popularity of community coalitions, communities are utilizing this vehicle as an effective way to improve conditions in which people live. Community coalitions in contrast to neighborhood, block, and other civic associations, present a blend of representatives from different entities that comprise community life working together to improve their community. Coalitions are dynamic organizations. They are affected by people, other organizations, funding streams and a myriad of other forces of change. Undeniably, coalitions have the potential to spark social change. As mechanisms for pooling the abilities, expertise, and resources of varied stakeholders (Granner & Sharpe, 2004), coalitions empower communities to realize common goals.

Association through community coalitions gained popularity in the mid-1990s as an effective tool for health promotion and community mobilization (Butterfoss, Goodman, & Wandersman, 1993). Since this time, several researchers have studied the effectiveness of coalition efforts. The majority of the coalition literature emerged during the mid to late 90s (Butterfoss, Goodman, & Wandersman, 1993, 1996; Chinman, Anderson, Imm, Wandersman, & Goodman, 1996; Cook, Roehl, Oros, & Trudeau, 1994; Florin, Mitchell, & Stevenson, 1993; Francisco, Fawcett, Wolff, & Foster, 1996; Kegler, Steckler, McLeroy, & Malek, 1998;

Kumpfer, Turner, Hopkins, & Librett, 1993; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Minkler, 1999; Taylor-Powell, Rossing, & Geran, 1998; Wandersman, 1995; Wandersman, Goodman, & Butterfoss, 1997; Wandersman et al., 1996; Wolff, 2001a) and continues into the new millennium. As in many community-based processes, there is potential for adjustment in coalition structure and methodology as time and community stakeholders change to meet community needs. Although many of the established behavioral measures of coalition characteristics and functions (e.g., leadership, individual participation, and member commitment) remain salient, these and other measures are not widely tested on more recent, non-traditional, community-based coalitions that have emerged.

Study Rationale

This study examines factors that have lead to the continued sustainability of and active engagement in the Clarkston Health Collaborative, more than 14 years after its founding. For the purposes of this study, "collaborative" and "coalition" are interchangeable terms. Specifically, the focus is on factors that foster participation (past and current) in the Clarkston Health Collaborative, as well as member commitment to the work of the group. This research is designed to answer the following questions: What primary factors (i.e., leadership, communication, decision making, and sense of community) influence or predict overall participation in and commitment to a non-topic focused, volunteer, community-based coalition? How still do other variables (i.e., member satisfaction, participation benefits, social resources, and empowerment) help explain (i.e., mediate) the relationships between these primary factors and participation or commitment?

Understanding the factors that influence member participation and member commitment can provide insight into overall member engagement and thus, set a platform toward developing

strategies to ensure coalition sustainability for the planning and implementation of other coalitions. Moreover, for community mobilizing efforts that involve coalitions, this study seeks to shed light on those mechanisms that interrelate to foster participation and commitment in community-based efforts, in general, and that directly affect participation and commitment in a volunteer community coalition, specifically. For those currently engaged in a non-topic based community coalition (i.e., there is no singular focus, but topics are community generated and vary) or contemplating initiating one with similar structure and dynamics to those of the Clarkston Health Collaborative, this study provides a clearer understanding of which components of the process directly influence continued participation and commitment by members, and thus sustainability.

In the following sections, a brief account of community mobilization and community organizing as one way of framing the efforts of community-based coalitions is provided. Then, community coalitions, how they work, and how they have been popularized as vehicles of health promotion is described. Next, the current research on coalition functioning and the contextual variables related to active member engagement in coalitions is reviewed. Finally, a case report of the coalition to be examined in this study is presented.

As a result of the above examination, hypotheses were tested to determine what characteristics and functions of the Clarkston Health Collaborative, a non-traditional, community-based volunteer coalition, have fostered member engagement since its inception in 1994. A mixed-methods approach was employed.

CHAPTER 1

LITERATURE REVIEW

Community Associations

Why, in general, do people in a community organize or form associations? People organize for various reasons, but it is shared or overlapping interests and values that are at the basis of their common action (Tarrow, 1994). It is this common purpose that is believed to help create a sense of self-efficacy through psychological empowerment (Zimmerman, 1995, 2000), and sense of community (Chavis & Wandersman, 1990; McMillan & Chavis, 1986; Sarason, 1974). These individual-level benefits are created or enhanced through community mobilization by various mechanisms, including social support, social capital, resource mobilization, and resource conservation. The underpinnings of these factors across different organized groups appear to be the fostering of connections and relationships among people.

Social Support

Social support is a key aspect of community association efforts and is defined as helping transactions that occur between people who share the same households, schools, neighborhoods, workplaces, organizations, and other community settings (Barrera, 2000). It is a central tenet of community mobilization and has been studied as a byproduct of community efforts (Barrera, 2000; Hobfoll, Freedy, Lane, & Geller, 1990; Minkler, 1981). As a consequence of helping transactions, a more recent construct called social capital has developed.

Social Capital

Social capital is defined as the features of social organization such as networks, norms, and social trust that facilitate coordination and cooperation for mutual benefit (Putnam, 1993, 1995). This aspect of community association is not widely understood, but social capital is also

believed to be a byproduct of the mobilizing effort. Putnam (1995) claims that the mechanisms through which civic engagement and social connectedness produce mutually beneficial results–better schools, faster economic development, lower crime rates, and more effective government–are multiple and complex. He notes the striking similarities of these mechanisms across hundreds of empirical studies in a dozen disparate disciplines and subfields (Putnam, 1995). Other researchers agree that social capital is critical to social order and in community associations (Coleman, 1998; Fukuyama, 1999).

Resource Mobilization

A prominent impetus to community associations is explained by the resource mobilization theory, which suggests that organizing and action occur when people have access to resources they can use to create change (McCarthy & Zald, 1977; Walsh, 1981). The theory was first posited by McCarthy and Zald (1977), and assumes that strain/grievances are constant, and that what changes, thus giving rise to movements, is the accessibility of resources to mobilize, not a realization of deprivation, for example. Thus, the association phenomenon not only facilitates social cohesion in a community, but it works to realize what resources (or assets) are available, as well as those that might be brought to bear.

Resource Conservation

As a complement to resource mobilization, Hobfoll, Freedy, Lane, and Geller (1990) developed a motivational model of social support based on a general stress model termed Conservation of Resources (COR) theory. The theory suggests that individuals have as a primary goal to preserve and protect those resources that they value. Social support provides a major reservoir for resources outside those endowed to the self (e.g., high self-esteem, sense of mastery). Hobfoll et al. (1990) further suggest that social support may be a central building

block of health and well-being because together with personal resources, it is related to overall sense of identity. Community associations, then, work to safeguard and maintain critical community resources necessary for continued vitality.

Community-based Associations

A tenet of community psychology is citizen participation (Florin & Wandersman, 1990). Citizen participation is defined as "a process in which individuals take part in decision making in the institutions, programs, and environments that affect them" (Heller, Price, Reinharz, Riger, & Wandersman, 1984). Unfortunately, coalition efforts to impact the community should, but often do not, involve community residents and grassroots organizations. Participation in coalitions by these groups distinguishes the coalition from other, more directed, community development efforts. Chavis and Florin (1990) originally introduced the concept of citizen participation in coalitions using the terms "community-based" and "community development."

The "community-based" approach works with community members primarily as consumers of services. Community-based coalitions also include both professional and grassroots leaders to influence more long-term health and welfare practices for their communities and are often formed in relation to a funding proposal (Butterfoss, Goodman, & Wandersman, 1993).

The "community development" approach works with community members in planning and producing services and builds on the community's strengths (Chavis & Florin, 1990). Community development is based upon a philosophy that emphasizes competencies and helping people to become subjects instead of objects, acting upon their situation instead of reacting to it (Christenson, Fendley, & Robinson, 1989). According to Christenson et al. (1989), the aims of community development are to: (1) stimulate local initiative by involving people in community

participation, specifically the process of social and economic change, (2) build channels of communication that promote solidarity, and (3) improve the social, economic, and cultural well-being of community residents. Examples of community development coalitions include Project ASSIST Coalitions; Communities That Care coalitions; Alcohol, Tobacco and Other Drugs coalitions; and Family Connections Coalitions.

Both community-based and community development approaches have value, and both involve citizen participation. Although they represent two ends of a spectrum, elements of each can be present in any given coalition. For the purposes of this study, the focus is on assessing member engagement in a community-based volunteer coalition that employs a strengths-based approach toward improving the health and well-being of the community, and thus embodies aspects of both traditions (see Appendix A. The Clarkston Health Collaborative: A Case Report).

Association through Community Coalitions

How Coalitions Work

"Coalition" comes from the Latin *coalescere* ("to grow together") and *coalitia* ("a union"). Coalitions are inter-organizational, cooperative, and synergistic working alliances that unite individuals and groups in a shared purpose (Butterfoss, Goodman, & Wandersman, 1993). Butterfoss and Kegler (2002) describe them as a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal. Over the last 20 years, coalition building has become a prominent intervention employed in communities across America (Wolff, 2001a). Wolff (2001a) outlines the criteria for a community coalition as:

> "The coalition [must] be composed of community members; it focuses mainly on local issues rather than national issues; it addresses community needs, building on 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." (p. 170)

Based on these criteria, community coalitions are prime vehicles for fostering social support within communities and prominent mechanisms for building local capacities to address health and social concerns. Coalitions also provide a means of pooling the abilities, expertise, and resources of numerous stakeholders to affect positively community health (Granner & Sharpe, 2004) through a broad range of issues including: economic development, affordable housing, substance abuse, tobacco control, domestic violence, racism, deteriorating neighborhoods, violence prevention, and toxic environments (Wolff, 2001a). As an action-oriented partnership, a coalition usually focuses on preventing or ameliorating a community problem by (1) analyzing the problem, (2) gathering data and assessing need, (3) developing an action plan with identified solutions, (4) implementing those solutions, (5) reaching community-level outcomes, such as health behavior changes, and (6) creating social change (Butterfoss & Kegler, 2002). Butterfoss and Kegler (2002) also note that coalitions can form in response to an opportunity, threat or mandate. Ultimately, they maximize power through collective action to respond to either or all.

Wandersman et al. (1996) outlined a contextual aspect of community coalitions that fosters community health. They conclude that coalitions fit a social ecology perspective of health promotion because they work with multiple domains to promote community change. This social ecological perspective has its foundation in the ecological theory (Bronfenbrenner, 1977) which describes the interdependence of the individual and his/her context and the relationship between the individual this context. These contextual factors influence behavior and are deeply embedded within multiple levels of the environment and the relational aspect among these

domains fosters social cohesion (Maton, 2000). According to the ecological theory, the individual is viewed in context or as part of concentrically larger systems, beginning with microsystems such as social and friendship networks. Then, there is the organizational level, which includes social clubs, faith institutions, and community coalitions. Localities, which might be neighborhoods, communities, cities, or counties, are the next level. Finally, macrosystems, which refer to the larger society, are the outer system level. There is a relationship between the individual and these levels that is bidirectional and transactional in nature, so the systems affect the behavior of the individual and vice versa. Coalitions, although considered to be an organizational-level entity, may have influence across all levels of the ecology, from the individual to the larger society.

Vehicles for Health Promotion

In the 1990s, health promotion became the prominent public health strategy. However, this strategy not only encompassed the individually-focused, health-directed behavior of reducing risk of disease and premature death, but addressed the broader, more pervasive, and more problematic web of health-related behavior of whole families, groups, communities and organizations (Green & Kreuter, 1990). Green and Kreuter (1990) accurately predicted that addressing this more pervasive behavior has to involve patterns and conditions of living, eating, playing, and working, most of which lie outside the realm of the health sector and are not consciously health directed. Minkler (1981) noted that the large body of evidence linking social support and health provides an important supplement to earlier theory and research suggesting the more direct role social contacts may play in influencing health behavior. Certainly community coalitions, as broad-based vehicles for social contact within communities, are now an

accepted strategy for promoting health through community development (Butterfoss, Goodman, & Wandersman, 1993; Reinert, Carver, & Range, 2005).

Though recent years have witnessed broad changes in public health practice, central to these changes is that partnerships and collaborative work are increasingly mandated by the U.S. Department of Health and Human Services and employed as a vehicle for health education and promotion and for disease prevention (Anari & Weiss, 2006). In fact, Lasker and Weiss (2003) report that substantial interest and investment in health partnerships in the United States is based on the assumption that collaboration is more effective in achieving health and health system goals than efforts carried out by single agents. The rationale for using community coalitions or consortia is based on the belief that such groups of individuals from the target population not only foster the development of culturally appropriate health programs but influence the context of the program in ways that enhance the service utilization plan (Issel, 2004). Coalitions are also viewed as creative local solutions in response to cutbacks in government funding for basic human needs (Wolff, 2001a).

In the early 1990s it was recognized that the development of coalitions of community agencies, institutions, and concerned citizens to combat chronic health conditions was gaining popularity as an intervention aimed at strengthening the social fabric (Butterfoss, Goodman, & Wandersman, 1993). Mitchell et al. (1996) identified a typology of prevention activities that coalitions typically engage in, such as increasing knowledge, building skills, increasing enforcement, and building community capacity. Since that time, hundreds of millions of dollars have been (and continue to be) invested in coalition development as a health promotion intervention (Butterfoss, Goodman, & Wandersman, 1993).

Characteristics and Functioning

Although there are case studies and descriptive reports on coalitions, there is limited empirical information about the coalition process and outcome (Francisco, Paine, & Fawcett, 1993). There are, however, several frameworks for conceptualizing coalition functioning, including collaboration, empowerment, community capacity/competence, citizen participation, and community development (Francisco, Fawcett, Wolff, & Foster, 1996; Kegler, Twiss, & Look, 2000).

An inventory of measurement tools for evaluating coalition functioning was created by Granner and Sharpe (2004) based on an analysis of the combined research literature and the Internet. This inventory of common tools to measure coalition characteristics and functioning sheds considerable light on how researchers have attempted to capture factors that predict efficacy, participation, and other factors of sustainability in community coalitions. In their analysis, Granner and Sharpe (2004) identify five themes or categories of coalition characteristics and functioning (which are not necessarily mutually exclusive) within which they grouped similar measurement tools. The categories within this inventory are: (1) member characteristics and perceptions, (2) organizational or group characteristics, (3) organizational or group processes and climate, (4) general coalition function or scales bridging multiple constructs, and (5) impacts and outcomes. The current study utilizes measurement tools included in this inventory from the categories of member characteristics and perceptions, group characteristics, and group processes and climate.

According to Granner and Sharpe (2004), the category 'member characteristics and perceptions' is defined by the recruitment and retention of participants who provide the coalition with skills, experience, and community representation. These skills, experience, and

representation guide and enable the partnership's activities. 'Group characteristics' encompass a building of capacity for action and planning for action that are supported by the group characteristics of leadership, staff, and formalized structures and procedures. The category 'group processes and climate' enable members to work together to accomplish goals through community capacity, group relationships and decision making, communication, resources, sense of community, social support, and social capital.

Within each category, Granner and Sharpe (2004) include subheadings that group together sets of similar constructs with measures, many of which include measures of validity and reliability. The five general categories they use roughly correspond to the stages of coalition development that Florin, Mitchell, and Stevenson (1993) describe as being initial mobilization, establishing an organizational structure, building capacity for action, planning for action, implementation, refinement, and institutionalization (or sustainability).

Summary. In all, people organize for various reasons, but it is shared or overlapping interests and values that are at the basis of their common action. Byproducts of these associations, such as social support, social capital, resource mobilization, and resource conservation enhance individual-level benefits, and impact the broader community. Community coalitions as a modern form of association provide the connections individuals in community need for improving health and well being. Although several measures have been developed to understand better their characteristics and functioning, the sustainability of coalitions and coalition efforts is often in question. Understanding member engagement through participation and commitment is a starting point for examining the durability of coalitions and their long-term effectiveness.

Toward a Model of Member Engagement: Key Contextual Variables

Although sustainability is a goal of many projects, programs, activities, and coalitions, it is a multi-faceted construct that has been difficult to conceptualize, define, and measure. In general, research related to community collaboration projects provides limited discussion of the merits of coalition sustainability. The Community Coalition Action Theory (CCAT) describes the formation, structure, and processes of community coalitions in specific stages of development (formation, maintenance, and institutionalization) (Butterfoss & Kegler, 2002). Butterfoss and Kegler (2002) describe the roots of CCAT as originating from community development, community organization, empowerment, citizen participation, political science, inter-organizational relations, and group process. Although additional refinement and validation are needed, CCAT may be optimal for understanding how coalitions work (Granner & Sharpe, 2004). However, there remains no clear guidance on how to sustain coalition function over time.

Public health professionals have been particularly vocal about the lack of research on the institutionalization of community action projects (Altman, 1995; Holder & Moore, 2000). Although the concept of sustainability has been broadly studied, there is modest agreement among theoreticians and researchers as to its theoretical and operational definition. Moreover, there is very little research on the factors that foster a sustainable community-based volunteer initiative, as well as little research on the community coalitions that have continued work after initial funding has ceased (Lodl & Stevens, 2002). Furthermore, most studies and case reports fail to identify factors that are important in non-topic based community coalitions in sustaining efforts. As a result, measurement of the concept of coalition sustainability is complex, and yet unclear. For the purposes of this study, coalition sustainability, an organizational-level construct, is explored based on member engagement, an individual-level variable.

Conceptualization of Member Engagement

Although an initiative might appear to be sustained, to what degree are the members engaged? What factors cause people to be engaged in a particular community-based process? What does engagement mean? Engagement is a concept most often used in military science, and more recently, educational research to refer to a student's attendance, discipline, or attentiveness in the classroom setting. However, it has not been widely studied as a concept in coalition research. Without such knowledge, as noted by Metzger, Alexander, and Weiner (2005), coalition leaders and coalition facilitators must sort through the often speculative and sometimes contradictory advice found in wisdom literature about how to energize and sustain member involvement.

For the purposes of this study, member engagement is conceptualized as a construct with two components, a behavioral component and a psychological component. Participation is a behavioral indicator of engagement. Therefore, member engagement can be partially measured by an individual's level of participation (e.g., how many meetings one has attended in a 12-month period, degree of involvement in discussion, number of roles played in the coalition). Commitment is a psychological indicator of engagement. Therefore, member engagement can be partially measured based on an individual's degree of commitment to, care for, or concern about the coalition and its efforts. Although other variables might be considered as comprising member engagement (e.g., number of referrals by members to others to attend coalition meetings), participation and commitment are critical. Consequently, factors that affect and/or influence participation and commitment, and therefore member engagement, are the focus of this study.

Participation (Dependent Variable)

What prompts people to participate voluntarily in a forum for sharing their thoughts and concerns about their community and ways to improve it? More importantly, what keeps them participating or intending to participate? Several studies highlight participation as a key construct in community coalitions (Butterfoss, Goodman, & Wandersman, 1996; Chinman, Anderson, Imm, Wandersman, & Goodman, 1996; Giamartino & Wandersman, 1983; Hays, Hays, DeVille, & Mulhall, 2000; Kegler, Steckler, McLeroy, & Malek, 1998; Kumpfer, 2005; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Taylor-Powell, Rossing, & Geran, 1998). Wandersman, Goodman, and Butterfoss (1997) suggest that coalition characteristics, such as member participation, are important determinants of coalition activities and accomplishments. Earlier research on voluntary organizations demonstrated member participation to be important for organizational viability (Butterfoss, Goodman, & Wandersman, 1993; Chinman, Anderson, Imm, Wandersman, & Goodman, 1996). Butterfoss and Kegler (2002) also note that active participation contributes to enhanced acceptance and permanence of changes. Participation is the behavioral aspect of member engagement.

However, it is commonly understood that projects that introduce a new endeavor and have high visibility for a short period, but fail to be sustainable after the initial thrust, create a sense of resentment in local communities (Lodl & Stevens, 2002). As a result, communities and individuals in the community have become wary of participating in yet another opportunity that may be short lived. In a study of community key leaders in a Utah coalition, Kumpfer (2005) examined barriers to coalition participation. Many grant-based initiatives face challenges to participation, prompting grantors to require documentation of sustainability beyond the life of

funding. Still, as previously noted, sustainability is often an elusive goal of most initiatives that focus on community-driven processes.

Political economy theory suggests that in organizations a social exchange takes place in which participants will invest their energy in the organization only if they expect to receive some benefits such as increased networking, information sharing, or access to resources (Minkler, 1999). Participation by community residents creates the potential for schools, neighborhoods, and other institutions, environments, and services to be responsive to individuals and families. According to Heller, Price, Reinharz, Riger, and Wandersman (1984) citizen participation involves individuals taking part in decision making in the institutions, programs, and environments that have an impact on them. For example, in a study by Hays, Hays, DeVille, and Mulhall (2000), member participation was assessed based on how often members attended or provided input in coalition activities through various roles they played. The researchers measured the frequency with which members of the coalition participated through making comments, expressing ideas at meetings, or serving as a member of a committee. Wolff (2002) further notes that in community-based initiatives, the purpose of participation is to increase the community's control and ownership in improving social conditions in the community. Participation is a dependent variable in this study and represents a behavioral aspect of engagement.

Bidirectional relationships. Together, participation and commitment describe both the behavioral and psychological aspects of member engagement. In the following sections, several relationships are hypothesized as predictors of these two constructs. It is important to note that this examination involves a cross-sectional view of member perceptions. Therefore, although direction of the hypotheses from left to right is implicit, in some proposed relationships a

bidirectional or reverse order is plausible. For example, it is hypothesized that member empowerment leads to increased participation. It can be argued as well that continued participation increases member empowerment. To account for this, it is the researcher's *a priori* theory, based on the correlational relationships reported in the literature and knowledge gained as a participant-observer of the population being researched, that lead to the proposed direction of the following testable, mediated relationships. All potential relationships among factors that lead to participation and commitment will not be able to be addressed in one study. It is this study's goal to tease out those that are most appropriate for the population and the context in which this coalition operates.

Social Resources, Leadership, and Participation

Social Resources. Do social resources which are mobilized through effective leadership foster member participation in the coalition? This study hypothesizes that the way that leadership influences participation is through social resources.

The literature yields additional theories that explain why communities organize specifically for the purposes of resource mobilization and resource conservation. Numerous communities have used coalitions to mobilize their resources to successfully solve the emerging problems they are facing (Wolff, 2001a). In fact, coalitions are also frequently referred to as social action organizations. Social action organizations are defined by Mondros and Wilson (1994) as groups of people organized to attain power. More specifically, they are a self-generated (as opposed to a legally-mandated) association of people organized to wrest power resources from established individuals and institutions and create change. This change can be in multiple realms, including social, political, health, and economic.

Therefore, gaining access to resources through community mobilization is a key to moving from discontent to social change. Resource mobilization theory refers to these resources as of at least two types: tangible resources, which include money, facilities, and/or means of communication, and intangible resources, which include human assets such as legal skills, social support, and/or the association itself (McCarthy & Zald, 1977; Walsh, 1981). Community coalitions, for example, offer the intangible resource of mobilizing and thereby bridge gaps for gaining access to tangible resources which influences participation. Coalition studies have examined resource mobilization (Kegler, Steckler, McLeroy, & Malek, 1998), and satisfaction with allocation of resources, be they financial or personal (Rogers et al., 1993; Taylor-Powell, Rossing, & Geran, 1998).

Effective leaders foster an inclusive organizational climate that attracts committed members, works to resolve conflicts, and enhances coalition success in acquiring funding and mobilizing resources (Wolff, 2001b). Prestby et al. (1990) found that member participation was related to the leaders' efforts in social and organizational management as well as in incentive management (i.e., social resources). Hays et al. (2000) and Kumpfer (2005) each examined resources brought about through effective and empowering leadership and found a relationship. In fact, in a recent study on the effects of leadership and governance on member participation in community health coalitions, Metzger, Alexander, and Weiner (2005) found that empowering leadership has an indirect, positive effect on the level of participation by way of social resources. This research involved grant-funded Community Care Network demonstration coalitions, and not community-based, voluntary health coalitions such as the Clarkston Health Collaborative.

Leadership and Participation. Several studies of coalition function have identified effective leadership as an important facilitator of coalition action and sustainability (Butterfoss,

Goodman, & Wandersman, 1996; Butterfoss & Kegler, 2002; Hays, Hays, DeVille, & Mulhall, 2000; Kegler, Steckler, McLeroy, & Malek, 1998; Kumpfer, Turner, Hopkins, & Librett, 1993; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rogers et al., 1993; Taylor-Powell, Rossing, & Geran, 1998). Leaders can play an important part in developing participative and collaborative environments within their coalitions.

Review of the literature shows that there is a relationship between leadership and participation (Butterfoss, Goodman, & Wandersman, 1996; Prestby, Wandersman, Florin, Rich, & Chavis, 1990). Studies of coalitions indicate that effective management of the dynamics of group process increases participation (Butterfoss, Goodman, & Wandersman, 1993; Rogers et al., 1993). In addition, Butterfoss et al. (1996) found that participation hours outside of meetings, as well as the number roles members participated in, were related to leadership. Hays et al. (2000) and Kegler et al (1998) each assessed leadership effectiveness by examining members' perceptions of the extent to which the leader directs the group toward collaborative group achievement, encourages all points of view, and manages conflict. The challenge for coalition leaders is to encourage positive communication and group decision making across the range of members' personalities, agendas, and skill sets (Hahn, Greene, & Waterman, 1994).

Empowerment, Sense of Community, and Participation

Empowerment. Are coalition members who are empowered by a sense of community, more likely to participate in the coalition? This study hypothesizes that the way that sense of community influences participation is through empowerment.

According to Maton and Salem (1995) relationship structures, such as community coalitions, cultivate empowering organizations or empowering settings that have certain characteristics. Maton and Salem (1995) report four characteristics of empowering settings that

are unique attributes of community coalitions. Of these, two are particularly important aspects of a sense of community and include: (1) fostering a group-based belief system that is strengths based and encourages thinking beyond the self, and (2) having a support system that is encompassing and peer based.

As noted above, Sarason (1974), considers sense of community a major basis for self-definition. The self-definition that comes from a sense of community is related to one's self-efficacy, or their belief about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. This is a form of empowerment. At the individual level, empowerment is defined in theoretical terms as the process and consequence of efforts to exert control and influence over decisions that affect one's life, organizational functioning, and the quality of community life (Perkins & Zimmerman, 1995; Rappaport, 1981). At the community level of analysis, empowerment may refer to collective action to improve the quality of life in a community and to the connections among community organizations and agencies (Freire, 1970; Zimmerman, 2000) that are experienced in community-based coalitions.

McMillan et al. (1995) have shown that sense of community is correlated with psychological empowerment. Although there is no one recognized measure of empowerment, researchers have found ways to capture the concept through other constructs, including general self-efficacy and perceived control. With regard to community coalitions, Israel, Checkoway, Schulz, and Zimmerman (1994) examined perceived control and found a significant relationship between an individual's sense of community and their perceived control. In a subsequent study, Bosscher and Smit (1998) examined individual, general self-efficacy using a scale originally developed by Sherer et al. (1982) to assess individual level empowerment. They found that

general self-efficacy was also related to cohesiveness of the membership (an aspect of sense of community) (Bosscher & Smit, 1998).

In addition, empowerment has been shown to have a direct, positive effect on participation. It is this sense of empowerment that prompts, facilitates, and/or sustains participation. In fact, participation is considered a sign of empowerment (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rappaport, 1981). Both Israel et al. (1994) and Bosscher and Smit (1998) found that perceived control, and general self-efficacy, respectively, were associated with participation. Psychological empowerment is also shown to correlate with level of participation (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995). Conversely, empowerment is a byproduct of participation.

Sense of Community and Participation. As a result of the social cohesion and connectedness produced in community coalitions, there is creation of what McMillan and Chavis (1986) refer to as a "sense of community." The theory, originally outlined by Sarason (1974), proposes that psychological sense of community becomes the conceptual center for the psychology of community, asserting that it is one of the major bases for self-definition. The theory describes elements of the social environment that foster community, or that cooperative spirit within a group or among groups.

Sense of community is a catalyst for participation (Chavis & Wandersman, 1990). Wolff (2001a) notes that coalitions build community by creating a forum where diverse members of the community can gather to exchange information and solve local problems. Heller (1989) identifies the importance of relationship structures such as coalitions, as key components in determining collective action. He adds that members frequently report that they receive personal and professional support in the social network of the coalition (Wolff, 2001a). Kegler, Steckler,

McLeroy, and Herndon Malek (1998) examined sense of community, or the feelings of connection, support, and collective problem solving that is exhibited in community coalitions as it relates to member participation and found that there is a relationship.

Member Satisfaction, Communication, and Participation

Member Satisfaction. Does effective communication within a coalition improve member satisfaction and thus, participation in the coalition? This study hypothesizes that the way communication influences participation is through member satisfaction.

Coalitions that effectively address local problems are typically comprised of diverse memberships (i.e., race, class, or positional power) which fosters participation (Trickett & Watts, 1994). However, the satisfaction of these individuals with aspects of the coalition has been found to be important in coalition functioning (Butterfoss, Goodman, & Wandersman, 1996; Cook, Roehl, Oros, & Trudeau, 1994; Giamartino & Wandersman, 1983; Kegler, Steckler, McLeroy, & Malek, 1998; Kumpfer, Turner, Hopkins, & Librett, 1993; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rogers et al., 1993). Member satisfaction represents a global satisfaction with the work of the coalition (Kegler, Steckler, McLeroy, & Malek, 1998). Both Kegler et al. (1998) and Rogers et al. (1993) found that it was significantly correlated with communication. Kumpfer, Turner, Hopkins, and Librett (1993) examined member satisfaction with the coalition operations and accomplishments and found a significant relationship. Because member satisfaction represents a global satisfaction with the coalitions work, it has been studied as a predictor of both participation and commitment. As such, member satisfaction is a key mediator in three relationships in the current study.

As noted above, member satisfaction is important in coalition participation as well. According to the literature, there is a direct effect of member satisfaction on participation

(Kegler, Steckler, McLeroy, & Malek, 1998; Rogers et al., 1993; Trickett & Watts, 1994). Rogers et al. (1993) found that member satisfaction was related to participation and participation costs.

Communication and Participation. Communication is a key factor in getting people involved in a community coalition and in fostering their participation. Famed 20th century organizer Saul Alinsky devoted an entire chapter in his community organizing how-to book, Rules for Radicals, to communication, where he notes:

> "One can lack any of the qualities of an organizer – with one exception – and still be effective and successful. That exception is the art of communication. It does not matter what you know about anything if you cannot communicate to your people. In that event you are not even a failure. You're just not there." (Alinsky, 1971), page 81.

In fact, Minkler (1999) stated that smooth internal communication among the membership may be the most essential ingredient for enhancing the climate of a coalition. Open communication helps the group focus on a common purpose, increases trust and sharing of resources, provides information, and allows members to express and resolve misgivings. In coalition functioning, communication has been operationalized as the quality of communication among members and between leaders and members, its frequency and its productivity (Kegler, Steckler, McLeroy, & Malek, 1998; Rogers et al., 1993). Communication is a key factor in member participation. It is the central concept of information sharing, and as such, leads to increased participation. At least one study of coalition functioning identified communication as an important facilitator of member participation (Kegler, Steckler, McLeroy, & Malek, 1998). Kegler et al. (1998) note that with more communication and sharing of important information that is relevant to the community, there was increased participation.

Butterfoss et al. (1996) examined how members view communication in the coalition. They assessed the frequency, clarity, and productivity of communication. Researchers have also noted the most frequently used methods of communication, as well as the perceived importance of respective methods of communication (Kegler, Steckler, McLeroy, & Malek, 1998; Kumpfer, Turner, Hopkins, & Librett, 1993).

Participation Benefits, Decision Making, and Participation

Participation Benefits. Does collaborative or shared decision making lead to personal benefits for members and thus, facilitate continued participation? This study hypothesizes that the way decision making influences participation is through participation benefits.

Personal, social, material, and purposive benefits (e.g., changes in perceived knowledge, skills, beliefs) have been described by coalition researchers as participation benefits (Butterfoss, Goodman, & Wandersman, 1996; Chinman, Anderson, Imm, Wandersman, & Goodman, 1996; Kegler, Steckler, McLeroy, & Malek, 1998; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rogers et al., 1993; Taylor-Powell, Rossing, & Geran, 1998). Prestby et al. (1990) wrote the most extensively about participation benefits and defined them in two ways: (1) as “personal gain” benefits (such as learning new skills and gaining personal recognition) and (2) as “social/communal benefits” (such as improving the neighborhood and helping others). Research suggests that when participants perceive the benefits of participation as high and the costs as low, they are more likely both to choose to participate in the coalition and participate more fully (Butterfoss, Goodman, & Wandersman, 1996; Metzger, Alexander, & Weiner, 2005; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rogers et al., 1993). In their study, Butterfoss et al. (1996) assessed skills,

material, solidarity, and purposive benefits that can be realized as a result of participating in a coalition.

Collaborative or shared decision making and member involvement in group processes fosters participation (Butterfoss, Goodman, & Wandersman, 1996; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995). Metzger et al. (2005) also showed that open and collaborative decision making has an indirect, positive effect on the level of participation by way of participation benefits and vision consensus.

Decision Making and Participation. Effective coalitions involve members in shared decision making and action. Collaborative or shared decision making fosters participation (Butterfoss, Goodman, & Wandersman, 1996) as does member involvement in group processes (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995). In their research, Butterfoss and Kegler (2002) noted that people should participate in changes for their community in a true democratic sense. Research involving block associations finds that the more active groups involved members in deciding the policies and actions of the group than did the less active groups (Prestby & Wandersman, 1985). Butterfoss et al. (1996) and Kegler et al. (1998) each studied coalition members' individual perception of involvement in coalition decision making and how that related to their engagement. Both studies found that a perception of involvement improved participation. Therefore, there is a direct relationship between shared decision making and levels of participation.

Commitment (Dependent Variable)

Member commitment is an important psychological component of member engagement in a community coalition. Metzger, Alexander, and Weiner (2005) define organizational commitment as an individual's propensity to remain with an organization (or in this case, a

coalition). According to Wolff (2002) in his practical approach to evaluating community collaborations, a core belief of community coalitions is that widespread community ownership, commitment, and participation by diverse citizens should be encouraged. Minkler (1999) notes that membership commitment is a key aspect of the operations of organizations, especially when they depend upon voluntary effort. Although less studied than participation, researchers have found commitment a compelling factor in coalition sustainability (Kumpfer, Turner, Hopkins, & Librett, 1993; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rogers et al., 1993). Kumpfer et al. (1993) in their study of leadership and team effectiveness in community coalitions revised Chavis et al.'s (1987) measure of commitment to assess the strength of member commitment to the coalition and caring about the future of the coalition. On the other hand, Rogers et al. (1993) considered commitment to be an endorsement of the coalition's mission and efforts.

From a more psychological perspective, McMillan et al. (1995) found commitment to represent a sense of pride in the group. Commitment was found to be related to participation benefits, member satisfaction, leadership, member communication (Kumpfer, Turner, Hopkins, & Librett, 1993; Rogers et al., 1993), and psychological empowerment (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995). A sense of ownership or commitment is also related to the individual's perception of influence on organizational processes (i.e., decision making) (Israel, Checkoway, Schulz, & Zimmerman, 1994) and the influence various constituencies perceive themselves to have on program or group goals, processes, and structure (Flynn, 1995). Commitment is the second dependent variable in this study and represents a psychological indicator of engagement.

Member Satisfaction, Decision Making, and Commitment

Member Satisfaction. Does collaborative or shared decision making lead to improved satisfaction of members and thus, facilitate continued commitment? This study hypothesizes that the way decision making influences commitment is through member satisfaction.

As previously mentioned, member satisfaction represents a global satisfaction with the work of the coalition and, thus, fosters participation and commitment (Kegler, Steckler, McLeroy, & Malek, 1998). Member satisfaction was found to be related to commitment (Rogers et al., 1993). Kegler et al. (1998) also found that a members' satisfaction is directly related to that members' commitment. In the same study, Kegler et al. (1998) found that member satisfaction correlates with decision making. Decision making was found to be related to both member satisfaction and member commitment (Rogers et al., 1993).

Decision Making and Commitment. As noted in the introduction, commitment is the psychological aspect of engagement and although less studied than participation, has been found to be a compelling factor in coalition sustainability (Kumpfer, Turner, Hopkins, & Librett, 1993; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rogers et al., 1993) and an integral component of member engagement. Kumpfer et al. (1993) conceptualized it as the strength of member dedication to the coalition and caring about the future of the coalition. Rogers et al. (1993) considered commitment to be an endorsement of the coalition's mission and efforts, whereas McMillan et al. (1995) found commitment to represent a sense of pride in the group.

Member Satisfaction, Leadership, and Commitment

Member Satisfaction: Case for a mediated model. Does effective leadership lead to greater satisfaction for members and thus, facilitate continued commitment? This study hypothesizes that the way leadership influences commitment is through member satisfaction.

Leadership fosters members' satisfaction and satisfied members support effective leaders. And empowering style of leadership increases member satisfaction and perceptions of team efficacy which ultimately increases team effectiveness (Kumpfer, Turner, Hopkins, & Librett, 1993). In turn, member satisfaction was found to be related to directly related to member commitment (Kegler, Steckler, McLeroy, & Malek, 1998; Rogers et al., 1993).

Leadership and Commitment. Commitment was also found to be related to leadership (Rogers et al., 1993). Wolff (2001b) notes that effective leaders foster an inclusive organizational climate that attracts committed members, works to resolve conflicts, and enhances coalition success in acquiring funding and mobilizing resources. Both Kegler et al. (1998) and Rogers et al. (1993) found communication by the leader is correlated with member commitment.

Hypotheses

The following hypotheses were tested in this research. Hypotheses I through IV represent specific mediated relationships that examine predictors of participation, a behavioral indicator of engagement.

Hypothesis I: Mediating effect of social resources (see Figure 1). Taking the positive effect of leadership on participation (c), and the indirect relationship through social resources (a, b), this study hypothesizes that leadership influences participation through social resources. The present study proposes a path model to test social resources' mediating role in partially explaining leadership's effect on participation in a non-topic based community health coalition.

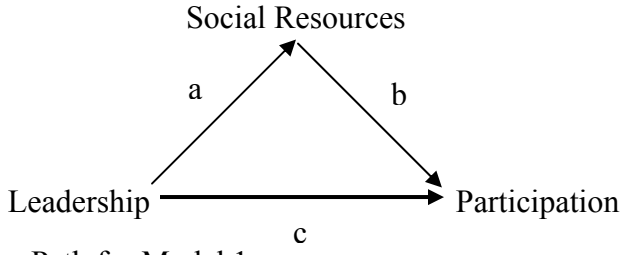

Figure 1. Mediation Path for Model 1

Hypothesis II: Mediating effect of empowerment (see Figure 2). Taking the positive effect of sense of community on participation (c) and empowerment (a), and the direct relationship between empowerment and participation (b), this study hypothesizes that sense of community influences participation through empowerment. Based on the literature, the present study proposes a path model to test empowerment's mediating role in partially explaining sense of community's effect on participation in a non-topic based community health coalition.

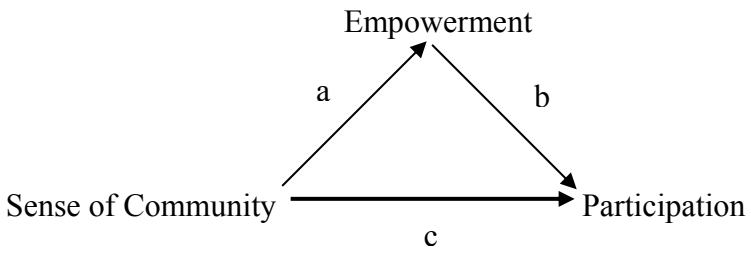

Figure 2. Mediation Path for Model 2

Hypothesis III: Mediating effect of member satisfaction (see Figure 3). Taking the direct effect of communication on participation (c), the relationship of member satisfaction to communication (a), and influence in participation (b), this study hypothesizes that communication influences participation through member satisfaction. Based on the literature, the present study proposes a path model to test member satisfaction's mediating role in partially explaining communication's effect on participation in a non-topic based community health coalition.

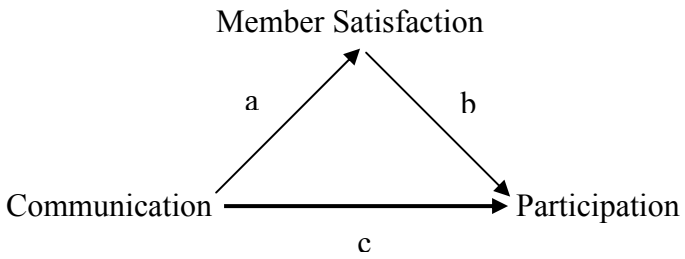

Figure 3. Mediation Path for Model 3

Hypothesis IV: Mediating effect of participation benefits (see Figure 4). Based on the relationship of decision making and participation (c) and the indirect effect of decision making on participation through participation benefits (a, b), this study hypothesizes that decision making influences participation through participation benefits. Based on the literature, the present study proposes a path model to test participation benefits' mediating role in partially explaining decision making's effect on participation in a non-topic based community health coalition.

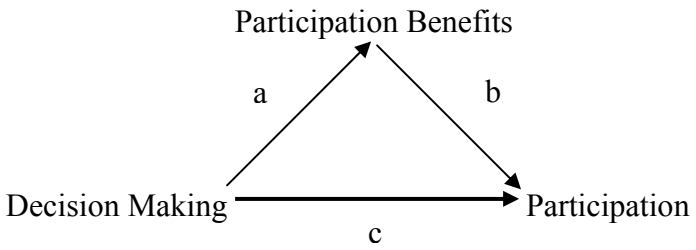

Figure 4. Mediation Path for Model 4

Hypothesis V and Hypothesis VI represent specific mediated relationships that examine predictors of commitment, a psychological indicator of engagement

Hypothesis V: Mediating effect of Membership Satisfaction (see Figure 5). Taking the relationship of decision making to commitment (c) and the relationship of decision making to member satisfaction (a) and member satisfaction's relationship to commitment (b), this study hypothesizes that decision making influences commitment through member satisfaction. Based on the literature, the present study proposes a path model to test the mediating role member satisfaction plays in partially explaining decision making's effect on commitment in a non-topic based community health coalition.

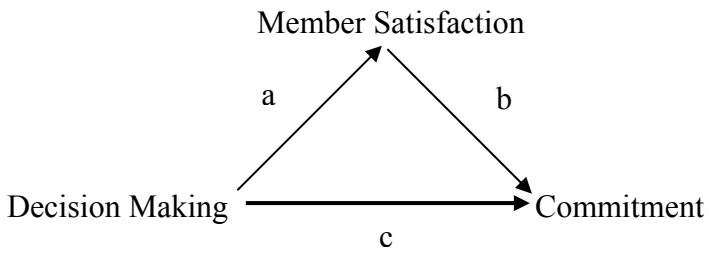

Figure 5. Mediation Path for Model 5

Hypothesis VI: Mediating effect of Member Satisfaction (see Figure 6). Taking the relationship of leadership to commitment (c) and the relationship of leadership to member satisfaction (a) and member satisfaction to commitment (b), this study hypothesizes that leadership influences commitment through member satisfaction. Based on the literature, the present study proposes a path model to test the mediating role member satisfaction plays in partially explaining leadership's effect on commitment in a non-topic based community health coalition.

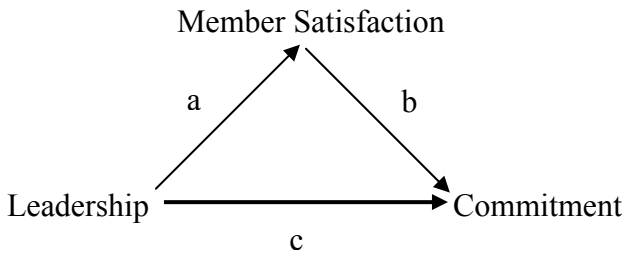

Figure 6. Mediation Path for Model 6

Expanded Relationships: Conception of Path Models of Participation and Commitment

Because part of the objective of this study is to test how well process models fit the coalition data rather than to rule out competing hypotheses, a path analytic approach was proposed. Based on the relationships reported in the literature and the hypothesized mediation models, the following path models predicting participation and commitment are proposed. These combined models theorize a broader context of the relationships between predictor variables and the outcome variables, participation and commitment, than separate mediation models. In order to determine the relative strength and direction of these relationships, two path models were examined–a path model of participation (Figure 7), and a path model of commitment (Figure 8).

The direct effects in the figures that are predicted to be zero are depicted with dashed lines. Also, because not all variables have the same scale, the standardized estimates were used to enable comparison. In figure 7, these predictions represent the hypotheses that (1) the effect of leadership on participation is indirect and mediated only by social resources, (2) the effect of sense of community on participation is indirect and mediated only by empowerment, (3) the effect of communication on participation is indirect and mediated only by member satisfaction, and (4) the effect of decision making on participation is indirect and mediated only by participation benefits. The presence of the *e* above the dependent variable signifies the error variance in participation, and indicates an imperfect prediction. The relationships between mediator variables and between independent variables are unanalyzed with simply a covariance between them with no implied direction of effect. In figure 8, these predictions represent the hypotheses that (1) the effect of decision making on commitment is indirect and mediated only by member satisfaction, and (2) the effect of leadership on commitment is indirect and mediated only by member satisfaction.

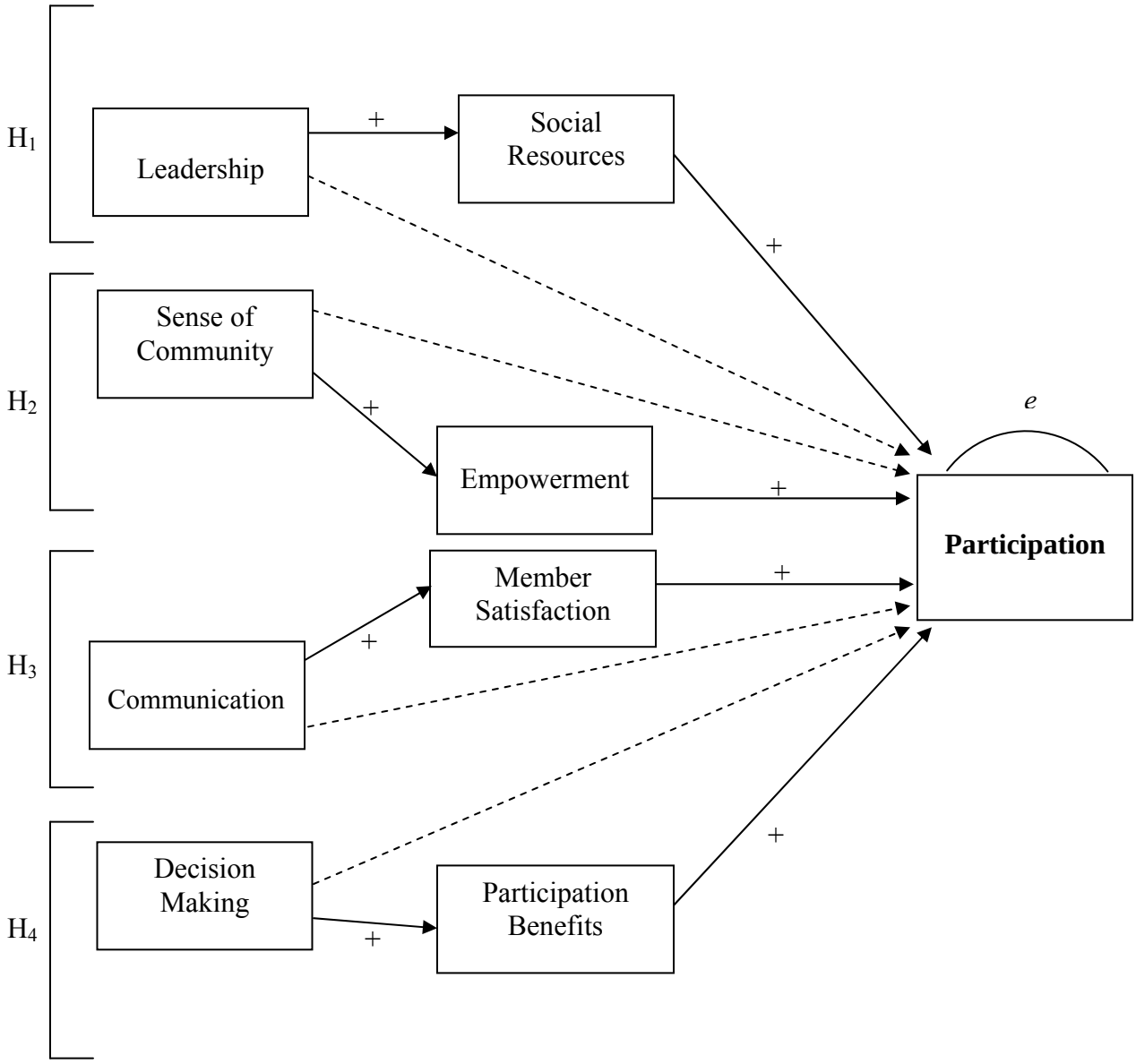

Figure 7. Contextual Predictors of Participation, a Conceptual Path Model

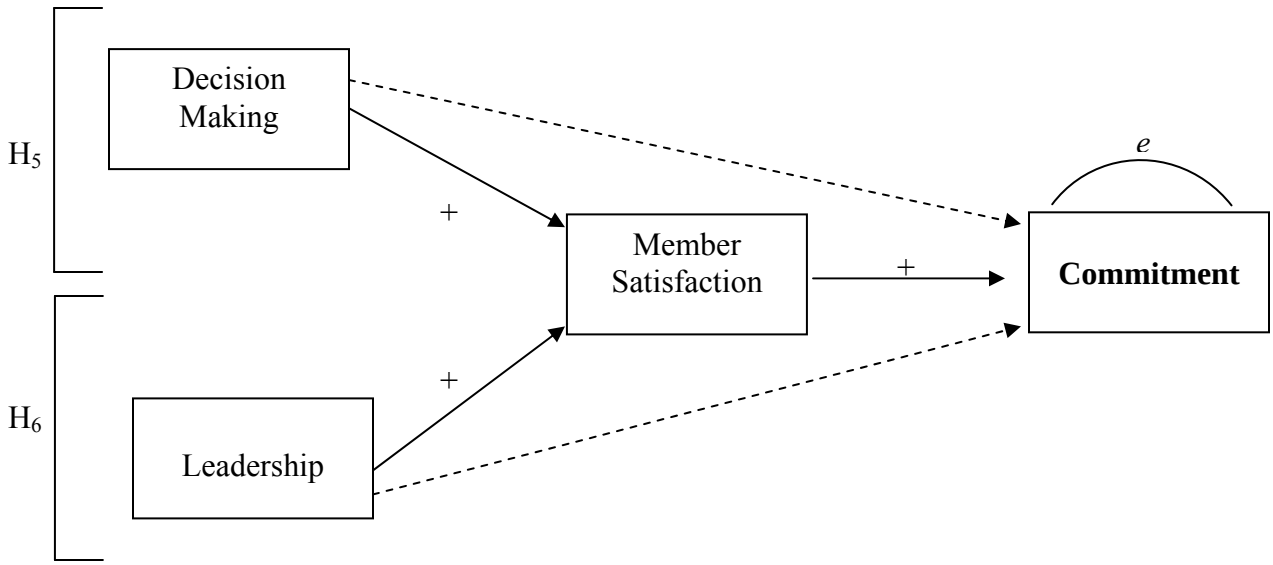

Figure 8. Contextual Predictors of Commitment, a Conceptual Path Model

Summary

What has kept people participating in and committed to the work of the Clarkston Health Collaborative? Prior research has examined several key variables that influence or predict overall participation and commitment in community-based coalitions, including: leadership effectiveness (Butterfoss, Goodman, & Wandersman, 1993, 1996; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rogers et al., 1993), sense of community (Chavis & Wandersman, 1990; Wolff, 2001a), communication (Kegler, Steckler, McLeroy, & Malek, 1998), and shared decision making (Butterfoss, Goodman, & Wandersman, 1996; Prestby & Wandersman, 1985). The literature has largely focused on community-based coalitions that are topic-driven (e.g., diabetes, gang violence, drugs, or obesity). However, these studies fail to identify those factors that are important in non-topic-based, non-grant-funded, volunteer community coalitions in sustaining coalition efforts by fostering member participation and commitment.

Moreover, the question remains how other variables (i.e., member satisfaction, participation benefits, social resources, and empowerment) help explain (i.e., mediate) the relationships between these primary factors and participation or commitment? To answer these questions, the proposed cross-sectional study examined the role of various predictors in influencing participation and commitment, or member engagement in the Clarkston Health Collaborative. I proposed two main ideas toward understanding member engagement in the Clarkston Health Collaborative: (1) to identify key indicators of participation and commitment associated with member engagement, which have fostered the coalition's sustainability from 1994 to the present, and (2) to examine the nature and strength of the relationships among these variables.

Based on the review of the literature, this proposal hypothesized specific mediating relationships predicting participation and commitment. However, to give a full understanding of how participation and commitment are effected in the context of multiple predictor variables, a path analytic approach tested how well process models fit the coalition data.

This study contributes to the body of knowledge on coalition function as it relates to sustainability. The importance of this study is the opportunity to better understand the factors that influence member participation and member commitment which can provide insight into the planning and implementation of other coalitions and provide strategies to help ensure coalition sustainability. Moreover, for community mobilization efforts, this study seeks to shed light on those mechanisms that interrelate to foster participation and commitment in community-based efforts, in general, and that directly affect participation and commitment in a volunteer community coalition, specifically. For those engaged in a non-topic based community coalition (i.e., there is no singular focus, but topics are community generated and vary) or contemplating

initiating one, this study provides a clearer understanding of which components of the process and strategies foster continued participation and commitment by members, in efforts with similar structure and dynamics to those of the Clarkston Health Collaborative.

As a part of this research, eight key variables noted above and their influence on member engagement via participation and commitment are examined. They are: leadership, social resources, sense of community, empowerment, member satisfaction, communication, decision making, and participation benefits. Based on the review of the literature, specific mediating relationships have been hypothesized. Finally, as a result of multiple interrelationships among predictors, path models are hypothesized and tested for each dependent variable.

Specific Aims. Based on this review:

1. Specific variables associated with member engagement in the Clarkston Health Collaborative that have fostered its sustainability in the community from 1994 to the present were identified.
2. The nature and strength of the relationships among these variables was examined.

CHAPTER 2

METHODS

Mixed-Methods Approach

Because of the complexity of community coalitions and coalition-building, triangulation of data collection has been suggested to help avoid bias inherent in any one type of methodology and to enhance validity (Wandersman et al., 1996). Use and integration of both qualitative and quantitative data is recommended to provide a comprehensive assessment and understanding of coalition development, function, and impact (Francisco, Fawcett, Wolff, & Foster, 1996; Goodman, 1998; Wandersman et al., 1996).

A mixed methods approach was employed to gather a broad-based perspective on the phenomenon of coalition engagement. This methodology provides the opportunity to examine member views regarding participation and commitment using a structured, written survey, and subsequent qualitative interviews (i.e., key informant interviews) to broaden and deepen the quantitative findings. The type of mixed methods design used was a sequential explanatory design (Creswell & Plano Clark, 2007; Creswell, Plano Clark, Guttman, & Hanson, 2003). The inference quality (Tashakkori & Teddlie, 2003) or validity procedures in mixed methods research, is the ability of the researcher to draw meaningful and accurate conclusions from all of the data in the study.

The mixed methods sequential explanatory design consists of two distinct phases: quantitative followed by qualitative (Creswell & Plano Clark, 2007; Creswell, Plano Clark, Guttman, & Hanson, 2003). In this design, the researcher first collects and analyzes the quantitative (numeric) data. The qualitative data (e.g., texts, interview transcripts) are collected and analyzed second in the sequence and help explain, or elaborate on, the quantitative results

obtained in the first phase. The rationale for this approach is that the quantitative data and their subsequent analysis provide a statistical explanation of the research problem. The qualitative data and their analysis provide a better understanding of the phenomena by exploring participants' views in depth based on the quantitative results (Creswell & Plano Clark, 2007; Creswell, Plano Clark, Guttman, & Hanson, 2003; Rossman & Wilson, 1985; Tashakkori & Teddlie, 1998). The quantitative examination of coalition phenomena is the dominant methodology.

Quantitative Methods

Survey research is one of the most important areas of measurement in applied social research, and surveys represent one of the most common types of quantitative, social science research (Nardi, 2003). The broad area of survey research encompasses any measurement procedures that involve selecting a sample of respondents from a population and administering a standardized questionnaire. It is one way of apprehending social phenomena, has certain strengths, and is based in a positivistic system of thought (Nardi, 2003), that is, measures what is experienced using scientific techniques.

Participants

Study participants consisted of a sample of current and previous attendees of the Clarkston Health Collaborative obtained from a cumulative database of attendees ($N = 320$), from 1994 through 2008. A power analysis was conducted using the standard power formula (Bakeman, 1992), to assess the ideal sample (n*) needed to detect a medium effect size of $f^2 = .15$. According to Bakeman (1992), the formula yields the recommended sample size for detecting a significant effect with a power of .90, alpha of .05, and a medium effect size of .15. Cohen (1992) also recommends the use of .15 as a medium effect size estimate for multiple

correlation analyses, when no other information is known. This formula produced a recommended sample size of 88 for this study. Cohen (1992) recommends an addition of 20% to the calculated sample size in an effort to minimize the influence of missing data or incomplete measures. This addition would yield an ideal sample size of 106 participants. The population of participants sampled from (N=320) yielded an adequate sample size (N=93), which exceeded the minimum sample size requirement to detect a medium effect.

Participants represented people who live, work, and/or are involved in recreational activities in the City of Clarkston, who have attended the Clarkston Health Collaborative, and who completed a sign-in sheet with their name, agency (if any), address, phone number, and electronic mail (e-mail) address. The sign-in sheet solicits active consent from participants to be placed on the mailing list and receive regular coalition updates, minutes, and agendas by postal or electronic mail. As a result of monthly updates, participants that can no longer be reached (i.e., with both an invalid mailing address and no forwarding information and an invalid e-mail address) are purged from the alphabetic listing.

Sampling and Procedures

The sampling protocol for this study was designed to recruit coalition participants, who were active in the coalition at some point, from a cumulative listing of CHC attendees. This purposive or judgmental sampling (Nardi, 2003) involved designating a group of people for selection because the investigator knew they had some traits relevant to the study. This procedure allowed the investigator to construct a representative sample from CHC attendees, make statistical inferences to the larger population of attendees, and theorize about the introduction of biases that may limit generalization of results to the target population. The total sampling frame for this study was 320 participants.

Selection Criteria. Every attendee in the alphabetical database listing who supplied a valid e-mail address was sent an online version of the survey instrument. All those providing only a valid mailing address were mailed a paper copy of the survey instrument, along with a self-addressed, stamped, return envelope. The online survey instrument was administered through a web-based tool called Survey Monkey. The self-assessment survey queried members on their level of participation, their level of commitment, as well as their perceptions of leadership, sense of community, satisfaction, social resources, empowerment, communication, decision making, and participation benefits.

Consent Procedures. An informed consent form explaining the purpose, procedures, risks and benefits of participating in this study was provided to all participants. To protect confidentiality and minimize the risk of releasing sensitive information, all survey data was collected anonymously. A unique identifier was ascribed to each survey (electronic and hard copy) and was not able to be linked back to respondent's e-mail or postal address. The only exception to complete anonymity applied to those respondents who self-identified to be contacted for a follow-up, key informant interview. An informed consent form was included with the survey instrument in the mailing to participants. It was required that the signed consent form be returned with the completed survey. In addition, the online survey administered through Survey Monkey required that each participant read the informed consent and give electronic consent prior to initiation of the survey. This required field did not allow participants to proceed to the survey instrument until consent was given.

Incentives. For the quantitative measure, all participants were offered the results of the survey and findings at the completion of the study as an incentive for completing surveys. In addition, it was noted that completion of the survey would assist in further development of the

coalition and ultimate benefit to the community. All participants agreeing to complete the key informant interviews by phone were offered an incentive described under the qualitative methods section.

Survey Procedures

Survey Distribution (Paper and Electronic). As noted, those participants providing only a valid mailing address were sent the CHC member survey instrument (see Appendix B) by postal mail. An accompanying cover letter (Appendix J) instructed each participant to complete the survey and return it in the stamped envelope provided.

Those participants providing a valid e-mail address were sent the same survey instrument in electronic form. The e-mail announcement (Appendix I) instructed participants to click on the hyperlink provided, which would direct them to the survey in Survey Monkey. Survey Monkey is an online survey management tool (www.surveymonkey.com) that allows creation of a survey via an online survey editor. The tool was developed for behavioral science surveys and allows conditional logic to customize the path a respondent takes through a survey by adding skip logic. It allowed the administrator to require answers and download all data to an Excel file to create graphs or download the raw data directly into SPSS. This ability eliminated a source of error that often occurs when researchers or their assistants enter data from a questionnaire by hand.

Each group of participants received only one form of the instrument, in order to prevent duplicate surveys. All electronic and hard copy correspondence was signed by the faculty advisor and chair of the dissertation committee, in lieu of disclosing the student PI's identity. Regular follow-up was provided via reminder postcards and e-mails (two weeks after initial mailed distribution), see Appendix K. Initial response rates were inadequate, so reminder e-

mails were sent to participants completing online survey. A second online distribution of the survey, as well as a second hard-copy mailing, was sent out (four weeks after initial distribution). Of the 320 individuals identified in the sampling frame, 93 (29.1%) returned usable surveys, leaving 227 (70.9%) non-responders.[1]

The survey instrument is a 90-item measure (administered one time only) that covered 12 areas of coalition characteristics and functioning (e.g., leadership, commitment, member satisfaction). Each area (or construct) had multi-item, Likert-type questions (i.e., 5 to 8 items/scale), each of which measured those constructs identified in the literature review, as salient to member commitment and participation. Readability statistics were run on the survey instrument in Microsoft Word, yielding: 6% passive sentences, a Flesch Reading Ease score of 49.7, and a Flesch-Kincaid grade level rating of 9.6. The Flesch Reading Ease score, as the name implies, is a measure of the difficulty level of a text. The scale goes up to 120, with higher scores indicating material that is easier to read; lower numbers mark harder-to-read passages. The Flesch-Kincaid grade level rating refers to the number of years of education generally required to understand the respective text (Wikipedia, 2007).

Pilot Testing. The measure was piloted with a sample (n=10) of current members of the coalition.[2] These members represented different ethnic, socioeconomic, and educational levels. After administering the measure, a respondent debriefing (Campanelli, Martin, & Rothgeb, 1991) was conducted. As part of the debriefing, each respondent was asked about their

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[1] This relatively low response rate was believed to be partially the result of sampling during the holidays when many members were away from offices or homes on vacation, and past members not being able to be reached by electronic mail or postal mail because of address changes.

[2] Ideally, the measure would be pilot tested on approximately 50-100 members of the sample frame to have sufficient reliability (5-10 respondents per construct). The responses from the piloted measure would be subjected to a variety of psychometric analyses, to assess the uni-dimensional structure of the scale (Kline, 1994). This is done using item factor analysis, in order to establish the factorial properties and reliability of the scale and to determine if the factors measured appear to form a single construct (Kline, 1994). However, with only a 25% rate of response (n=88) anticipated from this population (N = 320), it is not practical to pilot the survey with this number of participants. Therefore, this procedure was not performed.

understanding of the terms, how they arrived at their answers, the clarity of the directions, whether there was anything offensive, and the average length of time it took to complete the survey. Based on this feedback, adjustments were made accordingly to the measure. Although readability statistics were slightly higher than desired, overall understanding and navigation of the survey was not reported as a problem for the pilot group.

Reliability. According to Hoyle, Harris, and Judd (2002), the reliability of a measure is defined as the extent to which it is free from random error. To establish the reliability of the scale, a measure of internal consistency was conducted. This is a measure of how highly each of the items correlates with all the other items in a set, suggesting a certain consistency of measurement. When the scale under investigation produces discrete, ordinal data, a measure using a Cronbach's alpha coefficient (α) is calculated. Existing measures from prior research studies were used to compile the measures for the current study. Therefore, internal consistency, as measured by Cronbach's alpha, in most prior instances is reported in addition to new Cronbach's alpha coefficients on each scale with population data from the current study (see Key Measured Variables). There was only one administration of this measure; therefore, test-retest reliability cannot be measured. In addition, inter-rater reliability was not measured, as this study does not require the direct observation of behavior by different raters.

Design Validity. This is a cross-sectional, non-experimental research study. Due to the lack of manipulation in this study, there are some potential threats to internal validity (Hoyle, Harris, & Judd, 2002). History is always a potential threat when dealing with community-based processes and it refers to any event occurring in the political, economic, or cultural lives of the participants that coincides with the independent variable(s) that could affect the dependent variable. It is possible that during the course of data collection some social, economic, or

political issue occurred that affected individual responses to the quantitative and qualitative questions. Instrumentation refers to any change that occurs over time in measurement procedures or devices. Given that this study utilized a mixed-method approach instrumentation could have been a threat, but was not. Although the same measure was used, there was a threat of variability in responses based on method - the survey administered electronically to participants providing a valid e-mail address, and a paper survey was mailed to participants providing only a valid mailing address. Computers have varying internet speeds and may require that some respondents take considerably longer to take the survey. As well, manually completed surveys might be completed over time or at once in varied settings. There were 85 electronic surveys returned (out of 276 sent to valid e-mail addresses) and 8 hard-copy surveys returned (out of 44 mailed to valid addresses). The responses were analyzed separately to rule out mode bias. There was no significant variability between data from the two modes, so the data was aggregated. The 8 hard-copy surveys were manually entered into Survey Monkey, yielding 93 total returned surveys.

Social Desirability. An additional threat to design validity was social desirability. The effects of social desirability were chiefly reduced by administering the primary survey tool as a voluntary, anonymous instrument (both web-based and paper versions). Therefore, the following measures reduced these effects: (1) letting respondents know their answers were not linked to their personal information, (2) allowing respondents to opt out or terminate their survey at any time, and (3) allowing respondents to answer the survey privately. The relative anonymity of self-administered questionnaires permits respondents to be candid. However, the secondary interview protocol called for phone interviews with an interviewer.[3] Interviewers are thought to

[3] The interviewer was a trained graduate community psychology student that administered qualitative surveys via telephone with a standard interview protocol. The interviewer recruited was paid $25 per survey.

affect both the rate of responding and the quality of responses (Singer, Frankel, & Glassman, 1983; Sudman, Bradburn, Blair, & Stocking, 1977). Effects on response quality, which may lead to bias in responses, are believed to come about because of self-presentation or social desirability issues (Sudman & Bradburn, 1974). That is, when the topic of the interview is sensitive or threatening, the mere presence of the interviewer may lead to distorted reporting of the sensitive behavior or beliefs. Or, if the topic of the interview is salient and closely related to observable characteristics of the interviewer, such characteristics may tend to produce systematic variations in response. Interviews were conducted by phone to reduce this effect.

Reducing Bias. Social desirability effects are important considerations. All interviews were conducted by a trained interviewer. It is critical to note that the student PI of this research is also a primary facilitator of monthly coalition meetings.[4] Therefore, significant caution was exercised to remove researcher influence and bias. Therefore, concealment of the student-researcher's identity was important for this portion of the research. Concealment was approved by the Institutional Review Board (IRB). In addition, anonymous survey responses by members allowed protection from retribution by the researcher if unfavorable responses about the student researcher's role as the coalition facilitator were conveyed. In further reducing bias, the student investigator assured:

1. the hiring and training of a non-project-affiliated interviewer to administer key informant interviews via phone with key informants[5];
2. the interviewer had IRB approval/current CITI certification (note: student investigator's IRB certification is approved through November 20, 2008); and

[4] The student investigator's personal experience as a participant observer is critical to the understanding of the ways in which people participate in coalitions. However, caution was exercised in minimizing researcher bias and participant influence.

[5] The interviewer did not know, and thus, was unable to disclose significant quantitative results during qualitative questioning as it would have introduced both interviewer and responder bias.

3. the interviewer was experienced and trained in the subject matter.

It is also important to note that this study is an assessment that was solicited by members of the coalition and not by the student PI. Although the conceptual aspects of the study were designed by the student investigator with feedback from coalition members, the request for an examination of coalition effectiveness and sustainability came from coalition membership.

Key Measured Variables

This study examined interrelationships between 10 key variables. The survey administered measured the two dependent variables, participation and commitment. In addition, eight predictor variables were measured that included: leadership, sense of community, satisfaction, social resources, empowerment, communication, decision making, and participation benefits. The sources for questions used to measure these constructs are listed in Appendix C (Survey Item Source by Construct) at the end of the survey instrument (Appendix A). The table lists the variables measured; the number of items used to measure each, the source reference, and reported reliability of the measure.

Background. The first set of questions in the survey was about member involvement (or participation) in the Clarkston Health Collaborative. Participants were asked the length of time they have been a member of the coalition (in years and months), whether they lived in the area served by the coalition and the sector of the community they represent (e.g., schools, social services, faith community, etc.). A final question in this section asked participants which elements of the coalition they felt attracted members.

Participation. Member participation was assessed by a 9-item scale based on Hays, Hays, DeVille, and Mulhall's (2000) measure of participation. The measure assesses two aspects of participation. The first section (Item 1) asked how often members attended meetings.

Meeting attendance was measured on a 5-point scale ranging from 1 (“0 meetings”) to 5 (“10-11 meetings”).

The second section under this construct (items 2 – 9) asked how often members played certain roles in the coalition activities during the time in which they were actively involved. These items were rated using a 5-point Likert-type scale ranging from 1 ("Never") to 5 ("Always"). Examples include, “Made comments, expressed ideas at meetings” or “Served as a member of a committee.” Items 2 – 9 were summed to compute the participation variable. Scores ranged from 8 to 40 with lower scores reflecting lower levels of participation. Hays, Hays, DeVille, and Mulhall (2000) reported a reliability estimate of .87 for this measure using Cronbach’s measure of internal consistency. The alpha for the current sample is .93. A final, qualitative question from Kumpfer (2005) was added to this section of the survey. It was included to determine members’ perceptions of barriers to coalition participation.

Commitment. Commitment was assessed by a 3-item scale based on Chavis et al.’s (1987) measure of commitment. This measure was subsequently revised by Kumpfer et al. (1993) to assess the strength of member commitment to the coalition and caring about the work of the coalition. An example includes, “I really care about the future of this coalition.” The items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree ") to 5 ("Strongly Agree"). Scores ranged from 3 to 15 with lower scores reflecting less commitment to the coalition. Chavis et al. (1987) originally reported a reliability of .60. In their study, Kumpfer et al. (1993) reported reliability for this measure using Cronbach’s measure of internal consistency ($\alpha = .93$). The alpha for the current sample is .88.

Leadership. Leadership effectiveness was assessed using a 16-item scale derived from previous measures assessing leadership (Hays, Hays, DeVille, & Mulhall, 2000; Kegler,

Steckler, McLeroy, & Malek, 1998). This scale examined members' perceptions of the extent to which the leader directs the group toward collaborative group achievement, encourages all points of view, and manages conflict. These items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree ") to 5 ("Strongly Agree"). Scores ranged from 16 to 80 with lower scores reflecting less effective leadership. In a previous study, Hays et al. (2000) reported reliability for seven items in this measure using Cronbach's measure of internal consistency ($\alpha = .92$). Kegler et al. (2000) reported an alpha of .86 on eight of the items. The alpha for the current sample is .97.

Sense of Community. Sense of community was assessed by a 5-item scale, one item from Hays et al. (2000) and 4 items from Kegler et al. (1998) studies both examining feelings of connection, support, and collective problem solving. These items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Items included "There is a feeling of unity and cohesion in this coalition" and "There is a strong feeling of belonging in this coalition." The revised scale eliminated one item which, if deleted, substantially increased the reliability of the measure. The remaining 4 items were summed to compute the sense of community variable. Scores ranged from 6 to 20 with lower scores reflecting a lower sense of community. In prior studies, neither Kegler et al. (1998) nor Hays et al. (2000) reported reliability using Cronbach's measure of internal consistency. The alpha for the current sample is .85.

Satisfaction. Members satisfaction with the coalition was assessed by an 8-item scale (Kumpfer, 2005; Kumpfer, Turner, Hopkins, & Librett, 1993) examining satisfaction with operations and accomplishments. The scale contained items that were rated using a 5-point Likert scale ranging from 1 ("Very Dissatisfied") to 5 ("Very Satisfied"). Scores ranged from 12

to 40 with lower scores reflecting a greater dissatisfaction with the coalition. In a previous study, Kumpfer et al. (1993) utilized this measure reported reliability ($\alpha = .91$) using Cronbach's measure of internal consistency on nine of the items. The alpha for the current sample is .91.

Social Resources. Resources was assessed by a 6-item scale (Hays, Hays, DeVille, & Mulhall, 2000; Kumpfer, 2005) examining resources brought about through effective and empowering leadership. Respondents were asked to select the answer that best represents their response. These items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Scores ranged from 10 to 30 with lower scores reflecting little or no exchange or mobilization of social resources. A prior study examined the exchange or mobilization of resources using this scale, however, no Cronbach's alpha was reported (Hays, Hays, DeVille, & Mulhall, 2000). The alpha for the current sample is .78.

Empowerment. Given there is no one recognized measure of empowerment, a 12-item general self-efficacy scale, originally developed by Sherer et al. (1982) and revised by Bosscher and Smit (1998) was used to assess individual level empowerment. A sample question is "When I decide to do something, I go right to work on it." These items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Questions 4 – 8 were negatively worded and were reverse-scored for ease of analysis. After reliability analysis, items 4-12 were summed to create the empowerment variable. Scores ranged from 9 to 38 and the higher the score, the greater the person's self-efficacy or individual level empowerment. Bosscher and Smit (1998) reported reliability of over .60 for this measure using Cronbach's measure of internal consistency. The alpha for the current sample is .79.

Communication. Communication was assessed using three sets of questions. A 3-item scale (Butterfoss, Goodman, & Wandersman, 1996) examining how members perceive

communication in the coalition was used in the first section. These items were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Example items include "Communication among members of this coalition is clear" or "there is very little communication among coalition members" and "The discussion and communication in this coalition is productive." Based on acceptable alpha levels, the revised scale eliminated the second item which, if deleted, substantially increased the reliability of the measure. The revised measure summed the remaining two items to establish the communication variable. Scores ranged from 2 to 9 with lower scores reflecting less clear and less productive communication. Butterfoss et al. (1996) did not report reliability for this measure. The alpha for the current sample is .77.

In addition, two descriptive sections (not included in the communication variable) asked the most frequently used methods of communication (e.g., meetings, minutes, newsletters), as well as the perceived importance of respective methods of communication (Kegler, Steckler, McLeroy, & Malek, 1998; Kumpfer, Turner, Hopkins, & Librett, 1993). Perceived importance items were rated using a 4-point Likert scale ranging from 1 ("Not at all Important") to 5 ("Very Important"). Scores ranged from 4 to 16 with lower scores reflecting less important modes communication.

Decision Making. Decision making was assessed using a 7-item scale (Butterfoss, Goodman, & Wandersman, 1996; Kegler, Steckler, McLeroy, & Malek, 1998) of individual perception of involvement in coalition decision making and perception of . This scale contained items that were rated using a 5-point Likert scale ranging from 1 ("Strongly Disagree") to 5 ("Strongly Agree"). Scores ranged from 13 to 35 with lower scores reflecting less shared decision making. In a previous study, Butterfoss et al. (1996) reported reliability for three of the

items in this measure using Cronbach's measure of internal consistency (α = .47). Also, in a previous study, Kegler et al. (1998) reported reliability for four of the items in this measure using Cronbach's measure of internal consistency (α = .84). The alpha for the current sample is .82.

Participation Benefits. Participation benefits was assessed by an 11-item scale (Butterfoss, Goodman, & Wandersman, 1996) examining personal benefits (e.g., improved skills, improved public speaking, networking, support from others in community). The scale contained items that were rated using a 5-point Likert scale ranging from 1 ("Not at all a Benefit") to 4 ("Very Much of a Benefit"). Scores ranged from 11 to 44 with lower scores reflecting little or no participation benefits. Butterfoss et al. (1996) assessed member benefits using 14 items on this scale and reported reliability for this measure using Cronbach's measure of internal consistency (α = .90). The Cronbach alpha coefficient for the current sample is .88.

Demographics. Five items were included at the end of the survey to capture the following demographic variables: age, gender, race/ethnicity, education level, and country of origin (Hays, Hays, DeVille, & Mulhall, 2000).

Qualitative Methods

According to Creswell (1998), qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. Creswell (1998) also notes that in qualitative research the researcher builds a complex, holistic picture, analyzes words, reports detailed views of information, and conducts the study in a natural setting.

Key Informant Interviews. Structured interviews were conducted by phone in this qualitative research, in which carefully worded interview questions were asked of key CHC participants. According to Patton (1987), key informants, as sources of information, can add

what the observer has not or cannot experience, as well as a source of explanation for things that the observer has actually witnessed. The emphasis is on obtaining answers to carefully phrased questions. The qualitative interview contains questions about member participation, member commitment, and satisfaction with the work of the collaborative. The interviewer was trained to deviate only minimally from the question wording to ensure uniformity of interview administration. Significant relationships between study variables are expected in the quantitative analyses and based on these significant findings, questions were asked of key informants to get more in-depth information about the meaning of these significant relationships.

Participants

Study participants consisted of a sample of current and previous attendees of the Clarkston Health Collaborative obtained from the cumulative database of attendees (N = 320), from 1994 through 2008. Participants represent people who live, work, and/or play in the City of Clarkston and who have previously attended the Clarkston Health Collaborative and completed the sign-in sheet with their name, agency, address, phone number, and electronic mail (e-mail) address. The sign-in sheet solicits active consent from participants to be placed on the mailing list and receive regular coalition updates, minutes and agendas by mail or e-mail.

Sampling and Procedures

The sampling protocol for the qualitative portion of this study was designed to select CHC participants (n = 6) from a cumulative listing of CHC attendees that indicated high participation in and high commitment to the coalition on the quantitative analyses noted above.

Selection Criteria. Members were actively recruited through the web-based survey (see Appendix D) to participate in interviews to further expound upon relationships assessed at the quantitative stage that foster engagement in the Clarkston Health Collaborative. After self-

selection to be interviewed through the member survey, key informants were screened to determine eligibility for the study (see Appendix L). Participants were assessed for inclusion in key informant interviews based on two criteria: (1) high participation or high commitment and (2) length of participation. First, their level of participation (e.g., Low, Medium, or High) in the CHC was determined by the number of CHC meetings they attended in a coalition calendar year (i.e., 11 months) when they were active (i.e., Low = 0-3 meeting/year, Med = 4-6 meetings/year, High = 7-11 meetings/year). Secondly, their level of commitment was determined based on their response to items on the commitment measure. If they reported that they agreed with all items (i.e., I really care about, I am proud of, and I feel strongly committed to the coalition), they were deemed "highly committed." Although examining low participation and low commitment among participants might be a consideration for contrast purposes, in the current study the focus is on those who have or continue to engage and the reasons why they engage. Therefore, we are examining the motivating or facilitating factors of highly committed and highly participative members. The ultimate idea is to determine what mechanisms create or attract more people like this, in this and in other community-based coalition efforts.

Finally, members' length of participation in the CHC was determined by how long (in months or years) they were involved in the Health Collaborative. For length of participation, the minimal time to qualify for an interview was active engagement for 7 months, or at least 7 meetings in a calendar year (see Table 1, Key Informant Interview Screening Grid). The procedures outlined here allowed the investigator to construct a representative sample of "high participating" (or "highly committed") CHC attendees who had been involved a minimum of seven months, make qualitative inferences to the larger population of similar attendees, and

theorize about the introduction of biases that may limit generalization of results to the target population.

Of the 93 survey respondents, 31 consented to be interviewed as key informants. Of this number, 9 respondents met the selection and screening criteria and 6 were selected for contact and interview as hypothesized. Additional respondents that were screened in were considered alternates if any of the initial 6 were unable to be reached. It is critical to note here that the three that were considered as alternates were not interviewed as part of the primary group of key informants because although they were screened in through the established selection criteria, upon closer review, their respective scores on participation either did not meet threshold or were at the bottom edge of the criteria. Based on the researcher's participant-observer knowledge, each is a relatively new member to the coalition and reported to have been involved in the coalition at most 7 months. However, at closer examination of coalition records of attendance, their reported participation in 7 meetings was across two calendar years. When examined during the periods when they were active (within each respective year) their participation fell in the low to medium range, and therefore, below criteria cut-off. Because this is a purposeful sampling where particular member attributes are critical to expanding upon significant quantitative findings, for full inclusion in the primary key informant group, the researcher needed the confidence that this sub-sample of the population contained informants that were truly high participating and highly committed. Therefore, the 6 participants deemed fully eligible were contacted by the interviewer, a fifth-year clinical/community psychology student within Georgia State University's Department of Psychology.

Table 1

Key Informant Interview Screening Grid

Name (Last, First)	**Gender** (M/F)	**Nationality/Ethnicity** *(e.g., White American, Black American, Somali, Bosnian, Kurdish, etc.)*	**Representation** *When you attend (or attended) who do (whom did) you represent (e.g., resident, faith, business, etc.)?*	**Length of Participation** *How long were you (or have you been) active in the Health Collaborative (in months and/or years)?*	**Level of Participation (*M*)** *When you are (or were) active, what is (or was) your level of participation? (e.g., 1-3 , 4-6, 7-9, or 10-11 meetings/yr)*	**Level of Commitment (*M*)** *I really care about, I am proud of, and I feel strongly committed to the coalition? (e.g., low, moderate, high)*
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						

Consent Procedures. It was originally proposed that the interviewer and interviewee meet at a convenient public location for a face-to-face interview. However, because attrition was a critical factor and participants might be hesitant to meet an unfamiliar person for an interview, an amendment was submitted to the IRB to request interviews be conducted by phone. The request was approved (Amendment #1, 2/20/08). The interview was administered by phone by the interviewer according to the interview protocol (Appendix E) and each interview took approximately 30 minutes. The interviewer explained the study and obtained verbal consent for participation. A standard, IRB-approved consent form (Appendix H) was read over the phone to participants during the phone interview and informed participants that their interviews would be tape recorded. They were assured that their responses would be kept confidential and only be used for the purpose outlined. Participants were given the opportunity to ask any questions. Therefore, respondents that volunteered for the key informant interviews gave verbal, recorded consent by phone and were mailed a copy of the consent form for their records, along with an incentive.

Incentives. For the key informant interviews, all participants that completed the interview by phone were given a $20 grocery store gift card. Incentives were mailed to participants within a week of completion of the interview.

Interview Procedures

Concealment. Concealment of student-researcher's identity was important for this portion of the research as well. As a result of involvement in the coalition as a facilitator, member knowledge that the key informant interviews were part of graduate work by the student-researcher may have influenced or biased participant responses. IRB-approved concealment of student researcher's identity was continued in this portion of the research.

The six key informant interviews were conducted by a trained interviewer. During the phone interview, the interviewer administered a 16-item qualitative protocol (see Appendix E) to explore participant views on factors that were found in the quantitative analyses to be significant predictors of engagement in the Clarkston Health Collaborative.

Interview Protocol. A standard interview protocol (Creswell, 1997) was administered to all key informants who met the screening criteria. As part of the interview protocol, the interviewee was briefed on the project and its purpose. The interviewer noted the date, the time the interview began and ended, their name as the interviewer, and the interviewee's name. The interviewee was asked a series of open-ended questions about member participation and member commitment that assist in understanding engagement in the Clarkston Health Collaborative. Sample questions include: "When did you last participate in the health collaborative?" and "What was it about the meeting that kept you engaged?" and "What are some things that keep you participating?"

Data Collection. Six key informant interviews were completed. The interviewer took verbatim notes of the answers from each respondent. Interviews were audio recorded on tape (with the consent of the participants), and transcribed after each interview. Written notes allowed the transcriber the opportunity to fill in any missing information. This was necessary because there were at least two the key informants for whom English was not their first language. Therefore, the written notes were used to complete thoughts and words that were either inaudible or unable to be understood on the tapes. Detailed recording was a necessary component of interviews since it forms the basis for analyzing the data. The interview data was subjected to traditional qualitative analyses, including data reduction, display, verification and conclusion drawing. The standard protocol and standard measurement procedures, including

audio-taping interviews and coding schemes, facilitated these analyses (Hoyle, Harris, & Judd, 2002).

Post-Study Debriefing of Participants. At the conclusion of the two phases, that is upon completion of all quantitative and qualitative data collection and analyses, the study participants were debriefed (i.e., full disclosure) on the nature and the use of the survey and interview data for dissertation research as well as coalition assessment (see Debriefing Script, Appendix M). The student PI's identity was disclosed. Although survey participants were anonymous, those participants for whom a name was clearly attributable to response (i.e., key informants) were given the option to withdraw their response data.

Data Analysis Procedures

Quantitative Data Analysis Procedures

Data Preparation. All quantitative analyses were performed using SPSS REGRESSION and SPSS EXPLORE for descriptive statistics and evaluation of assumptions using SPSS (Version 15.0). Data screening was conducted. Descriptive statistics (i.e., means, standard deviations, and frequencies) were calculated for each independent, dependent, and mediating variable and for demographic characteristics (e.g., age, gender, race, and level of education). For all categorical variables, the frequencies were computed using SPSS procedures to obtain the appropriate number of respondents for the data analyses and the extent of missing data. For continuous variables, descriptive statistics were computed using SPSS to obtain summary statistics (e.g., mean, median, and standard deviation) of all variables.

Prior to analysis, all variables were examined through various SPSS programs for missing values, outliers, minimum and maximum values, and fit between their distributions and the assumptions of multivariate analysis. There were missing cases across variables with no

obvious pattern. A missing values analysis (MVA) was performed and revealed that Communication, Decision Making and Benefits all had less than 5% missing values. Participation, Commitment, Sense of Community, Resources, and Empowerment had between 5% and 7.7% missing values, and Leadership and Satisfaction both had just over 10% of their values missing. According to Tabachnik and Fidell (2001), if variables are critical to analysis, deletion of items is not plausible. With medium-sized samples, the missing values may be substituted with group or scale means. This procedure is conservative in that the mean for the distribution does not change and the researcher is not required to guess at missing values. On the other hand, with this technique, there is a reduction in the variance of a variable because the mean is closer to itself than to the missing value it replaces. As a result, the correlation the variable has with other variables is reduced because of the reduction in variance. Therefore, scale or group mean substitution was not performed.

As part of the MVA, Expectation maximization (EM) was employed to address missing values. According to Tabachnik and Fidell (2001), this procedure in SPSS generates imputed values for randomly missing data that produce realistic estimates of variance and avoids over fitting of the data. EM forms a missing data correlation matrix by assuming the shape of a distribution (such as normal) for the partially missing data and basing inferences about missing values on the likelihood under that distribution. Missing values were replaced using this procedure. The procedure yielded 93 complete cases.

To ascertain whether the complete data met the assumptions of regression, all histograms and box plots were inspected for normal distributions using kurtosis and skewness analyses to determine if there were any extreme cases. All variable distributions were moderately to substantially negatively skewed (except participation and empowerment) with between 1 and 7

extreme cases at the lower end of the distribution. Both square root and logarithmic transformations were performed on reflected (i.e., reversed) scores to determine which method significantly improved normality and reduced the effect of any extreme scores or outliers. The square root transformation significantly improved distribution of scores across variables, with absolute values of skewness close to zero (less than .50, *SE* = .25) across variables and kurtosis less than 2.4 across variables.

As a result of a substantial negative skew, the communication variable responded best to log transformation, resulting in acceptable skewness (-.08) and kurtosis (-.41) scores. All variables were again reverse-scored to allow original interpretation (see transformed variables, Table 2). There were no violations of other statistical assumptions (e.g., linearity, homogeneity of variance, or homogeneity of regression) in the transformed data.

Table 2

Transformed variables used in analyses

Dependent Variables (DVs)	
SQRTParticipation	
SQRTCommitmentREV	
Independent Variables (IVs)	
SQRTLeadershipREV	SQRTSenseofCommunityREV
SQRTDecisionMakingREV	LOGCommunicationREV
Mediator Variables (MVs)	
SQRTSatisfactionREV	SQRTResourcesREV
SQRTEmpowerment	SQRTBenefitsREV

After transformation, extreme scores or outliers were re-examined based on boxplots. There were very few extreme cases as a result of the transformations. However, case #92 had at

least two extreme scores or multivariate outliers, based on the Mahalobois test (Tabachnick & Fidell, 2001) post transformation. As the extreme scores for this case were determined to be actual participant responses and not the result of data entry errors, inferential statistics were run (post-transformation) with and without this case and there was no significant difference in results. Therefore, this case was not excluded. The resulting N was 93 participants.

After calculating descriptive statistics, a zero-order correlation matrix was created to examine significant correlations between predictor variables. No high inter-correlations were detected, and therefore there was no multi-collinearity (Pedhazur & Pedhazur-Schmelkin, 1991). To establish mediation, however, there is an expectation of correlation between the independent, mediator, and dependent variables (Baron & Kenny, 1986). These correlations were present.

Inferential Statistical Analyses – Mediation. Multiple regression was performed to assess the six models predicting the mediating effects of various indicators on participation and commitment. To test the mediation model, the path model was tested (see Figure 9). The indirect effect is measured as the product of the magnitude of the direct effects of which it is comprised (a x b). Evidence for a mediation effect was implied by a statistically significant test of the indirect effect. Using hypothesis 5 as an example, according to Baron and Kenny (1986), detecting a mediated effect requires that (1) the predictor variable (e.g., decision making) is correlated with the dependent variable (e.g., commitment), which establishes a main effect, path c_1, (2) the predictor variable (e.g., decision making) is correlated with the mediator variable (e.g., member satisfaction), or path a, (3) the mediator variable (e.g., member satisfaction) affects the dependent variable (e.g., commitment), while controlling for the effect of path a, and (4) the effect of the predictor variable (e.g., decision making) on the outcome variable (e.g.,

commitment), controlling for the mediator is no longer significant or zero, path c_2. The effects in steps 3 and 4 are estimated in the same equation.

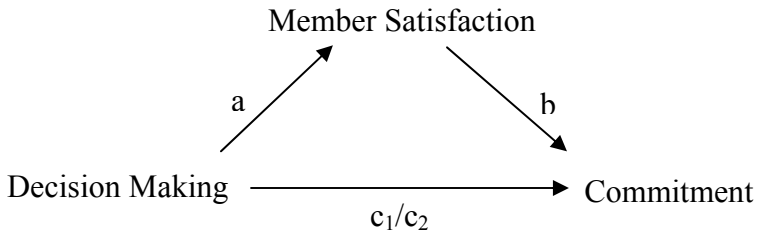

Figure 9. Mediation model.

Keeping with the same example, the mediated effect of member satisfaction on the decision making – commitment relationship was assessed using two hierarchical multiple regressions (HMR). In the first HMR, the mediator variable (member satisfaction) was regressed on the independent variable (decision making) and represents equation 1 (path a). In the second HMR, the dependent variable (commitment) was regressed on the independent variable (decision making) in the first step, or equation 2 (path c_1), and on the mediator variable (member satisfaction) in the third step, or equation 3 (path b). If a mediated effect was detected, decision making affects member satisfaction in the first equation (path a), decision making affects commitment in the second equation (path c_1), and member satisfaction affects commitment in the third equation (path b). Also, the effect of decision making on commitment was less in the third equation (when controlling for member satisfaction, path c_2) than in the second equation (before considering member satisfaction, path c_1). The significance level for testing a mediated effect was set at $\alpha = .05$. Post hoc, confirmatory analyses were performed using the Sobel test via an interactive, online calculation tool for mediation tests (Preacher & Hayes, 2004).

Inferential Statistical Analyses – Path Analysis. Path analysis is an extension of multiple regression. Its aim is to provide estimates of the magnitude and significance of hypothesized causal connections between sets of variables. Path analysis tests the fit of the correlation matrix

against two or more causal models that are being compared by the researcher. Within a given path diagram, path analysis can tell us which are the more important (and significant) paths. This may have implications for the plausibility of pre-specified causal hypotheses (Kline, 2005).

A regression is conducted for each variable in the model as dependent on others which the model indicates are causes. The regression weights predicted by the model are compared with the observed correlation matrix for the variables, and a goodness-of-fit statistic is calculated. The best-fitting of two or more models is selected by the researcher as the best model for advancement of theory.

Path analysis requires the usual assumptions of regression. According to Kline (2005), it is particularly sensitive to model specification because failure to include relevant causal variables or inclusion of extraneous variables often substantially affects the path coefficients, which are used to assess the *relative importance* of various direct and indirect causal paths to the dependent variable. Such interpretations should be undertaken in the context of comparing alternative models, after assessing their goodness of fit. LISREL 8.7 (software package for Structural Equation Modeling) was used for path analysis in lieu of a stand-alone path analysis program.

Assumptions. Recursive models explaining participation and commitment were examined. The assumptions for these path analyses were as follows (Joreskog & Sorbom, 1993):

1. All relations are linear and additive. The causal assumptions (what causes what) are shown in the path diagram.
2. The residual/error terms are uncorrelated with variables in the model and each other.
3. The causal flow is one-way.
4. The variables are measured on interval scales or better.
5. The variables are measured without error (perfect reliability).

Identification. Identification is important for both the estimation of parameters and the testing of model fit. A parameter is said to be *identified* if a unique, best fitting estimate of the parameter can be obtained based on the sample of data at hand. For example, a path coefficient is identified if a single beta weight is associated with it and the beta weight can be estimated with the given data. A model (i.e., path diagram) is said to be identified if all of the parameters in the model are identified. If a parameter is not identified, it is said to be *under-identified*, *unidentified*, or *not identified* (Joreskog & Sorbom, 1993). The same term is applied to the model if one or more parameters were not identified. Parameters can be under-identified for many reasons. According to Joreskog and Sorbom (1993) the most common reason for under-identification is that the set of simultaneous equations implied by the path diagram does not have enough correlations in it to offer a unique solution to the parameter estimates.

Model Testing. A model is said to be *just identified* if the set of simultaneous equations implied by the parameters has just enough correlations in it so that each parameter has a solution; if there were any more parameters to estimate, one or more of them would not be identified. If there are some correlations left over after all the parameters have been estimated, the model is said to be *over identified*. It may be that the endogenous variables (dependent variables) are also affected by variables other than the identified exogenous variables (independent variables) and thus not in the model.

Evaluating Path Fit. The approach typically used is to first examine the significance of the chi-square statistic along with the respective degrees of freedom for overall goodness of fit. The researcher wants it to be as low as possible (close to 1). Then, examination of the Comparative Fit Index (CFI) adds additional confidence in model fit. This statistic should also be close to 1 (.90 or above is very good). The Root Mean Square Error of Approximation

(RMSEA) is the best indicator of fit and considers parsimony and sample size. Along with 90% confidence intervals, the fit is great if this statistic is less than or equal to .05. The Root Mean-square Residual (RMR) is the final statistic often used to evaluate path models. It is computed by subtracting the predicted from the actual, squaring the result, taking the average over the correlations, and taking the square root (Joreskog & Sorbom, 1993). The standardized version of this statistic (i.e., SRMR) is commonly used in model fit assessment. This can be thought of as a standard error of prediction or the standard deviation of the residuals. These statistics are examined in concert to determine the overall goodness of fit of the model to the data. When comparing the fit of subsequent models, the chi-square difference test (χ^2_D) is used to determine if fit was significantly improved as a result of addition (i.e., building) or elimination (i.e., trimming) of paths in the model.

Qualitative Data Analysis Procedures

Qualitative analysis provided ways of discerning, examining, comparing and contrasting, and interpreting meaningful patterns or themes. This study adopted a similar framework developed by Miles and Huberman (1994) to describe the major phases of qualitative data analysis: data reduction, data display, and conclusion drawing and verification.

Data Reduction. Using the procedure described by Miles and Huberman (1994), data reduction was conducted. Data that appeared in transcriptions was selected, focused, simplified, and abstracted. The data were condensed for the sake of manageability so they could be made intelligible in terms of the issues being addressed (Denzin & Lincoln, 1994).

Coding. All interviews transcripts were coded and re-coded for themes by the student researcher (see Appendix F). Ryan and Bernard (2003) suggested that using software to generate a common word list is an efficient way to begin looking for themes. A factor mentioned by more

than one respondent was considered a theme. Because of the use of a standard interview protocol, a careful look at questions that expanded upon relationships that were significant in the quantitative analyses was facilitated. These items were examined for content frequency to identify patterns and themes (Ryan & Bernard, 2003). For this study, NVivo 7, a qualitative data management software program was used. For the key informant interviews, verbatim transcripts were imported from Microsoft Word into NVivo 7. The NVivo 7 software allowed classifying, sorting, and arranging information, exploring of trends in qualitative data, and the building and testing of theories. The software allowed manipulation of the data and what Tesch (1990) called data condensation or data distillation, which helps researchers concentrate on the core of the data. Miles and Huberman (1994) note that computer software packages for qualitative data analysis aid in the manipulation of relevant segments of text. While helpful in marking, coding, and moving data segments more quickly and efficiently than can be done manually, they caution that the software cannot determine meaningful categories for coding and analysis or define salient themes or factors. In qualitative analysis, concepts must take precedence over mechanics: the analytic underpinnings of the procedures must still be supplied by the analyst (Miles & Huberman, 1994).

Data Display. Data display is the second element in Miles and Huberman's (1994) method of qualitative data analysis. Data display goes a step beyond data reduction to provide "an organized, compressed assembly of information that permits conclusion drawing." A codebook to code the data for common themes was developed (see Appendix G). Data was organized into a matrix according to each theme category for each interview. A thematic weighting scheme was followed. Themes were deemed strong if the theme was mentioned in

four or more interviews, moderate if the theme was mentioned in three interviews, and low if in two or less interviews.

Conclusion Drawing and Verification. "The meanings emerging from the data have to be tested for their plausibility, their sturdiness, their 'confirmability' - that is, their validity" (Miles & Huberman, 1994). As part of this process of conclusion drawing, the third element of qualitative analysis involved stepping back to consider what the analyzed data mean and to assess their implications for the questions at hand. The data were verified, which entailed revisiting the data as many times as necessary to cross-check or verify these emergent conclusions (Miles & Huberman, 1994). Quotes were used to illustrate major themes and implications, and are presented in the forms of quotes and theme areas in the discussion section.

Inter-rater Reliability. Inter-rater reliability is the extent to which two or more individuals (coders or raters) agree or intercoder agreement (Miles & Huberman, 1994). The student researcher did all the coding for all interview transcripts. Therefore, there was no measure of inter-rater reliability or intercoder agreement. The main argument against using verification tools with the stringency of inter-rater reliability in qualitative research has, so far, been that "expecting another researcher to have the same insights from a limited data base is unrealistic" (Armstrong, Gosling, Weinman, & Martaeu, 1997). Many of the researchers that oppose the use of inter-rater reliability in qualitative analysis argue that it is practically impossible to obtain consistency in qualitative data analysis because "a qualitative account cannot be held to represent the social world, rather it 'evokes' it, which means, presumably, that different researchers would offer different evocations" (Armstrong, Gosling, Weinman, & Martaeu, 1997).

CHAPTER 3

RESULTS

Descriptive Statistics

Quantitative Data. Prior to conducting inferential statistical analyses, descriptive analyses of demographic, input and outcome variables for this sample were performed. Table 3 presents the frequencies of select demographic study variables. All study participants ($N = 93$) completing the member survey were participants of the Clarkston Health Collaborative. Of survey participants, the largest racial group was Caucasian (47.2%), and participant were predominantly female (61.3%). They ranged in age from 21-70 years of age, with the largest age group being 41-50 years (48.4%). Greater than a third of participants (31.1%) reported having a bachelor's degree or graduate degree (37.8%). Figures 10 and 11 display regions or countries of origin reported by participants. Of those participants reporting their country of origin, nearly two-thirds reported being from the U.S., 16% were from African countries (i.e., Cameroon, Ethiopia, Nigeria, Somalia, and Sierra Leone), a tenth from Asian countries (i.e., China, Nepal, Pakistan, and Vietnam), and less than 10% reported being from East European (i.e., Bosnia and Herzegovina, Russia, and Serbia), Latin American (i.e., Guyana and Haiti), or Caribbean (i.e., Antigua and Virgin Islands) countries.

Table 4 shows that nearly half (46.2%) of participants reported that they were residents of Clarkston. The majority reported representing community residents (16.5%) or the government (20.8%) or healthcare (14.3%) sectors of the community. The remaining reported representing various other sectors of the community, each of which was less than 8%.

Table 3

Frequencies of Member Demographics (N =93)

Variables	N (%)
Gender (n=93)	
Male	36 (38.7)
Female	57 (61.3)
Race (n=91)	
Black	30 (33.0)
White	43 (47.2)
Asian/Pacific Islander	11 (12.1)
Latino	2 (2.2)
Other	5 (5.5)
Age (n=93)	
21-30	7 (7.5)
31-40	20 (21.5)
41-50	45 (48.4)
51-60	12 (12.9)
61-70	9 (9.7)
Education (n=90)	
Some college	18 (20.0)
Bachelor degree	28 (31.1)
Some grad school	10 (11.1)
Graduate degree	34 (37.8)

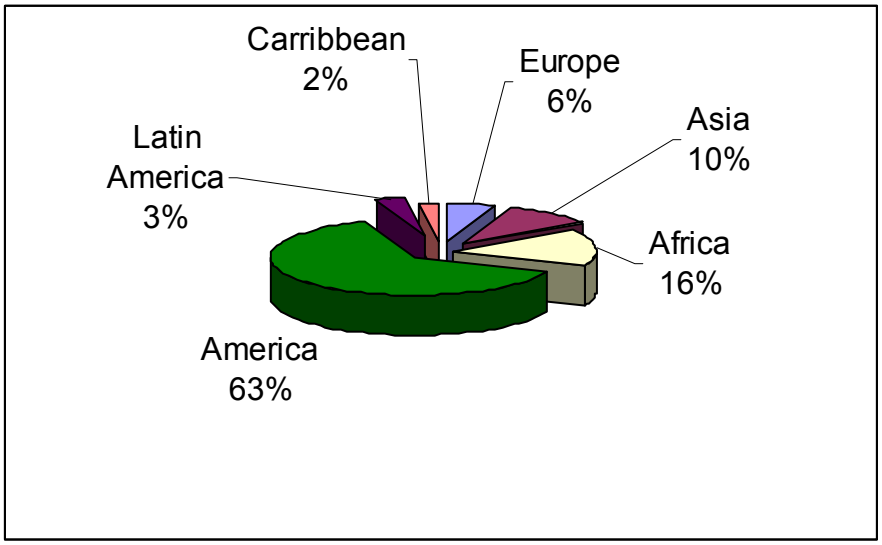

Figure 10. Participant Continent or Region of Origin

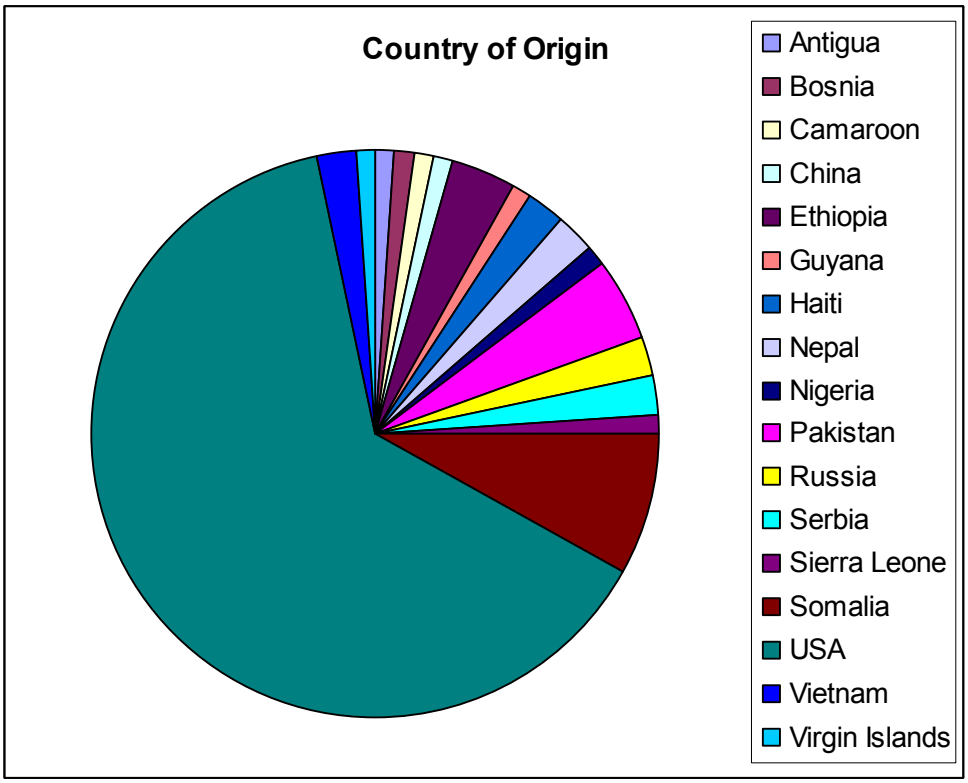

Figure 11. Participant Country of Origin

Table 4

Coalition Member Representation

Variables	N (%)
Residency (N=93)	
Yes	43 (46.2)
No	50 (53.8)
Sector (n=91)	
Resident	15 (16.5)
Government	19 (20.8)
Health/Healthcare	13 (14.3)
Non-Profit	7 (7.7)
Faith	6 (6.6)
Higher Education	6 (6.6)
Resettlement	5 (5.5)
Education	4 (4.4)
Business	4 (4.4)
Media	3 (3.3)
Grassroots	2 (2.2)
Social Services	2 (2.2)
Recreation	2 (2.2)
Youth	1(1.1)
Public Housing	1(1.1)
Law Enforcement	1(1.1)

Dependent Variables

Participation. Participation, a key dependent variable in this study, was examined in three separate ways: meeting attendance, playing an active role, and length of participation. It is important to note that member participation is measured for the period of time when a member

was actively attending over the coalition's 14-year existence. Therefore, past and present members are included in this sample.

First, member participation assessed how often members attended coalition meetings in a year when they were actively involved. There are 11 meetings per year. The majority (50%) of respondents reported attending 1-3 meetings per year with nearly a fifth (19%) reporting moderate attendance (4-6 meetings per year). Seventeen percent of participants considered high attendees, reported attending 7-11 meetings in a year and the remaining 14% responded that they did not regularly attend coalition meetings.

Secondly, member participation was assessed by how often members played active roles in coalition activities in a year, for example, "[I] made comments, expressed ideas at meetings" or "[I] served as a member of a committee." During the time in which they were involved with the coalition, on average, participants reported actively playing certain roles in the coalition a moderate amount of time ($M = 19.25$, $SD = 8.03$). On a 5-point Likert scale, the variable mean for participation was 2.41.

When asked how long they had been involved with the coalition, participants' responses ranged from 0 to 12 years, with an average involvement of 36 months (3 years) during the time in which they were consistently active in the coalition. Between a fourth and a half of participants indicated that the topics discussed, the forum structure, guest speakers, and the leadership were the most important factors that attracted them to the CHC (Table 5). When asked what other factors attracted them to the coalition, two predominant themes emerged. Thirteen percent of respondents said that "addressing the issues that affect the community" attracts members. The "coalition as a resource" and the "resources" realized through the coalition work were additional reasons.

A final question in this section assessed barriers to coalition participation. Those respondents who attended less than four meetings, or indicated their participation as "rarely" or "never" reported that the primary barrier to participation in the coalition was that they "didn't have time to attend" (59.3%), or for some "other reason" (24.1%). Barriers with the least influence on participation included a lack of transportation (3.7%), and having no knowledge (i.e., dates and times) of the meetings (1.9%).

Table 5

Factors attracting members to coalition

Factors*	N (%)
Topics	48 (51.6)
Forum Structure	27 (29.0)
Guest Speakers	24 (25.8)
Leadership	24 (25.8)
Government	19 (20.8)
Other Attendees	14 (15.1)

*Participants were allowed to select more than one option

Commitment. Commitment, a second dependent variable in this study, was examined by looking at the strength of member commitment to the coalition and caring about the future of the coalition. It is important to note that member commitment is measured for the period of time when a member was actively attending over the coalition's 14-year existence. Therefore, similar to participation, past and present members are included in this sample. The majority of respondents agreed with the following commitment questions which included, "I feel/felt strongly committed to this coalition" (61.8%), and "I am proud to tell others that I am/was a part of this coalition" (71.9%), and "I really care about the future of this coalition" (74.2%).

During the time in which they were involved with the coalition, on average respondents reported the strength of their commitment to the coalition was relatively high (*M* = 11.5, *SD* = 2.99). On a 5-point Likert scale, the variable mean for commitment was 3.83. Descriptives of all study variables are presented in Table 6.

Table 6

Descriptives of Outcome and Predictor Variables (N=93)

Variables	*Range*	*Mean*	*SD*
Dependent Variables			
Participation	8 – 40	19.25	8.03
Commitment	3 – 15	11.50	2.99
Independent Variables			
Leadership	16 – 80	64.06	11.44
Communication	2 – 9	7.36	1.37
Decision Making	13 – 35	26.40	3.54
Sense of Community	6 – 20	13.64	2.60
Mediator Variables			
Member Satisfaction	12 – 40	30.70	4.80
Participation Benefits	11 – 44	33.83	5.91
Social Resources	10 – 30	21.27	3.59
Empowerment	9 – 38	19.55	5.28

Each construct was assessed for its measure of internal consistency. The reliability estimates for each variable are presented in Table 7. In addition, reported reliability estimates from prior research studies are presented for comparison.

Table 7

Construct Reliability, N = 93

Variable	Prior Research† α	Current Research α
Dependent Variables		
Participation	.87	.93
Commitment	.93	.88
Independent Variables		
Leadership	.92	.97
Communication	.87	.77
Decision Making	.84	.82
Sense of Community*	–	.85
Mediator Variables		
Member Satisfaction	.91	.91
Participation Benefits	.90	.88
Social Resources*	–	.78
Empowerment	.60	.75

*No alpha reported in prior research
†Specific studies noted in Methods section

Correlations. Zero-order correlations for all variables are shown in Table 8. As Baron and Kenny (1986) state, testing a mediator model requires that the predicted relationship between the mediator variables and both the independent and dependent variables be uncorrelated ($r < .80$) for clear interpretation of interaction terms. There were no correlations above .80. The correlation coefficients for most paths are statistically significant. These results indicate that at the bivariate level, each of the conditions necessary to test for the possible role of a mediator has been met.

Independent and Dependent Variables. As predicted, there were several significant positive correlations between the two dependent variables, participation and commitment, and all of the independent variables (i.e., leadership, sense of community, communication, and decision making). However, counter to what was predicted, there was no significant correlation between participation and sense of community, $r = .15$, *n.s.*

Independent and Mediator Variables. As predicted, there were several significant positive correlations between each independent variable and its corresponding mediating variable (i.e., leadership – social resources, communication – satisfaction, and decision making – benefits). However, counter to what was predicted, there was no significant correlation between sense of community and empowerment, $r = –.04$, *n.s.*

Mediator and Dependent Variables. As predicted, there were significant positive correlations between mediator variables and their corresponding dependent variable (i.e., social resources, satisfaction, and participation, and member satisfaction and commitment). However, there were no significant correlations between empowerment and participation, $r = -.04$, *n.s.* and benefits and participation, $r = .06$, *n.s.*

Table 8

Zero Order Correlations Matrix for all Study Variables

	1.	2.	3.	4.	5.	6.	7.	8.	9.	10.
1. Participation (DV)	–									
2. Commitment (DV)	.507***	–								
3. Leadership (IV)	**.289****	**.544*****	–							
4. Sense of Community (IV)	**.153**	.271**	.165	–						
5. Satisfaction (MV)	**.259***	**.542*****	**.567*****	.319**	–					
6. Resources (MV)	**.330****	.393***	**.378*****	.358***	.615***	–				
7. Empowerment (MV)	**-.041**	.067	.042	**-.044**	-.005	-.145	–			
8. Communication (IV)	**.252***	.362***	.245*	.636***	**.425*****	.564***	-.069	–		
9. Decision Making (IV)	**.251***	**.409*****	.249*	.370***	**.457*****	.382***	-.013	.503***	–	
10. Benefits (MV)	**.057**	.222*	.268**	.344**	.359***	.286**	.097	.159	**.425*****	–

*** Correlation is significant at the 0.001 level (2-tailed).

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

* Correlation is significant at the 0.05 level (2-tailed).

Correlations in bold were hypothesized relationships as part of mediation

Inferential Statistical Analyses

Mediation Analyses for Participation and Commitment

A total of six separate hierarchical multiple regressions (HMR) were performed to assess the six models predicting the mediating effects of social resources, empowerment, benefits, and member satisfaction on the relationship between independent (leadership, sense of community, communication, and decision making) and dependent variables (member commitment and participation). A test of each mediation model was performed to determine significant interaction effects, or the role of the mediator in explaining the relationship. Post hoc, confirmatory analyses were performed using the Sobel test via an interactive, online calculation tool for mediation tests (Preacher & Hayes, 2004). Tables 9 and 11 show the steps of regression for all mediations performed predicting participation and commitment, including unstandardized betas, and their respective standard errors, which were used to calculate Sobel test statistics (Sobel, 1982).

Significant Mediator Effects for Participation

The mediating effect of social resources. Hypothesis 1: Leadership influences member participation through social resources. The analysis supports social resources' mediating role in partially explaining leadership's effect on participation in a non-topic based community health coalition. The model as a whole was significant and explained 14.0% of the variance in participation, R^2 =.140, $F(2, 90)$=7.33, p = .001. Social resources explained an *additional* 5.7% of the variance in participation (ΔR^2 =.057), after controlling for the effect of leadership. As well, social resources made a statistically significant contribution to participation (beta = .257, t = 2.44, p <. 05) beyond leadership. This standardized value indicates that as social resources increases by one standard deviation (3.59), participation increases by .257 standard deviations.

The standard deviation for participation is 8.03 and so this constitutes a change of 2.1 (.257 x 8.03). Therefore, for every 3.59-unit increase in social resources, there is a 2.1 increase in participation. This interpretation is true only if the effects of leadership are held constant.

Using the unstandardized regression coefficients for paths *a* and *b* of the path model, and their respective standard errors (see Table 9), the Sobel test confirmed the mediated effect of social resources (Sobel test statistic = 2.062, p = .039) on the relationship between leadership and participation. There were no other significant mediator effects for participation, and thus hypotheses 2-4 were not supported.

Table 9

Mediation effects and confirmatory Sobel test statistics for participation

	Regression result		
Path/effect	*β*	*SE*	Sobel (*p*)
Hypothesis 1			
c (leadership ⟶ participation)	.202**	.070	
a (leadership ⟶ social resources)	.170***	.044	
b (social resources ⟶participation)	.400*	.164	
c'	.134	.074	
a x *b*	.068	.007	2.062*
Hypothesis 2			
c (SOC ⟶ participation)	.279	.189	
a (SOC ⟶ empowerment)	-.091	.120	
b (empowerment ⟶participation)	-.042	.166	
c'	.275	.190	
a x *b*	.004	.020	*NS*
Hypothesis 3			
c (communication ⟶ participation)	1.030*	.415	
a (communication ⟶satisfaction)	1.492***	.333	
b (satisfaction ⟶ participation)	.216	.129	
c'	.708	.454	

a x *b*	.322	.043	*NS*
Hypothesis 4			
c (decision making ⟶ participation)	.405*	.164	
a (decision making ⟶ benefits)	.683***	.153	
b (benefits ⟶ participation)	-.060	.113	
c'	.446*	.182	
a x *b*	-.041	.017	*NS*

Note. *N* = 93.

*** Correlation is significant at the 0.001 level (2-tailed).

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

* Correlation is significant at the 0.05 level (2-tailed).

Significant Mediator Effects for Commitment

The mediating effect of member satisfaction. Hypothesis 5: Decision making influences commitment through member satisfaction. The analysis supports member satisfaction's mediating role in partially explaining decision making's effect on commitment in a non-topic based community health coalition. The model as a whole was significant and explained 32.7% of the variance in commitment (Table 10). Member satisfaction explained an *additional* 15.9% of the variance in commitment, after controlling for the effect of decision making. As well, satisfaction made a statistically significant contribution to commitment (beta = .449, $t = 4.62$, $p < .001$) beyond the significant contribution of decision making (beta = .204, $t = 2.10$, $p < .05$). These standardized beta values indicate that as decision making increases by one standard deviation (3.54), commitment increases by .204 standard deviations. The standard deviation for commitment is 2.99 and so this constitutes a change of .61 (.204 x 2.99). In this model, if member satisfaction increases by one standard deviation (4.80), commitment increases by .449 standard deviations and so this constitutes a change of 1.3 (.449 x 2.99). This interpretation is true only if the effects of decision making are held constant. Taken together, one standard

deviation increase in decision making, and one standard deviation increase in satisfaction, leads to a 1.91 increase in commitment (.61 + 1.3).

Hypothesis 6: Effective leadership influences member commitment through member satisfaction. The analysis supports member satisfaction's mediating role in partially explaining leadership's effect on commitment in a non-topic based community health coalition. The model as a whole was significant and explained 37.6% of the variance in commitment (see Table 10). Member satisfaction explained an *additional* 8.1% of the variance in commitment, after controlling for the effect of leadership. As well, satisfaction made a statistically significant contribution to commitment (beta = .345, $t = 3.41$, $p = .001$) similarly to the significant contribution of leadership (beta = .348, $t = 3.45$, $p = .001$). The beta for leadership indicates that as it increases by one standard deviation (11.44), commitment increases by .348 standard deviations. The standard deviation for commitment is 2.99 and so this constitutes a change of 1.04 (.348 x 2.99). Therefore, for every 11.44-unit increase in leadership, there is a 1.04-unit increase in commitment. This interpretation is true only if the effects of satisfaction are held constant.

In the same model, if member satisfaction increases by one standard deviation (4.80), commitment increases by .345 standard deviations and so this constitutes a change of 1.03 (.345 x 2.99). This interpretation is true only if the effects of leadership are held constant. If taken together, a one standard deviation increase in leadership and in satisfaction leads to a 2.07 increase in commitment (1.04 + 1.03).

Table 10

The mediating effect of Member Satisfaction on the relationship between independent variables and Commitment

	Member Satisfaction				
Independent Variable	β	R^2	ΔR^2	F	p
Decision Making (Hyp5)	.449*	.327	.159	21.86	<.001
Leadership (Hyp6)	.345*	.376	.081	27.13	<.001

*$p \leq .001$

As noted previously, Table 11 below shows the steps of regression for mediations performed with the dependent variable commitment, including unstandardized betas, their respective standard errors, and Sobel test statistics. Using the unstandardized regression coefficients for paths *a* and *b* in the model, and their respective standard errors, the Sobel test confirmed the mediated effect of satisfaction on the relationship between decision making and commitment (Sobel test statistic = 3.361, $p < .001$), and on the relationship between leadership and commitment (Sobel test statistic = 3.033, $p < .01$).

Table 11

Mediation effects and confirmatory Sobel test statistics for commitment

Path/effect	Regression result		Sobel (*p*)
	β	*SE*	
Hypothesis 5			
c (decision making → commitment)	.519***	.121	
a (decision making → satisfaction)	.634***	.129	
b (satisfaction → commitment)	.410***	.089	
c'	.259*	.123	
a x *b*	.260	.011	3.361***
Hypothesis 6			
c (leadership → commitment)	.298***	.048	
a (leadership → satisfaction)	.340***	.052	
b (satisfaction → commitment)	.315*	.092	
c'	.191***	.055	
a x *b*	.107	.005	3.033**

Note. *N* = 93.

*** Correlation is significant at the 0.001 level (2-tailed).

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

* Correlation is significant at the 0.05 level (2-tailed).

Path Analyses: Contextual Model of Participation

The feasibility of the hypothesized model of participation was tested using a maximum likelihood estimation procedure. In order to conduct path analysis, a recursive path model of participation factors was fitted to a covariance matrix constructed from correlations and standard deviations (Table 12).

Table 12

Covariance Matrix for Path Model of Participation

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Participation	0.820								
2. Leadership	0.339	1.680							
3. Sense of Community	0.069	0.106	0.247						
4. Satisfaction	0.182	0.572	0.124	0.605					
5. Resources	0.174	0.285	0.104	0.279	0.339				
6. Empowerment	-0.029	0.043	-0.017	-0.003	-0.067	0.629			
7. Communication	0.051	0.070	0.070	0.073	0.073	-0.012	0.049		
8. Decision Making	0.127	0.181	0.103	0.199	0.125	-0.006	0.062	0.314	
9. Benefits	0.047	0.313	0.154	0.252	0.150	0.069	0.032	0.215	0.813

Model Estimation. The results of the path analysis of the model proposed in Figure 7 (p.33), taken together, indicated poor model fit and suggested that the model should be modified: χ^2_M (18, 93) = 117.73, p = 0.00, *CFI* = 0.69, *RMSEA* = .25, 90% *CI* (0.20;0.29), *SRMR* = .20. First, adding or estimating the covariances between the mediator variables was performed to see if this improved model fit. The resulting model produced χ^2_M (12, 93) = 56.57, p = 0.00, *CFI* = 0.86, *RMSEA* = .19, 90% *CI* (0.13;0.14), *SRMR* = .17. The χ^2 difference test, (or likelihood ratio for maximum likelihood) is 117.73 – 56.57 = 61.16, df = 18 – 12 = 6, $p < 0.001$. The model fit was significantly improved with the addition of the covariances. The data support the notion that the variables are correlated. However, the fit was still relatively poor. As a result there was an attempt to identify appropriate modifications that would both significantly improve the model's fit and be justifiable on theoretical grounds.

Modifications. Modifications were oriented primarily toward improving the specification of the model and to make it more parsimonious. Based on modification indices, four paths were added to the model. The resulting model produced χ^2_M (8, 93) = 13.91, p = 0.08, *CFI* = 0.98, *RMSEA* = .085, 90% *CI* (0.00;0.17), *SRMR* = .06. The χ^2 difference test, based on the prior model, is 56.57 – 13.91 = 42.66, df = 12 – 8 = 4, $p < 0.001$. The model fit was significantly improved with the addition of the four paths. However, additional modifications are warranted to reach acceptable thresholds of fit for RMSEA. All non-significant paths were examined and six non-significant paths were trimmed from the model. The resulting model produced χ^2_M (14, 93) = 19.17, p = 0.16, *CFI* = 0.98, *RMSEA* = .058, 90% *CI* (0.00;0.13), *SRMR* = .08. The χ^2 difference test, based on these changes from the prior model, is 13.91 – 19.17 = –5.26, df = 8 – 14 = –6, and was not significantly larger. The resulting model had a better fit to the data and was more parsimonious. Therefore, the premise is that the observed covariances among the

measured variables arose because of the relationship between variables specified in the model; because the chi-square was not significant, we conclude that we should retain the modified model bof participation.

Direct Effects. Based on the revised path model, certain proposed direct effects were supported. As proposed, there was a main effect between sense of community and participation (standardized coefficient = .19). An increased sense of community was predictive of increased participation. Also as proposed, there were main effects between leadership and participation (standardized coefficient = .01), and between communication and participation (standardized coefficient = .03). However, because of their relatively small magnitude, these paths were eliminated in the final path model. The proposed main effect between decision making and participation was not supported by the final, revised path model. Finally, as proposed, there was a direct relationship (or direct effect) between all independent variables and their respective mediating variables (see Table 13 and Figure 12).

Indirect Effect. Of the four indirect effects proposed, one was supported. As hypothesized (Hyp 1) and supported by HMR results, the relationship between leadership and participation was mediated by social resources (coefficient for indirect effect = .04). Although relatively small, this supports the hypothesis that as a result of effective leadership, social resources increase and thus participation increases.

New Direct and Indirect Effects. The revised, best fitting path model produced additional direct and indirect effects that were not originally proposed. Of the direct effects, the most pronounced revision was the reversal of the proposed path from participation benefits to participation. The revised model shows that participation has a direct effect on participation benefits (standardized coefficient = .16). In addition, there is a direct effect between sense of

community and participation benefits (standardized coefficient = .47). Effective communication was predictive of increased social resources (standardized coefficient = .23). Finally, shared decision making was predictive of increased empowerment (standardized coefficient = .25)

Of the indirect effects, the relationship between sense of community and participation benefits was mediated by participation (coefficient for indirect effect = .03). The relationship between communication and participation was mediated by social resources (coefficient for indirect effect = .05). The final, revised path model with standardized coefficients is presented in Figure 12.

Table 13

Standardized Parameter Estimates for Revised Path Model of Participation

	Predictor Variables									
	Leadership		Sense of Community		Communication		Decision Making		Social Resources	
Outcome Variables	Direct Effect	Indirect Effect	Direct Effect	Indirect Effect	Direct Effect	Indirect Effect	Direct Effect	Indirect Effect	Direct Effect	Indirect Effect
Participation (DV)	**0.01***	**0.04**	**0.19**	–	**0.03***	0.05†	–	–	**0.24**	–
Social Resources (MV)	**0.04**	–	–	–	0.23†	–	–	–	–	–
Empowerment (MV)	–	–	**0.60**	–	–	–	0.25†	–	–	–
Member Satisfaction (MV)	–	–	–	–	**0.43**	–	–	–	–	–
Participation Benefits (MV)	–	–	0.47†	0.03†	–	–	**0.15**	–	–	0.04†

Standardized coefficients for hypothesized direct/indirect effects in bold

*Path not included in final, revised path model

†Standardized coefficient for direct/indirect effects produced as a result of revised model

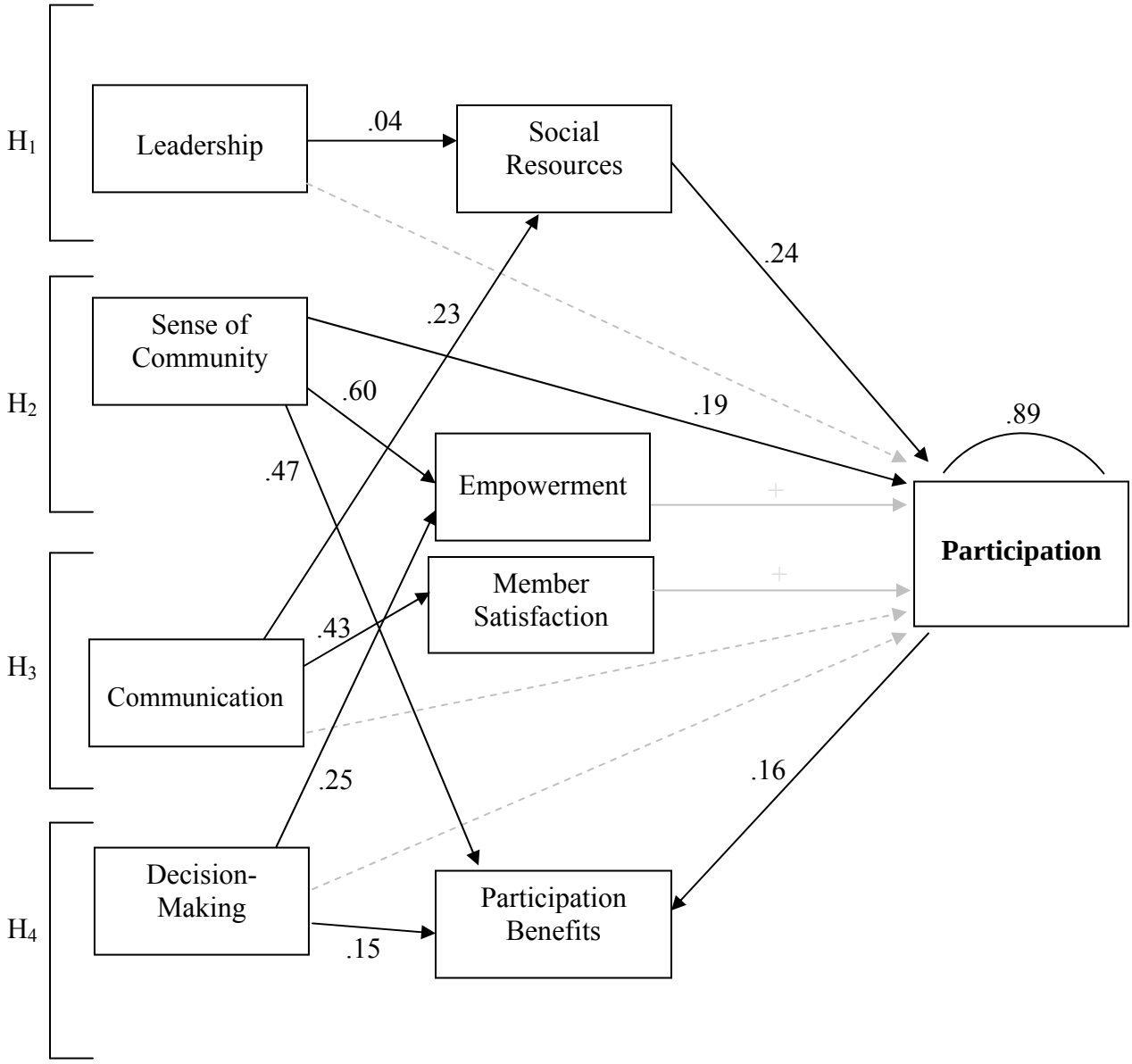

Figure 12. Revised Model, Contextual Predictors of Participation (Note: Faded arrows represent original hypothesized paths)

Path Analyses: Contextual Model of Commitment

The feasibility of the hypothesized model of commitment was also tested using a maximum likelihood estimation procedure. In order to conduct path analysis, a recursive path model of commitment factors was fitted to a covariance matrix constructed from correlations and standard deviations (Table 14).

Table 14

Covariance Matrix for Path Model of Commitment

	1.	2.	3.	4.
1. Commitment	0.505			
2. Leadership	0.501	1.680		
3. Satisfaction	0.300	0.572	0.605	
4. Decision Making	0.163	0.181	0.199	0.314

Model Estimation. Results of this analysis showed that the proposed model was saturated and provided a perfect fit for the data: χ^2_M (0, N = 92) = 0.00, p = 1.00, *RMSEA* = 0.000. These results indicate that the model has been correctly specified as hypothesized because the fit indices are ideal. However, there was a nonsignificant path from leadership to member satisfaction in the proposed model.

Modification. No post hoc model modifications were suggested. However, in an attempt to develop a more parsimonious model, the non-significant path from leadership to member satisfaction was deleted (i.e., trimmed) and as a result provided a better fit to the data: χ^2_M (1, 93) = 0.018, p = .89, *CFI* = 1.00, *RMSEA* = 0.00, 90% *CI* (0.0; 0.13), *SRMR* = .004. The resulting model had a better fit to the data and was more parsimonious. Therefore, the hypothesis is that

the observed covariances among the measured variables arose because of the relationship between variables specified in the model; because the chi-square is not significant, the modified path model of commitment was retained.

Direct Effects. Based on the revised path model, most proposed direct and indirect effects were supported (see Table 15 and Figure 13). As proposed, there was a main effect between decision making and commitment. Commitment increased as decision making increased (standardized coefficient = .25). In addition, there was a main effect between leadership and commitment. Commitment increased directly as a result of effective leadership (standardized coefficient = .21). Shared decision making was strongly predictive of greater member satisfaction (standardized coefficient = .57). This increased member satisfaction also increased member commitment (standardized coefficient = .35). In the final, revised path model, in contrast to HMR findings, there was not a significant direct relationship between leadership and member satisfaction.

Indirect Effects. There was one indirect effect in the final estimated model. The relationship between decision making and commitment was mediated by member satisfaction (standardized coefficient for indirect effect = .20). As with HMR findings, Hypothesis 5 was supported. As shared decision making increases, member satisfaction increases, and thus commitment is increased. This model substantially improves the amount of explained variance in commitment, compared to the original model. In the trimmed model 38% of the variance in commitment is due to the indirect effect of decision making on commitment through member satisfaction (R^2 = 0.38). In addition, 32% of the variance in member satisfaction is due to decision making (R^2 = 0.32). See Figure 13 for the final model with standardized coefficients.

Table 15

Standardized Parameter Estimates for Revised Path Model of Commitment

	Predictor Variables					
	Decision Making		Leadership		Member Satisfaction	
Outcome Variables	Direct Effects	Indirect Effects	Direct Effects	Indirect Effects	Direct Effects	Indirect Effects
Commitment (DV)	0.25	0.20	0.21	–	0.35	–
Member Satisfaction (MV)	0.57	–	–	–	–	–

Proposed standardized coefficients for hypothesized direct/indirect effects

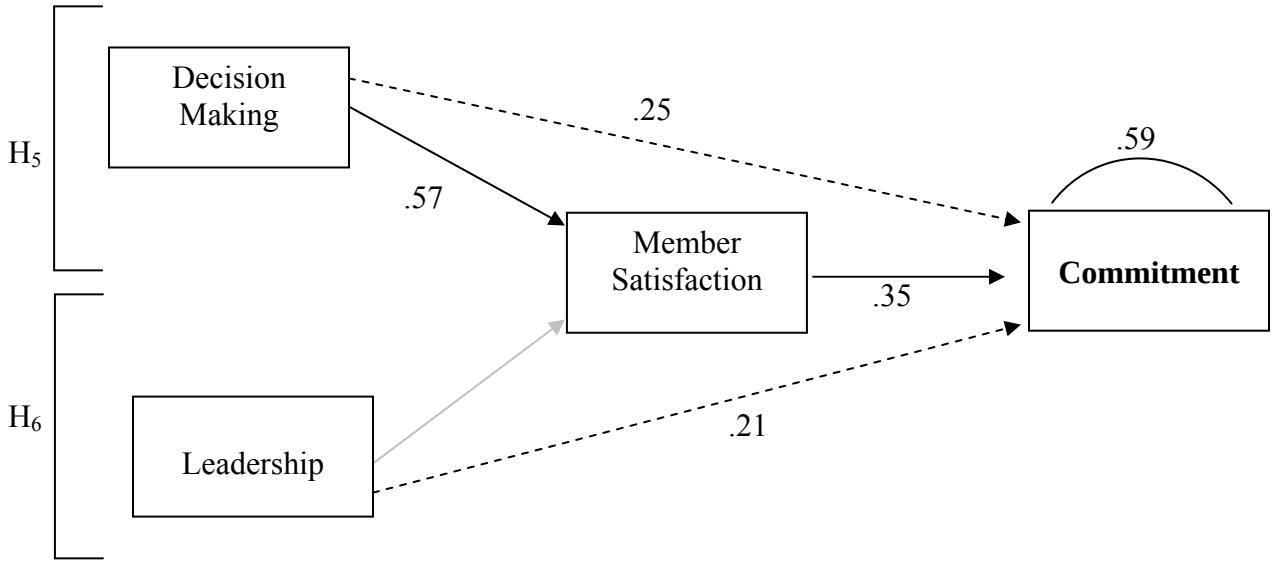

Figure 13. Revised Model, Contextual Predictors of Commitment (Note: Faded arrow represents original hypothesized path)

Member Engagement

Conceptual Model. Adding the significant mediations from ordinary least squares (OLS) regression to the final path model for participation and the final path model of commitment as the best fit to the data, a potential conceptual model of engagement emerges, See Figure 14.

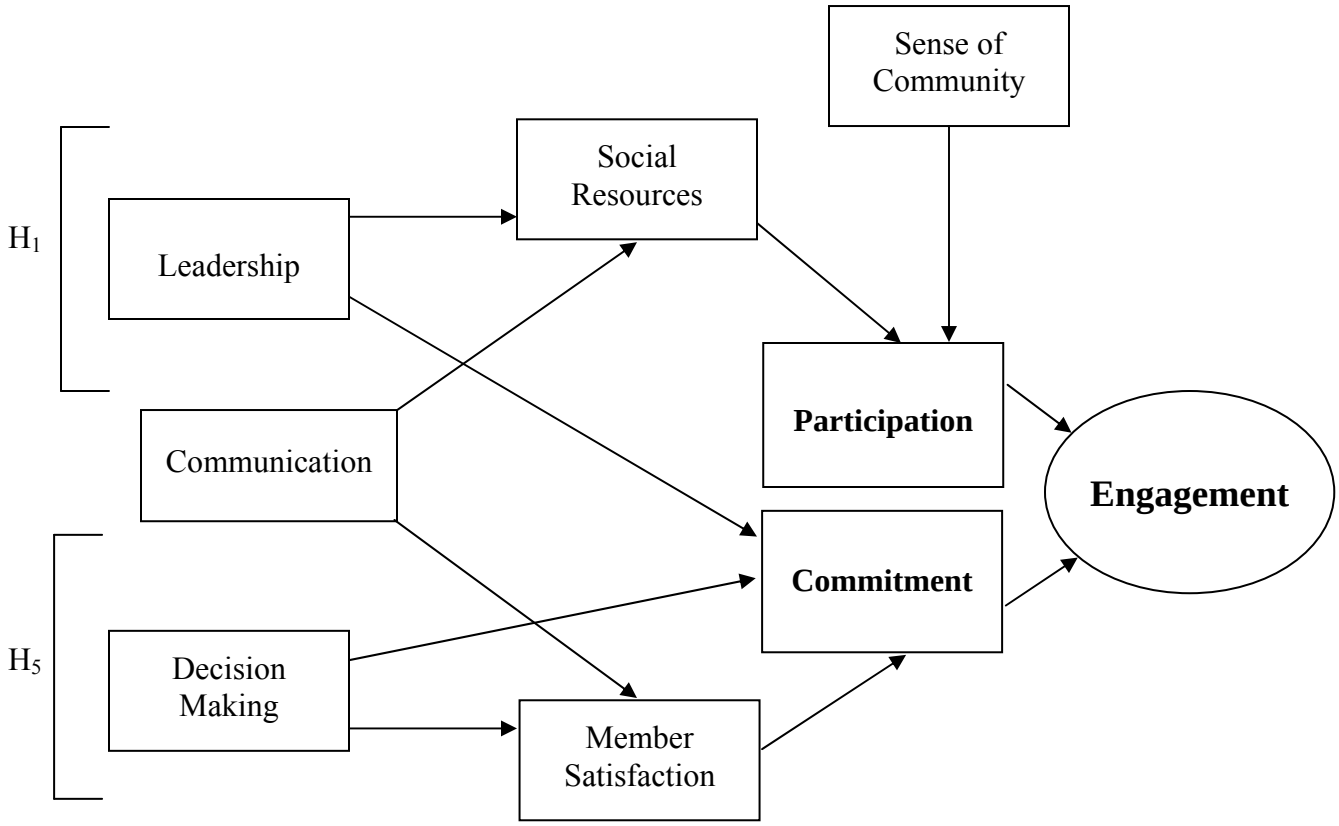

Figure 14. Potential Conceptual Model of Engagement, based on significant OLS and maximum likelihood estimation (MLE) analyses

Qualitative Statistical Analyses

Descriptive Statistics

Qualitative Data. In a sequential, explanatory design, the secondary, qualitative phase builds on significant results from the quantitative phase. To gain a better understanding of significant mediating relationships observed in the quantitative analysis, six key informant interviews were conducted. Prior to conducting qualitative analyses, descriptives of the key informants were performed. Table 16 presents select demographic information on the six key informants that completed interviews. They represent a sub-sample of the 17% of respondents who reported attending between 7-11 meetings in a year. Therefore, they represent nearly 40% of the sample of high participators. Of the more than 64% of the sample who felt strongly committed to the coalition, this sub-sample represents about 10%. Therefore, these informants were a representative sample of "high participating" and "highly committed" CHC attendees who had been involved in the coalition a minimum of seven months. The length of participation of these informants ranged from 1 – 12 years, with an average length of 6 years ($M = 6.1$).

Table 16

Key Informant Demographics

Race/Ethnicity	Gender	Age	Country of Origin	Sector Represented	Length of Participation
1. Asian	Female	31 – 40	Nepal	State government	7 years
2. Caucasian	Female	61 – 70	USA	Resident/community	5 years
3. Black African	Male	41 – 50	Somalia	Resident/media	12 years
4. Caucasian	Female	21 – 30	USA	Health	1.5 years
5. Caucasian	Female	31 – 40	USA	Resident/Non-profit	1 year
6. Black American	Female	41 – 50	USA	Resident/city	10 years

Interviews with Key Informants

To explore how participation in and commitment to the Clarkston Health Collaborative has been experienced first-hand by key informants, interview data were obtained from six Clarkston Health Collaborative members. As discussed previously, this is a purposeful sampling where particular member attributes are critical for expanding upon significant quantitative findings in this study. In order for inclusion as a key informant, it was the expressed goal of the researcher to acquire a sub-sample of the population that had knowledge of and experience with the coalition, and had spent sufficient, quantifiable time being participative in and committed to (that is, fully engaged) in coalition function and performance. As noted in the Methods section of this document, interviews with these key informants were expected to provide data that shed additional light upon significant quantitative findings from the first phase of this study. Confidence that informant input might reflect and expound upon findings is increased by interviewing coalition members who were deemed high participating as well as highly committed to the work of the association. Therefore, the six key informants are well suited for this examination.

Interview Findings

Four dominant thematic categories represented members' experiences related to participation and commitment in the Clarkston Health Collaborative. These included: *1) Leadership and Participation Thematic Category; 2) Decision Making and Commitment Thematic Category; 3) Leadership and Commitment Thematic Category; and 4) Member Engagement and Sustainability Thematic Category.* In addition, member perceptions of communications role as it affects both social resources and member satisfaction, and how sense of community affects participation are examined, based on the final, conceptual model of

engagement. The content of each thematic category is presented below. All of these findings lay the foundation for presentation of the final, conceptual model of member engagement, which is the overarching goal of this research.

Common Themes, Sub-Themes. There were ten study variables whose primary themes were established based on common definitions (or common themes) found in the coalition literature (see Appendix F). Although not study variables, perceptions of sustainability and member engagement were concepts included in this assessment. There were six mediated path models predicting either participation or commitment proposed in the quantitative analyses, as well as contextual predictors of each. It is the purpose of this portion of the study to examine whether significant dyadic relationships (i.e., significant relationships between study variables) which make up these models are confirmed through first-hand experience of members. Table 17 shows the number of references made by key informant members regarding the importance of proposed relationships as they view them in context.

The main effects from each significant hypothesized mediation (e.g., leadership and participation) were considered overall thematic areas. Sub-themes are identified as the intermediary relationships (i.e., predictor to mediator and mediator to outcome variable). As informants spoke to variable relationships that were important in supporting mediated and direct relationships found in the final, conceptual model of engagement (from the quantitative portion of the study), these common sub-themes were weighted and tracked. Based on weighting, the sub-theme was deemed strong if it was mentioned in four or more interviews, moderate if mentioned three times, and low if the theme was mentioned in two or fewer interviews. Low and moderate themes were not considered for this study, as this secondary examination of informant interviews as part of the sequential explanatory study, was designed only to interpret and make

inferences about significant findings. All of the significant mediating relationships observed in the quantitative analyses were confirmed as strong themes in the sub-themes of the key informant interviews.

Also, although not all proposed mediations models were not supported, significant main effects found within those models that were corroborated by qualitative assessment, are included in these findings. For example, member input on leadership's effect on commitment, and sense of community's effect on participation are analyzed here.

Table 17

Key Informant References of Significant Proposed Relationships

Thematic Categories	Common Sub-Themes	refs/sources
Hypothesis 1		
Leadership – Social Resources	Makes explicit statements about how leaders who help facilitate the convening, discussion, information-gathering, and action steps of the coalition *facilitate/bring about* community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work.	**4/4**
Social Resources – Participation	Discusses the community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work, *as reasons why* they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles, and length of participation/membership in coalition.	**5/5**
Hypothesis 5		
Decision Making – Member Satisfaction	Discusses how the coalition arrives at decisions or actions (e.g., collaborative, in group, by consensus, etc.) *leads to* a general feeling of approval of/contentment with the way the coalition is/has been meeting personal or community needs.	**8/5**
Member Satisfaction – Commitment	Expresses general feelings of approval that the coalition is/has been adequately meeting personal/community needs which *leads to* a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Hypothesis 6		
Leadership – Member Satisfaction	Makes statements about how leaders who help facilitate the convening, discussion, information-gathering, and action steps of the coalition *facilitate/bring about* a general approval or contentment with the way the coalition is/has been meeting personal and community needs.	**8/6**
Member Satisfaction – Commitment	Expresses how general approval/contentment with the way the coalition is/has been meeting personal/community needs *has facilitated* a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Additional Main Effects		
Leadership – Commitment	Makes statements about how leaders who help facilitate the convening, discussion, and action steps of the coalition *facilitate/bring about* a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Sense of Community – Participation	Discusses an individual/collective sense of connection and belonging to the community or a feeling of unity and cohesion in the coalition *as reasons why* they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles.	**9/6**

Thematic Category One: Leadership and Participation Thematic Category

There were nine references regarding the relationship of effective leadership to member participation, which accounted for 75% of all targeted references in the key informant interviews in this category. These data reflected two sub-themes: *Leadership and Social Resources; and Social Resources and Participation*. See Table 18 for an overview of these.

Table 18

Leadership and Participation Thematic Category Sub-themes (N=9)

Sub-Theme	# of References	% of Thematic Category
Leadership – Social Resources	(n = 4)	44.4%†
Social Resources – Participation	(n = 5)	55.6%

† Based on total number of references of category sub-themes.

A description of the content of these sub-themes follows.

Leadership and Social Resources. The majority of references about leadership and social resources (n = 4) were statements about how the effectiveness of coalition leaders facilitate or bring about community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work. All four were referenced individually by four different key informants.

These particular references noted instances when the coalition leadership was able to facilitate resources external to the coalition (e.g., finding new funding or arranging for special community presentations on fire safety by the DeKalb Fire Department) as well as the leader's ability to recognize resources internal to the coalition or within the membership (e.g. small business owners, or particular individual expertise). Findings reveal that members perceive that

the leaders' ability to mobilize resources, internal and external to the coalition, as important to coalition members, as evidenced by key informants who stated:

> *I think somebody who has a lot of connections, you know, is able to drive new funding opportunities much more easily than somebody who isn't. So I think the fact that if you have a good leader and facilitator who is good at building those relationships they're going to benefit the group as far as funding opportunities go. – CJ, white female, 1.5 years*

> *…everyone brings something to the group and everyone has certain resources that they tap into. So you know really understanding what is your resources currently and I think that is really, really important to figure out. So it depends. I mean you think there's a refugee mother there, [but] what does she have. She may have tremendous resources that we're going to need. Maybe she has [connections] with ten other pregnant women. You [the leader] have to identify what type of resources you're looking for and really look within your coalition to say okay, let's tap into our own resources first. – JB, Asian female, 7 years*

<u>*Social Resources and Participation*</u>. The majority of references about social resources increasing member participation (n = 5) were statements about how community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work, are reasons why they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles, and their length of participation (i.e., membership) in coalition. All five were referenced individually by five different key informants.

These references noted particular types of resources (e.g., job fair, funding, the Collaborative itself as resource) members felt were salient in their continued participation in the coalition. Findings support that the more community resources the leadership can help the group identify, mobilize, and bring to the table, the greater the member participation, a sentiment expressed by particular key informants:

> *…by bringing a job fair into the community… that would give [the] collaborative a big name and where people would be more [likely] to participate in the collaborative. – HM, African male, 12 years*

> *I think people go where the money is. If they don't think there's any opportunity for getting things done because they see a barrier as far as money goes they're not going to be active participants. Because again they're not going to see it as something that's going to be a functional group. – CJ, Caucasian female, 1.5 years*

Thematic Category Two: Decision Making and Commitment Thematic Category

There were 14 references regarding the relationship of shared decision making to member commitment, which accounted for all of the targeted references in the key informant interviews in this category. These data reflected two sub-themes: *Decision Making and Satisfaction; and Satisfaction and Commitment*. See Table 19 for an overview of these.

Table 19

Decision Making and Commitment Thematic Category Sub-themes (N=14)

Sub-Theme	# of References	% of Thematic Category
Decision Making – Satisfaction	(n = 8)	57.1%
Satisfaction – Commitment	(n = 6)	42.9%

A description of the content of these sub-themes follows.

Decision Making and Satisfaction. The majority of references about shared decision making and member satisfaction (n = 8) were statements about how the coalition arrives at decisions or actions (e.g., collaborative, in group, by consensus, etc.) leads to a general feeling of approval of/contentment with the way the coalition is/has been meeting personal or community needs. All eight were referenced by five different key informants.

These particular references note how shared decision making gives 'voice' to members and a feeling of being heard versus a directive or 'top-down process' of decision making. This relationship is further supported by key informants who stated:

I think that they [members] might not show up if, again you don't show up or put in their opinions if they think that it's just going to be a top-down process rather than a collaborative one. – CJ, Caucasian female, 1.5 years

I would really feel comfortable saying that I think it [shared decision making] does have some say, because people then feel empowered that they do have a say in what direction we go and that their time is being well used and we are talking about their passion. Yeah, I think satisfaction with that is really a big piece. – JB, Asian female, 7 years

If you know that your voice is being heard then you are satisfied with what happens. – RN, African-American female, 10 years

Mm-hmm. If you don't feel that you have a stake in what's going on – you know it's kind of like how people get apathetic towards the political process in our country. If I don't think that my vote matters what's my incentive to go and vote the next time? – LK, Caucasian female, 1 year

<u>*Satisfaction and Commitment.*</u> The majority of references about satisfaction and commitment (n = 6) express general feelings of approval that the coalition is/has been adequately meeting personal/community needs which leads to a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership. All six were referenced by all six different key informants.

These particular references noted instances when members describe how satisfaction of members directly affects their commitment as well as their intent to commit to the coalition. Key informants confirm this sentiment by stating:

You know people all do better at just simple social psychology. In fact if people feel like they have a choice in it they have personal agency, their satisfaction is higher and it will keep them engaged in any given activity. Just as you and I have been talking about. The satisfaction that I feel with it [the coalition] will depend on how committed I am to going the next time and the time after that. – LK, Caucasian female, 1 year

You have to really love it and I loved it. And that was my passion and that's very important for me and I think a lot of people, for them to be part of the Collaborative and to really trust the Collaborative, they have to have that [satisfaction] so that's really important. Yes, absolutely that affected how committed I was to it. – JB, Asian female, 7 years

Thematic Category Three: Leadership and Commitment Thematic Category

There were 14 references regarding the relationship of effective leadership to member commitment, which accounted for all of the targeted references in the key informant interviews in this category. These data reflected two sub-themes: *Leadership and Satisfaction; and Satisfaction and Commitment*. See Table 20 for an overview of these.

Table 20

Leadership and Commitment Thematic Category Sub-themes (N=14)

Sub-Theme	# of References	% of Thematic Category
Leadership – Satisfaction	(n = 8)	57.1%
Satisfaction – Commitment	(n = 6)	42.9%

A description of the content of these sub-themes follows.

Leadership and Satisfaction. The majority of references about effective leadership and member satisfaction (n = 8) are statements about how leaders who help facilitate the convening, discussion, information-gathering, and action steps of the coalition facilitate/bring about a general approval or contentment with the way the coalition is/has been meeting personal and community needs. All eight were referenced by six different key informants.

These references are mostly specific to the current coalition facilitator and perceptions of his effectiveness being a source of satisfaction as well as it fostering commitment. According to key informants, their perception of how leadership affects the satisfaction of members is important, as evidenced by statements such as:

> *Oh enormously. I mean you know CH [coalition facilitator] being the leader that he is, I always consider him the leader for the Health Collaborative. But you know he is so patient and dynamic and just like really able to keep the group rolling, keep them on*

target, and keep them on task. I think that's a key effect. – CJ, Caucasian female, 1.5 years

Oh he's a wonderful facilitator. I think it has a lot to do with it. He's been a wonderful facilitator. I have only known him as facilitator. – JG, Caucasian female, 5 years

I'd have been a lot less likely as a useful tool [member] if the satisfaction level was low among participants. I would have said well this is kind of pointless you know if people hadn't seemed to believe in it [leadership] and want to show up at meetings. I would have said what's the point of me going and staying with it [committing]? – RN, African-American female, 10 years

Satisfaction and Commitment. As noted above, the majority of references about satisfaction and commitment (n = 6) express general feelings of approval that the coalition is/has been adequately meeting personal/community needs which leads to a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership. All six were referenced by all six different key informants.

These references are mostly specific to the current coalition facilitator and perceptions of his effectiveness, commitment, and objectivity being a source of satisfaction as well as it fostering commitment. Member perception of how effective, committed leadership positively influences their commitment is evidenced by statements such as:

Yes, if you see the leaders commit to the community, if they are doing the best they can to bring the community together, you stay with them. – HM, African male, 12 years

Oh, a lot. Especially the facilitator because when I was doing Clarkston my relationship with people, you know you start off with kind of just a work relationship. You know you say hello, my name is…I'm with... You know you sort of start off with that, but then after a while you kind of become more than that. So actually there was a whole relationship going there. And when you as a leader could become that as well, I think you have a tremendous commitment. I mean we had from four to five people to over a hundred people and we made humongous changes so you could see facilitators and leaders is a very huge part of people wanting to continue being part of Clarkston and the Clarkston Collaborative. . – JB, Asian female, 7 years

The one thing that I commend our current facilitator, he does not allow himself to become involved in the nitty-gritty of it or voice his own opinion per se. He's gathering information and trying to report it back in the way he has it. So he's not putting his spin,

> *even though we all know we have personal opinions to what happens around us, he keeps this 'This is what the citizens are saying', which makes me happy. So to have an effective leader is very important when you have organizations such as this because once you start changing [the] tone of the organization or becoming a self-serving organization, that's the first thing to kill it. I think it [leadership] affects it [commitment] very much for the same reasons. – RN, African-American female, 10 years*

Main Effect. It also bears noting that there was a relatively strong them from key informant interviews about the more direct relationship between leadership and commitment. There were six references by six informants of statements about Insert about how leaders who help facilitate the convening, discussion, and action steps of the coalition facilitate/bring about a feeling of care or concern for or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership. This was considered as a confirmation in the final, conceptual model of member engagement.

Thematic Category Four: Member Engagement and Sustainability Thematic Category

There were11 references regarding the relationship of shared decision making to member commitment, which accounted for all of targeted references in the key informant interviews in this category. These data reflected two sub-themes: *Leadership and Sustainability; and Communication and Member Engagement*. See Table 21 for an overview of these.

Table 21

Member Engagement and Sustainability Thematic Category Sub-themes (N=11)

Sub-Theme	# of References	% of Thematic Category
Sustainability through Leadership	(n = 6)	54.5%
Engagement through Communication	(n = 5)	45.5%

A description of the content of these sub-themes follows.

<u>*Sustainability through Leadership*</u>. The majority of references about leadership's effect on coalition sustainability (n = 6) discuss the continuing the functioning and/or work of the coalition irrespective of traditional support structures of grant funding, formal membership, dues, etc., as most impacted by leadership. All six were referenced by all six different key informants.

These references are mostly specific to the current coalition facilitator and perceptions of effectiveness, and consistency as fostering sustainability. When asked overall, why they thought the coalition is still around nearly 15 years after it got started, key informants reported that leadership was the primary reason, as evidenced by statements such as:

> *I think it has a lot to do with really good leadership. I mean some of the best leadership you know that I've ever seen in the coalition is there. And I think kind of that. I don't want to say it's all because of that but a lot of it is. Because you know somebody is really taking the time to really care a lot and be unendingly optimistic, upbeat. – CJ, Caucasian female, 1.5 years*

> *I think because, I don't know who headed it up before [the current facilitator]…but I think there has been a constant there, a constant thing there to keep it going. I think that has a lot to do with it. There's never been a discussion, maybe there were four people. I think one day there were only five of us there. But we sat and we talked about what needed to be done and we reported, and the next month there were 19 people there. But there's been a desire to keep it going. I mean I was away for awhile, but it still existed. When I came back it was still there. – JG, Caucasian female, 5 years*

Member Engagement through Communication. The majority of references about communication's effect on member engagement (n = 5) discuss how it encourages people to participate and commit to the work of the coalition. All five were referenced by all five different key informants.

These references are mostly specific to the clear, honest communication of all things relevant to the community, whether good or bad as a key factor toward engaging members. When asked of all the elements of coalition functioning (e.g., benefits of participation, member satisfaction, leadership, decision making, communication, sense of community, etc.) discussed

during the interviews, which they thought had the most impact on member engagement, key informants reported that it was communication as evidenced by statements such as:

> *…if you have issues in the community, or you want to hear about your community, what's going on in your community, there is somebody[to] come and talk about immigration issue, there is somebody [to] come and talk about fire safety, there is somebody [to] come and talk about general things in the community. This is where people can come and talk about different [things], not only the bad thing, [but the]good thing too. – HM, African male, 12 years*

> *The ability to communicate your feelings in a safe and inviting environment. – RN, African-American female, 10 years*

> *I think perhaps the communication…Because if communication is not done in an orderly fashion, and if it's not clear, you know like I said, most of our plates are so full so to take on one more thing that just seems remotely chaotic is not even in the cards. – LK, Caucasian female, 1 year*

Additional Themes from Contextual Model of Participation

As part of the current study, path analysis was introduced to get a better understanding of how coalition data fit a proposed path model of participation and a model of commitment. All mediation analyses, which had been analyzed separately, were combined into a comprehensive model for each dependent variable. As noted above, the qualitative findings support a portion of the final, revised model of participation, that being leadership's effect on participation through social resources. Other relationships that were retained in the final, revised path model of participation were confirmed through this qualitative analysis. There were 18 references confirming specific contextual predictors of participation found in the final, revised model. This accounted for all of the targeted references in the key informant interviews in this category (i.e., contextual predictors of participation). These data reflected four sub-themes: *Sense of Community and Participation; Communication and Social Resources; and Communication and Satisfaction*. See Table 22 for an overview of these.

Table 22

Contextual Predictors of Participation Thematic Category Sub-themes (N=18)

Sub-Themes	# of References	% of Thematic Category
SOC – Participation	(n = 9)	50.0%
Communication – Social resources	(n = 4)	22.2%
Communication – Satisfaction	(n = 5)	27.8%

A description of the content of these sub-themes follows.

Sense of Community – Participation. The majority of references about SOC's effect on member participation (n = 9) discuss an individual/collective sense of connection and belonging to the community or a feeling of unity and cohesion in the coalition as reasons why they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles. All nine were referenced by six key informants.

These references are mostly specific to how a personal sense of community effects member participation. Regarding their personal sense of community and how that affects their participation in the coalition, several key informants expressed their perception of its importance:

> *For example like I have [an] issue in the community that need to be solved, I bring it to the community [the coalition] and see how the community solves that kind of problem…if I see the issue in my community and bring it to the health collaborative and see that issue and the issue gets solved and that's how I participate. – HM, African male, 12 years*

> *I think, like I said I don't actually live there, but I always felt like that [the coalition] was one of the most important examples of community in DeKalb County. So I think that I knew they all lived together in this small area and were really working together as a community group, it was one of the most satisfying things about being part of the Health Collaborative. – CJ, Caucasian female, 1.5 years*

> *It [sense of community] greatly impacts. It [the coalition] gives me an outlet to where I can speak up and say some things in public that I might not stand up and say at city hall, because it becomes very confrontational in that manner. – JG, Caucasian female, 5 years*

> *My personal sense of community? How does it affect my participation? Well I think that's the main reason I go. If I wasn't a resident, if I wasn't engaged with the communities here I probably wouldn't go, because then it would just be like one more thing on my calendar that would be optional. – LK, Caucasian female, 1 year*

<u>*Communication – Social resources*</u>. The majority of references about communication's effect on social resources (n = 4) discussed how clear communication, predominantly through face-to-face meeting discussions and verbal reports helped to recognize and seek out internal and external resources to the coalition. All four were referenced by four key informants.

These references are mostly specific to how a clear communication within the coalition sets the stage for knowing which resources are needed and/or attainable. This is a sentiment by a key informant who stated:

> *[regarding participation] For me it's the international communication. It's not just black, it's not just white, it's people from all countries that we're seeing and we hear the different problems, the different things that have been coming up. Then you figure what to do. – JG, Caucasian female, 5 years*

<u>*Communication – Member Satisfaction*</u>. The majority of references about communication's effect on member satisfaction (n = 5) discussed how clear communication, predominantly through face-to-face meeting discussions and verbal reports increases members' satisfaction with the coalition. All five were referenced by five key informants.

These references are mostly specific to how a clear communication within the coalition allows greater respect and generally makes members more satisfied, as evidenced by key informants who stated:

> *It makes me want to get involved, yeah it does. Because when you hear other people, some who can't even speak English, use a translator and say these things and you go 'Yes' I agree with that. I'm party to that as well. And I never saw the day for that or that they paid attention to it, but we all have the same issues and we just don't know how to voice them or where to voice them, so the Collaborative is very satisfying with everybody being able to talk to one another and respectfully. We're very respectful. No one jumps down anybody's throat for their opinion. We hear their opinion, we acknowledge it and*

the facilitator does a great job of stimulation that conversation. – RN, African-American female, 10 years

Again good communication I think is what really, is what makes them a lot happier, a lot more likely to go, but poor communication makes everybody just kind of miserable and not really interested in the group anymore. – CJ, Caucasian female, 1.5 years

Non-Significant Relationships. There were three relationship found in the final, revised model of participation that were not confirmed in the qualitative assessment. There was either no confirmation by informants as relationships they recognize, or that relationship was only mentioned once, and thus was not considered a part of this analysis. Those relationships were: (1) Sense of Community – Empowerment, (2) Sense of Community – Benefits, and (3) Decision Making – Empowerment.

CHAPTER 4

DISCUSSION AND CONCLUSION

The purpose of this study was to examine factors that foster the active engagement of members in the Clarkston Health Collaborative, a community-based volunteer coalition, nearly 15 years after its establishment. The focus was on factors predicting member participation and member commitment. Understanding these relationships provides insight into overall member engagement and, thus, sets a platform toward developing strategies to ensure coalition sustainability, and for the planning and implementation of other coalitions.

The present study highlights the importance of a multi-method examination of those factors that foster member engagement, and thus, coalition sustainability. This study is distinctive in that it uses multiple research methods to help identify the factors that keep members fully engaged in the work of a community-based coalition. Previous research on community coalitions tended to focus on stages of coalition development and implementation, and relied on quantitative data. Overall, particular elements were consistently shown to have a considerable impact on members' participation and their commitment.

Quantitative analyses revealed strong evidence of the role that social resources play in member participation, the behavioral aspect of engagement. Specifically, effective leadership was found to increase member participation through the mobilization of coalition and community resources. Equally compelling were the significant findings regarding the facilitation of commitment, the psychological aspect of engagement. Findings also point to the significant role member satisfaction plays in commitment to the coalition. Evidence shows that shared decision making, as well as effective leadership, increases member commitment by way of member

satisfaction. These findings were confirmed by maximum likelihood analyses, as well as verbal accounts from key informant members of the coalition.

Methods used in this study allow determination of a relationship between study variables. The cross-sectional nature of the data generally precludes making inferences of causality. However, qualitative data obtained may suggest the direction of that relationship. Whenever appropriate, I support my quantitative findings with qualitative data, and therefore use the word "influence" as well as specific terms (e.g., positive or negative, increase or decrease) to show the direction of that influence. In addition, although qualitative interviews were done at one point in time, the informants recounted their experiences across a range of time. Therefore, this study was able to assess some longitudinal effects through these interviews. For example, participants were asked to think about their participation in the Clarkston Health Collaborative over a year-long period.

This section discusses and interprets the findings of both phases of the study. More specifically, it will discuss: 1) how key informant input explains the quantitative findings, 2) the implications of integrated findings, 3) their limitations, and 4) future directions for this research.

Toward a Model of Member Engagement

For the purposes of this study, member engagement was conceptualized as a construct with two components, a behavioral component and a psychological component. Participation is a behavioral indicator of engagement. Commitment is a psychological indicator of engagement. Member engagement can be partially measured by an individual's degree of participation (e.g., how many meetings one has attended) and partially measured based on an individual's degree of commitment to, care for, or concern about the coalition and its efforts.

Through analysis and integration of quantitative and qualitative data, the findings suggest a conceptual model of member engagement. Quantitative analysis, which included examination of mediating relationships for both participation and commitment, as well as an expanded examination through maximum likelihood estimation (MLE) of contextual relationships affecting participation and commitment, yielded a model that proposes member engagement. The integrated quantitative findings suggest that effective leadership, clear communication, and shared decision making are key direct and indirect predictors of commitment and participation. The findings also suggest the clear role that social resources and member satisfaction play in increasing participation and commitment. The sequential, explanatory nature of this study precludes drawing conclusions without additional understanding of these data. Therefore, qualitative data, as a secondary source of information, are integrated here to expand the interpretation of these findings. Together, the findings substantiate a potential conceptual model of member engagement for the Clarkston Health Collaborative and similar efforts.

To understand member engagement, participation and commitment were examined separately within the context of the coalition. Below, I discuss how each was significantly increased through direct and mediating factors, and how key informant input further expounds upon these findings. Thereafter, I note those hypothesized relationships that were not found to be significant and possible reasons.

Participation

In this study, data suggest that member participation is increased by effective leadership through the mobilization of coalition and community resources. In general, participation can be looked at as the number of meetings members attend, their degree of involvement in discussion, and/or the number of active roles they play in the coalition. Coalitions allow members the

opportunity to work within a collective to identify and acquire resources, then preserve and protect (i.e., conserve) those critical community resources, be they financial or personal. The resources are then used to promote the health and well-being of the community, as well as to respond to and solve emerging community issues. The realization of these resources increases member participation.

The Mediating Effect of Social Resources (Social Resources, Leadership, and Participation). The use of coalitions by communities to mobilize their resources (both tangible and intangible) is a core function of coalition efforts (Wolff, 2001a). In the current study the data suggest that social resources play a significant role in increasing member participation. As hypothesized, social resources that are mobilized by effective leadership increase member participation. Therefore social resources, in part, explain the coalition leader's effect on member participation in a non-topic, community-based health coalition. The mediated model explained 14% of the variance in participation. In addition, maximum likelihood estimation through path analysis confirmed a significant indirect effect of leadership on participation through social resources. This relationship was confirmed in the qualitative findings where key informants referred to the importance of this relationship. These resources are the reason effective leaders are able to increase member participation. Five out of five informants noted that these resources increases their participation.

Members' comments were in keeping with what was reported in the review of the literature. That is, the mobilization of resources is a prominent impetus to sustaining community-based organizations (Kegler, Steckler, McLeroy, & Malek, 1998). Having access to resources that can be used to create social change works not only to promote action, but

facilitates social cohesion and participation in a coalition and in a community (Metzger, Alexander, & Weiner, 2005).

Expanded Model of Participation. As part of the current study, path analysis was introduced to get a better understanding of how coalition data fit a proposed path model of participation and a model of commitment. All mediation analyses, which had been analyzed separately, were combined into a comprehensive model for each dependent variable.

As expected, there were several direct relationships from the proposed, combined model of participation that were retained in the final, revised model. These relationships largely confirmed what was found in the literature and regression analyses. For example, each independent variable in the model related significantly to its corresponding mediator variable. The hypothesized mediation analysis found to be significant through multiple regression, was retained in the final revised path model as well – the indirect effect of leadership on participation through social resources.

However, there were several unexpected findings in the final model. The revised path model of participation suggests a combined effect of leadership and communication, both through social resources, as predictors of increased member participation. This was supported by key informant input, which noted that clear communication played a significant role in helping to mobilize resources.

Although the mediating relationship involving sense of community was not significant, data suggest that sense of community increases member participation directly, and thus, this direct effect was retained in the revised model of participation. The literature suggests that an individual or collective sense of connection and belonging to the community or a feeling of unity and cohesion in the coalition, increases meeting attendance, being involved in the discussion, or

playing active roles. Sense of community is a catalyst for participation (Chavis & Wandersman, 1990). Regarding their personal sense of community and how that affects their participation in the coalition, several key informants expressed their perception of its importance.

The significant mediated relationship, combined with the positive effect of sense of community on participation, give a more refined view of the influences that increase member participation in the Clarkston Health Collaborative. The support of these findings by coalition members has implications for similar community efforts and these relationships were therefore retained in the conceptual model of engagement.

Contrary to expectations, in the revised model of participation, shared decision making did not relate directly or indirectly to member participation. As depicted in the revised model, members expressed their opinions that the coalition's policy of shared decision making relates directly to a feeling of empowerment, as well as benefits they feel they gain from the process. Although important in understanding the contextual effect of shared decision making in the coalition, these relationships were not direct predictors of participation, and thus, were not retained in the final conceptual model. However, they are important insofar as they support quantitative findings and give a clearer perspective on the affect of shared decision making on member empowerment. As noted below, data suggest that shared decision is important in positively effecting member commitment.

Also contrary to expectations, neither empowerment nor member satisfaction affected member participation in the revised model. The fact that member satisfaction did *not* increase participation in the revised path model, as a result of either a direct or indirect relationship, actually supports this study's previous finding that member satisfaction accounts for a large proportion of the variance in member commitment, the psychological aspect of engagement.

Finally, contrary to what was proposed, participation benefits appear to be an outcome of participation rather than an antecedent. This may appear intuitive, but this is an example of the bidirectional relationships mentioned in the review of the literature. It is important to note that this examination involves a cross-sectional view of member perceptions. It was the researcher's *a priori* theory, based on the correlational relationships reported in the literature and knowledge gained as a participant-observer of the population being researched, that led to the belief that benefits gained through participation would promote increased participation. However, it can be argued that in order to gain those benefits, members would have had to participate initially. Neither relationship was confirmed in the qualitative analyses. Since quantitative data suggest benefits are a *result* of participation and not a predictor and there was no confirmation either way based on member input, this relationship was not included in the final conceptual model of engagement.

Commitment

In this study, commitment was increased by shared decision making, as well as effective leadership, both by way of member satisfaction. In general, member commitment is a compelling factor in coalition sustainability (Kumpfer, Turner, Hopkins, & Librett, 1993; McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rogers et al., 1993) and a component of member engagement. Kumpfer et al. (1993) conceptualized commitment as the strength of member dedication to the coalition and caring about the future of the coalition. Rogers et al. (1993) considers commitment to be an endorsement of the coalition's mission and efforts, whereas McMillan et al. (1995) found commitment to represent a sense of pride in the group.

The Mediating Effect of Member Satisfaction (Member Satisfaction, Decision Making, and Commitment). As proposed, both mediation models of commitment, based on member

satisfaction, were supported through multiple regression. Therefore, findings point to the significant role member satisfaction plays in commitment to the coalition, in general. Member satisfaction represents a global satisfaction with the work of the coalition and, thus, fosters commitment (Kegler, Steckler, McLeroy, & Malek, 1998). The first question regarding member satisfaction this research sought to answer was whether collaborative or shared decision making leads to improved satisfaction of members and thus, facilitates continued commitment. As noted, this hypothesis was supported. In the current research, member satisfaction explains shared decision making's effect on member commitment in the Clarkston Health Collaborative, a non-topic based, community health coalition. The model, as a whole, explained 33% of the variance in commitment. In addition, MLE confirmed a significant indirect effect of decision making on commitment through member satisfaction. Based on quantitative findings, it is clear that the way decisions are made in the coalition (e.g., by consensus, shared understanding, or collaborative agreement) is important for overall satisfaction of members. This relationship is further supported by key informant input.

In turn, the satisfaction of coalition members affects their commitment. The more members feel they are involved in the decisions of the coalition, the greater their satisfaction and their commitment to the work of the group. This relationship was also confirmed by key informant input.

As noted in the literature review, and confirmed by member input and quantitative analysis, decision making is related to member satisfaction (Rogers et al., 1993) and member satisfaction is related to member commitment (Kegler, Steckler, McLeroy, & Malek, 1998; Rogers et al., 1993) to the work of the coalition. Therefore, this indirect relationship was retained in the final, conceptual model of engagement.

The Mediating Effect of Member Satisfaction (Member Satisfaction, Leadership, and Commitment). Does effective leadership lead to greater satisfaction for members and thus facilitate their continued commitment? As noted above, findings point to the significant role member satisfaction plays in increasing commitment to the coalition. Kegler et al. (1998) categorize member satisfaction as a representation of coalition members' overall satisfaction with the work of the coalition. The fact that member satisfaction is important in member commitment has been supported in this research, as well as in other research (Kegler, Steckler, McLeroy, & Malek, 1998). Similar to decision making's effect on satisfaction, this study also sought to determine whether effective leadership leads to greater satisfaction for members and thus facilitates continued commitment. The multiple regression analyses supported this theory as well. Member satisfaction partially explains effective leadership's effect on member commitment in a non-topic based community health coalition. As a whole, the model explained a substantial (38%) proportion of the variance in commitment. The standardized beta values for leadership and satisfaction were virtually identical indicating that both variables have a comparable degree of importance in this model of commitment. According to key informants, their perception of how leadership affects the satisfaction of members is important. Equally important is member perception of how effective, committed leadership positively influences their commitment.

Based on integrated findings, member satisfaction appears to be a critical precursor to member commitment by way of both effective leadership and shared decision making. In general, the study would support the indirect relationship between leadership and commitment, through member satisfaction; however, it is interesting to note that during analyses using maximum likelihood estimation, this indirect relationship was not maintained.

Expanded Model of Commitment. Individually, the two mediating models of commitment were significant based on multiple regression analyses, accounting for substantial proportions of the variance in commitment. However, within the combined path model of commitment, the direct relationship between leadership and member satisfaction was not retained in the most parsimonious path model of commitment. In the literature review, commitment was reported to be related to leadership (Rogers et al., 1993). Wolff (2001b) notes that effective leaders foster an inclusive organizational climate that attracts committed members. The relationship between effective leadership and member commitment was supported by the regression analyses, and was confirmed by key informant reports.

With conflicting findings from these two methods of analysis with the same data, convention is that maximum likelihood estimation takes precedence over OLS as the best unbiased estimator. Whereas the least squares is a minimum distance estimator (i.e., trying to make the data points as close to the regression line as possible), maximum likelihood picks the values of the model parameters that make the data more likely than any other values of the parameters would make them (Joreskog & Sorbom, 1993). Taken together, the evidence shows that shared decision making increases member commitment, by way of member satisfaction. However, effective leadership has a stronger, direct positive effect on member commitment that does not necessarily rely on member satisfaction. Therefore, the direct relationship from leadership to commitment was retained in the final, conceptual model of engagement along with the indirect effect of decision making on commitment, through satisfaction (as originally hypothesized).

Non-Significant Proposed Mediators of Participation

Of the six proposed mediation analyses for participation and commitment in this study, one was supported for participation and the two were supported for commitment. However, contrary to what was theorized, the three mediating relationships predicting participation did not bear out in the analyses.

Empowerment, Sense of Community, and Participation. Do coalition members who are empowered by a sense of community participate more in the coalition? This study hypothesized that sense of community influences participation through empowerment. This relationship was not upheld. As noted above, the study found that sense of community increased member participation. As hypothesized, sense of community was also shown to increase member empowerment. McMillan et al. (1995) have shown that sense of community is correlated with psychological empowerment. However, the data from this study did not support empowerment's positive influence on participation. Therefore, there was no indirect effect. Why? According to the literature, community coalitions cultivate empowering settings through their relationship structures and support systems (Maton & Salem, 1995). Sense of community is a major basis for self-definition (Sarason, 1974) which is related to one's self-efficacy, or one's belief about their capabilities to produce designated levels of performance or exercise influence over events that affect their lives. This is a form of individual-level empowerment. It is this sense of empowerment that prompts, facilitates, and/or sustains participation. In fact, participation is considered a sign of empowerment (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995; Rappaport, 1981). Both Israel et al. (1994) and Bosscher and Smit (1998) found that perceived control and general self-efficacy, respectively, were associated with participation.

However, there was not a significant correlation between empowerment and participation (r = -.04, n.s.) which may explain the lack of a mediated effect. Other reasons for possible lack of effect associated with the measurement of empowerment are explored under Limitations. Because empowerment did not directly relate to participation in either analysis (OLS or MLE), nor was confirmed by key informant report, this relationship was not considered in the final conceptual model of engagement.

Member Satisfaction, Communication, and Participation. Does effective communication within a coalition improve member satisfaction and, thus, participation in the coalition? This study hypothesized that communication influences participation through member satisfaction. This relationship was not upheld in this study. As hypothesized, the study found that communication increased member satisfaction. Kegler et al. (1998) and Rogers et al. (1993) found that member satisfaction is significantly correlated with communication, which was supported by the very strong inter-item correlation found in this study. This relationship was relatively strong in the path analysis as well, showing that effective communication increases member satisfaction. Therefore, this direct effect was retained in the final, conceptual model of engagement.

However, neither communication nor member satisfaction directly increased participation. Therefore, there was no indirect effect. Because member satisfaction represents a global satisfaction with the coalition's work, it has been studied in this research and other research as a predictor of either participation or commitment. Although member satisfaction was a clear intermediary toward increased member commitment (described earlier), it did not mediate the relationship toward increased member participation. According to the literature, there is a direct effect of member satisfaction on participation (Kegler, Steckler, McLeroy, & Malek, 1998;

Rogers et al., 1993; Trickett & Watts, 1994). The inter-item correlation in this study showed a significant positive correlation between communication and participation. However, within the combined path model of participation, the direct relationship between communication and participation was not retained in the most parsimonious model of participation. In fact, based on MLE, communication was shown to be only indirectly related to participation through social resources. Therefore, only these relationships (communication – satisfaction, communication – social resources) were retained in the final conceptual model of engagement.

Participation Benefits, Decision Making, and Participation. Does collaborative or shared decision making lead to personal benefits for members and thus facilitate continued participation? This study hypothesized that the way decision making influences participation is through participation benefits. This relationship was not upheld in this study. Data suggest that decision making increased participation benefits as predicted, and increased empowerment. However, it was not significantly related to participation. Therefore, there was no indirect effect. To the contrary, Metzger et al. (2005) showed that open and collaborative decision making has an indirect, positive effect on participation by way of participation benefits. This was a different coalition sample, which may be one reason this indirect effect was not found. The literature also states that effective coalitions involve members in shared decision making which fosters participation (Butterfoss, Goodman, & Wandersman, 1996) as does member involvement in group processes (McMillan, Florin, Stevenson, Kerman, & Mitchell, 1995).

In addition, research suggests that when participants perceive the benefits of participation as high, they are more likely both to choose to participate in the coalition and participate more fully (Butterfoss, Goodman, & Wandersman, 1996; Metzger, Alexander, & Weiner, 2005; Prestby, Wandersman, Florin, Rich, & Chavis, 1990; Rogers et al., 1993). However, there was

not a significant inter-item correlation between participation benefits and participation (r = .06, *n.s.*) As noted earlier, MLE showed a reverse relationship between participation benefits and participation. This may be explained by Butterfoss et al. (1996) who assessed skills, solidarity, and purposive benefits that can be realized *as a result of* participating in a coalition. Therefore, in the revised path model of participation, the sample data fit better when benefits are increased as a result of participation. Because this finding did not lead to increased member participation, it was *not* included in the final conceptual model.

Implications

The findings of this study have significant implications for the field of community psychology and coalition research, specifically in the areas of intervention, policy, and future research. It is apparent that there is a continued need for interventions that recognize the ecological or contextual influences that foster and support behavior in community-based efforts, particularly surrounding engagement in community coalitions. In light of this research, there is also a need for funders to examine policies that mandate coalition development without the necessary support for sustainability, and for coalition leaders to establish coalition policies that promote full engagement of coalition membership. Finally, there is clear indication that scientists must conduct future research to help identify and refine models of sustainability for all types of community-based coalitions.

Based on the results of this study, there are some apparent implications for coalition development and facilitation that affect *both* participation and commitment. Study findings show that these aspects include leadership and communication. As a result of this research, coalition leaders, members, funders, etc., have better information on these factors and their relationship to one another in context that is of particular importance in member engagement.

Leadership. It bears noting that effective leadership appears to be a common influence for member commitment and member participation. The study has shown that leadership indirectly increases participation through social resources and directly increases member commitment. When asked overall, why they thought the coalition is still around nearly 15 years after it got started, key informants reported that leadership was the primary reason. The effective leader works to help the coalition realize what resources (or assets) are available, as well as those that might be brought to about. Strong leadership is essential to sustaining community coalitions. Effective and empowering leaders foster an inclusive organizational climate that attracts committed members and enhances coalition success in acquiring funding and mobilizing resources (Hays, Hays, DeVille, & Mulhall, 2000; Kumpfer, 2005; Wolff, 2001b). Having a leader who takes responsibility for the successes of the coalition by setting the public agenda for change, brokering connections among people and resources, and leveraging additional or new resources for projects can go a long way in supporting the longevity of a coalition.

Although this study is focused on the individual characteristics of members that lead to more sustained coalition efforts, particularly salient to this study of the Clarkston Health Collaborative (with implications for other efforts) are the resources that are available to the coalition. The leadership of agencies, such as the DeKalb County Board of Health, in effecting sustainability is not to be understated. Regarding leadership for the Clarkston Health Collaborative, the DeKalb County Board of Health has been instrumental in providing human and financial resources as a factor of sustainability. Agencies, in general, that would like to initiate or facilitate community coalitions need to consider capacity-building toward sustaining these efforts, and note that they must be will to commit critical resources. External resources are very important and are necessary, regardless of participation and commitment. If there are no

external resources (e.g., safe setting, supply of human resources, at least minimal financial for supplies and materials) then does having engaged members matter? These recommendations have implications for all agencies, regardless of the level, including national and international agencies who espouse the effectiveness of coalitions.

The combined data suggest leadership's importance as a precursor to both participation and commitment in coalition sustainability. This would imply that those developing, facilitating, or implementing a community-based health coalition similar to the Clarkston Health Collaborative might consider special skills training for its leadership, including facilitation and communication skills, training to empower the membership to recognize and mobilize internal and external resources, training on how to build leadership capacity, and training on how to facilitate shared decision making. Based on this research, these are all critical aspects of effective leadership that are key in sustaining the effort. Leaders should also focus on developing skills that are based on the principles of collaborative leadership as one method for improving the long-term outlook of their coalition, as well as cultivating new leadership with fresh perspectives.

Given the inherent challenges in facilitating coalitions, those leading and funding coalitions need guidance in selecting evidence-based coalition-building and sustainability actions that most likely result in positive outcomes. Where the literature is lacking, the current research adds to this guidance for community-based coalitions similar to the Collaborative. Individuals and organizations vested in the community-coalition model may consider joining forces to support coalition sustainability theory development that could produce a more reliable and consistent evidence-based literature.

Communication. In addition to the influence of effective leadership, the study found that clear communication also has a dual effect on increasing participation and commitment. This was supported by both the quantitative and qualitative data. When asked of all the elements of coalition functioning (e.g., benefits of participation, member satisfaction, leadership, decision making, communication, sense of community, etc.) discussed during the interviews, which they thought had the most impact on member engagement, key informants reported that it was communication. Communication was found to increase participation indirectly through social resources and to increase commitment indirectly through member satisfaction. Communication is a key factor in getting people involved in a community coalition and in fostering their participation. In fact, Minkler (1999) stated that smooth internal communication among the membership may be the most essential ingredient for enhancing the climate of a coalition. Open communication helps the group focus on a common purpose, increases trust and sharing of resources, provides information, and allows members to express and resolve misgivings. At least one study of coalition functioning identified communication as an important facilitator of member participation (Kegler, Steckler, McLeroy, & Malek, 1998). Kegler et al. (1998) note that with more communication and sharing of important information that is relevant to the community, there was increased participation.

The challenge for coalition leaders, including those that lead the Clarkston Health Collaborative, is to encourage positive communication and group decision making across the variety of personalities, agendas, and skill sets of members. For leaders this may require additional skills training in cross-cultural communication, or communication within diverse groups.

Other aspects of communication assessed in this study should also be considered by leadership of the Clarkston Health Collaborative, as well as leadership of similar efforts. For the Health Collaborative, the most frequently utilized methods of communication outside of monthly meetings were mailed meeting minutes and the Collaborative E-News (electronic newsletter). Interestingly, members reported that group discussions and verbal reports at monthly meetings were the most important forms of communication. Therefore, even in the electronic age, there appears to be little substitution for the face-to-face time that is the hallmark of community coalitions. This is when the social capital and social cohesion that are necessary for sense of community, shared decision making, and particularly clear communication occurs.

Policy and Practice. As a result of this research, there is additional insight into those infrastructure and policy practices (i.e., effective leadership and shared decision making) that need attention when planning and/or initiating similar coalitions or other community-based efforts. What should we be doing in coalitions to increase participative decision making? Structuring decision-making processes to allow more shared member input should facilitate member satisfaction and commitment. For example, setting coalition rules or policies that insure basic consensus methods, eliminate or reduce perceived hierarchies of status, and facilitate discussions so that no one person or group dominates the conversation while encouraging those who have not given input to do so. Other strategies or structures supporting participative decision making might include conducting coalition meetings in a circular seating format that encourages face-to-face conversation between all members. An empowering and participatory leader may more readily mobilize coalition resources that, in turn, motivate members to participate. The satisfaction of members, as well as the community and coalition resources

mobilized by effective leaders, are important in increasing and maintaining member participation and commitment.

This research also has implications for a practice of initiating these efforts where there may already be some sense of community present within the focus community. On the other hand, for communities where there is little sense of community, coalitions can be useful tools or interventions used to increase it. McMillan & Chavis' (1986) theory is most widely utilized to describe sense of community in the psychological literature. Taking from their theory of sense of community's four elements, coalitions can be considered vehicles that encourage membership by providing personal investment and a sense of belonging and identification; vehicles that provide influence through shared decision making; vehicles that provide integration and a fulfillment of needs through participation; and vehicles that foster a shared emotional connection because of shared community history and shared participation.

Multi-Method Approach. Finally, regarding research, multi-method strategies for understanding behavior in context are an optimal way to gain the fullest understanding of individual and community-level behavior. Whether using quantitative and qualitative analyses, in addition to case reports, or a mix of other analytical procedures, much more is gained from data generated from different epistemologies than from only one.

Limitations

There are certain limitations to this study. Some of these limitations may provide opportunities for future research. All potential relationships among factors that lead to participation and commitment were not able to be addressed in one study. It was this study's goal to tease out those that are most appropriate for the population and the context in which this coalition and similar efforts might operate.

Selection. As a cross-sectional, non-experimental study, selection was a threat to validity. With a purposive sampling, there is a pre-selection of the sample to be used. Therefore, there was something about the members of this population (i.e., attendees of the Clarkston Health Collaborative) that caused them to be considered in the general sampling frame (*N*=320). Of those members who were invited to participate, those who completed the member survey (i.e., self-selected) constituted a 30% response rate. As a result, there was the potential for study participants to have certain traits that no one in the general population has, and this limits the generalizability of the results beyond the coalition's membership (i.e., external validity). The low response rate may also be considered a limitation and future efforts might consider incentives to increase response. Representativeness of sample might also be considered a limitation. A random sampling of coalition members may have produced a more representative sampling.

Although it is encouraged that the findings from this study be shared, implications of ways commitment and participation might be increased should be considered with members of similar efforts as the Clarkston Health Collaborative. In addition, any interpretation of these findings should keep in mind that they reflect the experiences and perceptions of more active, more engaged members, rather than community coalition participants as a whole.

Measurement and Scientific Methods. Variable measurement, in general, might be considered a limitation. The measure of empowerment utilized in this analysis, for example, does not include all possible dimensions of empowerment. A general self-efficacy scale was used to assess individual-level empowerment. Self-efficacy is one aspect of empowerment that may also include locus of control or other aspects. As there is no one recognized measure of empowerment, it may be preferable to define and measure empowerment more broadly. A

similar study might be considered that examines empowerment of those involved in community-based health coalitions through self-efficacy and locus of control. This insufficient measurement may have added to the lack of significance of relationships with the empowerment variable.

From a broad perspective of scientific measurement of these phenomena (i.e., coalitions), I believe the mixed-methodological approach is very appropriate for studying communities in context. I disagree with assessments of coalitions and their outcomes that note limitations of coalition research, which include: (1) traditional scientific methodology is poorly suited for capturing fine-grained coalition outcomes, and that (2) coalitions and similar collaborative organizations are too complex to be adequately evaluated by the methodology that is now available. In contrast, data from survey research with validated, reliable measures that is corroborated by participant-observers, and other epistemologies, is critical in gaining a fuller, more accurate understanding of coalition functions, outcomes, and factors leading to sustainability.

There are also limitations in using an explanatory research design. The two-phase approach utilized in this study requires considerable time to implement. The fact that this study was conducted in a year may be considered a limitation. Future studies may need greater spans of time to fully study components affecting member engagement and sustainability. This study has the benefit of focusing on a coalition, the Clarkston Health Collaborative that has an already substantial history with feedback from members who have been engaged for many of the years of its existence.

Although I feel the tools used to determine significant factors predicting increased participation and commitment were adequate, it is worth noting that this assessment is limited to one community coalition in a single context, the City of Clarkston, Georgia. Therefore, it can be

argued that these findings have not been corroborated by prior research, and thus, have limited generalizability.

Social Desirability and Researcher Bias. Effects on response quality which may lead to bias in responses, are believed to come about because of self-presentation or social desirability issues (Sudman & Bradburn, 1974). That is, when the topic of the interview is sensitive or threatening, the mere presence of the interviewer may lead to distorted reporting of the sensitive information. Extensive efforts were taken to assure that study participants were unaware that the coalition facilitator was the author of this research (e.g., use of a web-based survey, telephone interviews by a trained graduate student not related to study, etc.). These efforts worked to reduce social desirability effects and bias in response to questions. Still, bias associated with self-report of behavior and perception is a limitation. In addition, measures were taken to assure that individual member identities remained anonymous to the investigator, to avoid the potential for retribution if information reported cast a negative light on investigator or coalition efforts. In future studies, a way one might deal with social desirability is by actually measuring it to see if there is an effect present. It has also been suggested that through longer-term studies versus a cross-sectional analyses, that participants are less likely to respond based on these effects over time.

Survey Research. Use of a web-based survey tool may have inherent limitations. Variations in computer capacity, access, and ownership based on race/ethnicity, age, gender, income, and education can dramatically affect the generalizability of findings from computer-based surveys. The online survey used in this study assumes that people from all categories noted above have equal access to a computer as well as the Internet to have been able to participate. Even with personal computers, Internet cafés, and access through public facilities

(e.g., libraries), it cannot be assumed that all coalition members would have been able to participate equally through a web-based survey tool. Therefore, in an attempt to mitigate this, a paper mailing of the survey was utilized. These considerations of membership capacity for those implementing or facilitating coalitions or similar efforts should constantly be evaluated.

Key Informants. In quantitative analysis, numbers and what they stand for are the material of analysis. By contrast, qualitative analysis, e.g., through key informant interviews, deals in words and is guided by fewer universal rules and standardized procedures than statistical analysis. We have few agreed-on canons for qualitative data analysis, in the sense of shared ground rules for drawing conclusions and verifying their sturdiness (Miles & Huberman, 1994). This relative lack of standardization is at once a source of versatility and the focus of potentially considerable misunderstanding. That qualitative analysts will not specify uniform procedures to follow in all cases, draws critical fire from researchers who question whether analysis can be truly rigorous in the absence of such universal criteria (Miles & Huberman, 1994).

In addition, key informants for this study self-selected to participate. They were screened in from a group of high participating, highly committed members. Although these kinds of members were the focus, there may be something different about highly committed, highly participatory members who self-select to be interviewed than similar members who did not self-select to be interviewed. Therefore, the findings may not necessarily be generalizable to all highly committed, participative members of the coalition. .

Finally, there may also be questions as to whether this small group (N=6) of key informants could give broad interpretation to quantitative findings obtained from nearly 100 people, or whether the questions they answered on the interview protocol were adequate to obtain this perspective. What is critical here is the issue of redundancy in the themes assessed.

There was sufficient redundancy in key themes among the six key informants. In order to get a broader perspective on these themes (and others), consideration should be given to increasing the number of informants, possibly though focus group inquiry, or try to get a more random qualitative input from coalition membership. Random purposeful sampling (still small sample size) can add credibility when potential purposeful sample is larger than one can handle or can reduce bias within a purposeful category (not for generalizations or representativeness)

There are benefits of the use of a purposeful sampling where particular member attributes (i.e., high participating as well as highly committed) are critical for expanding upon significant quantitative findings in this study. Foremost is that it greatly increases the researcher confidence that informant input could reflect the true nature of what was found in the quantitative, conceptual model of member engagement. The greater the confidence we have in support of the conceptual model, the greater the confidence in the study findings, in specific, and in potential directions for future inquiry, in general. This sampling is aimed at generating insights into theoretical assumptions, not empirical generalization from a sample to a population.

Future Directions

There are a number of directions that could be taken based on the findings of this research. Large amounts of data have been gathered and are impetus for additional questions that may be posed in understanding member behavior in this context. However, based on the findings of this research, additional investigation is necessary into verifying engagement as a latent construct of increased participation and increased commitment. In addition, future research should use the broadest possible range of levels or behavioral aspects of participation (e.g., number of referrals by members for others to attend coalition meetings) and the most comprehensive psychological measures of commitment (e.g., intent) to capture the experience of

all types of coalition participants. Also other variables might be considered as comprising member engagement (e.g., reading all correspondence, interaction with other coalition members, committee leadership, etc.)

This study has highlighted a number of questions that future research could address. In light of these, what other studies should be done? This research provided systematic documentation of one type of community coalition: non-topic based, long-term, non-funded, relatively informal, and substantially diverse, from the perspective of sustainability through member engagement. Additional research on sustainability is needed on other types of community health coalitions (e.g., topic focused, more formal, funded) to provide a foundation on which to base our understanding of coalition behavior leading to sustainability. Finally, three critical questions remain unanswered. First, what are other contextual factors predicting participation and commitment that have not been considered? Secondly, is there a better measure of the construct engagement? Third, is member engagement the best way to measure coalition sustainability? Answers to these research questions will help to move the field of community psychology, coalition research and theory, and community health promotion to a more sophisticated level.

In this fast-paced computer age where time is a high-priced commodity, social cohesion is often reported about in the past tense. Given this study's findings, insight is provided for funders and future coalition leaders into ways of promoting participation and commitment more effectively. "Not having time to attend" was the predominant barrier to participation reported in this study. This purports implications for changing the existing structure of the Health Collaborative and similar efforts to make them more user-friendly and able to meet busy

schedules. Discussions of meeting times, proximity of locations, etc., should be facilitated by coalition leadership.

In the current study, the focus is on those members who have engaged, or continue to engage and the reasons why they engage. Therefore, we are examining the motivating factors of highly committed and highly participative members. The ultimate idea is to determine what mechanisms create or identify, find or attract people like this to community-based health coalitions or similar community-based efforts for the purpose of sustainability. Insight on how this might be done is a direction for future inquiry. Finally, more research needs to be done on the non-participators or low committed members to see if there is something about these people that can be learned in order to determine what not to do, or what to do differently to encourage their full engagement.

CONCLUSION

Coalitions are prime vehicles for fostering social support within communities and prominent mechanisms for building local capacities to address health and social concerns. They are also ideal forums for our tendency toward association and for mobilizing to identify and conserve valuable community resources. In communities with limited internal or external resources, but some sense of community, this type of vehicle would be appropriate. However, sustaining these entities beyond initial efforts and funding is difficult. Beyond external supports, why do members stay engaged in these community-based efforts? Member engagement is a key to understanding why these efforts are sustained. More specifically, what has kept members participating in and committed to the work of groups such as the Clarkston Health Collaborative, a community coalition, nearly 15 years after its inception?

Associations within communities are alive and well in the new millennium. While there may not be nationally or internationally recognized leadership involved, or actions resulting in sweeping social change movements, collaborative exchanges are taking place on a regular basis to produce better, healthier communities. Alexis de Tocqueville's observations over 170 years ago are still true today, that is, our propensity to organize in associations to address local issues. Despite reports of decreasing social capital, one popular health promotion trend has pushed against this paradigm for nearly 20 years, that is, community association and community mobilization through community coalitions. Coalition building has become a prominent intervention employed in communities across America, including in the small city of Clarkston, Georgia, where the Clarkston Health Collaborative has been engaged in grassroots community mobilization and health promotion for a decade and a half.

Considering this study's findings regarding factors that increase member commitment and member participation, there is perhaps a better understanding of the concept of member engagement, as a sustaining factor of the CHC and similar community-based efforts. Although prior coalition research has examined several key variables that predict overall participation and commitment in community-based coalitions, none examined sustaining efforts in non-topic-based, non-grant-funded community coalitions similar to the Clarkston Health Collaborative. The explanatory power of this study is supported by a mix of methodologies that work together to give a broader base of understanding about the coalition phenomenon. The current study has shown that when these entities are facilitated by effective leaders and utilize clear communication to leverage internal and external resources, there is greater participation. When there is a shared decision-making structure, members are more satisfied, and more committed. These behavioral and psychological aspects of member engagement are critical to sustaining these community-based efforts.

> *Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has. – Margaret Mead*

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APPENDICES

APPENDIX A. Clarkston Health Collaborative: A Case Report

The following case report is an account of the origin and development of the Clarkston Health Collaborative, a community-based coalition operating in Clarkston, Georgia. This report provides context for the characteristics and functions of the present-day collaborative and adds to the understanding of member engagement since 1994.

The beginning. Change through collective action is the major thrust of VISION 2020, a regional planning process initiated by the Atlanta Regional Commission (ARC) in 1992. VISION 2020 is an effort to create and implement a shared vision of the Atlanta region's collective destiny in the 21st century. From its beginning, VISION 2020 was envisioned as a community-based, citizen-driven process. The process looks at ways of empowering local communities to improve the overall health of the population by the year 2020, including developing local-level coalitions to address various issues.

An early step included formation of the VISION 2020 Steering Committee headed by former Georgia Governor George Busbee. In 1992, the Steering Committee, on behalf of the ARC Board of Directors, began to explore possible future scenarios, with the assistance of a Delphi survey[6]. The survey identified some likely future trends across various aspects of community life (e.g., socioeconomic, race, and environmental issues). The committee then examined what might occur if current negative trends continue (e.g., poor health outcomes, pollution, poor housing conditions, etc.). They imagined the possibilities with proactive intervention that could change these trends.

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[6] A Delphi survey is a structured group interaction process that is directed in "rounds" of opinion collection and feedback. Opinion collection is achieved by conducting a series of surveys using questionnaires. The result of each survey is presented to the group and the questionnaire used in the next round is built upon the result of the previous round (Turoff & Hiltz, 1996).

Phase I: Reaching Out

Phase I of VISION 2020 began in earnest in 1993 with an extensive public outreach campaign designed to involve as many regional citizens as possible. Through 23 community forums; more than 100 speaking engagements; a live, televised town hall meeting; a newspaper supplement and survey; and many other avenues, thousands of citizens voiced their preferences and concerns for the future. Information gathered through this massive public outreach effort was summarized in a report called, "A Shared Vision for the Atlanta Region" (Atlanta Regional Commission, 1993).

Phase II: Establishing VISION 2020 Community Collaboratives

With the assistance of the National Civic League in Denver, Colorado, ARC began to design Phase II of VISION 2020. The work of VISION 2020 was divided into ten community collaboratives, each consisting of about 100 diverse representatives from the many perspectives in the regional community. These residents were invited to work for about a year to create strategic action plans to achieve the community's shared vision. According to "VISION 2020: A Community Building Process" (Atlanta Regional Commission, 1993), these ten community collaboratives were focused on:

- Diversity
- Economic Development
- Education
- Environment
- Governance
- Health
- Housing
- Human Services
- Public Safety
- Transportation

Throughout 1994 and the first half of 1995, these collaboratives worked to identify key steps necessary in each area to maximize positive outcomes for the future. A second report summarizing their work, "A Community's Vision Takes Flight, VISION 2020: Key Initiatives for the Future," was published in September, 1995 (Atlanta Regional Commission, 1996).

Phase III: Action Planning (Focus on Health Collaborative)

The third phase of VISION 2020, that of developing and implementing specific action plans to carry out the initiatives, began in July 1995 with representatives from all collaboratives meeting together to identify cross-cutting issues, develop strategies, and coordinate related efforts. A major thrust was to establish benchmarks or measures to help gauge how the region progressed toward its goals for the future (Atlanta Regional Commission, 1996).

Health Collaborative. In the first phase of the VISION 2020 project, the metro Atlanta community saw health as a major area of concern. The health collaborative was one of the ten collaboratives formed in mid-1994. Approximately 100 individuals or "stakeholders" including consumers of goods and providers of services convened to discuss the issues related to health, explore the options, and develop initiatives to help achieve the vision of the future. The original conveners of the health collaborative, called the Health Initiating Committee, included representatives from local public health agencies, Emory University, West End Medical Center, the Visiting Nurse Health System, the Atlanta Health Care Alliance, Columbia Healthcare Association, Prudential Health Care System, the American Red Cross, the American Hospital Association, and the American Cancer Society. These representatives began meeting in July 1994 to review input from the community collected during the first phase of VISION 2020 and in September of that year, identified five "Key Performance Areas" (KPAs) – quality,

affordability, accessibility, personal responsibility, and wellness. Community input elicited areas of concern and potential issues for the collaborative, which included:

1. Ensuring key leaders are at the table.
2. Continuing to take issues back to the community.
3. Expanding stakeholder influence by involving others in small groups.
4. Interfacing with the Governor's community initiatives and other planning efforts.
5. Remaining consistent with recommendations from Georgia Health Decisions[7].
6. Ensuring the plan is consistent with local, state, and national objectives.
7. Distributing letters to other stakeholders encouraging their involvement in a KPA.
8. Selecting co-chairs for each KPA.

As part of their work, the conveners established five subcommittees based on the KPAs to deliberate and plan based on the identified criteria. They examined potential measures, critical success factors, barriers, and initiatives.

Emergence of the Clarkston Health Collaborative

After many months of deliberation, the five KPA discussion groups arrived at the same conclusion. The Atlanta region must establish benchmarks in each area of consideration within the current health system before identifying ways to change the system in the future. To establish such benchmarks, the health collaborative determined that it must return to the citizens of the region for answers, and that a specifically designed survey administered in a selected community within the region would be the best way to begin (Atlanta Regional Commission, 1996). A work committee comprised of interested health collaborative stakeholders was established to design the research project, expand upon the original vision, and develop a master plan to improve health status and provide a model that is sustainable and replicable in the region.

[7] Since 1991, Georgia Health Decisions, a non-profit, non-partisan organization, has been working across Georgia to give public voice to the health values and viewpoints of citizens. Distinct from other grassroots groups that address health issues from advocacy and consumer oriented perspectives, Georgia Health Decisions attempts to elicit a self-consciously "civic" or citizenship outlook on health issues (Georgia Health Policy Center, 2007).

Through the entire process, the work committee agreed that community consensus on what works as measured by survey results is to be valued with particular attention being given to "the ability of the community to talk about what works and help…to implement decided action" (Atlanta Regional Commission, 1996).

The health collaborative instructed the committee to make the project interdisciplinary, have high community involvement, be in a geographic area that is representative of the region and reflects cultural diversity, have a broad age spectrum, include varying income levels, and speak different languages. After receiving this direction, the work committee met several times to consider possible locations within the metropolitan area that would meet the criteria. A number of Census tracts were considered and the one most nearly matching the criteria was Census tract 220.02 comprising the City of Clarkston in DeKalb County. This gave rise to the Health Collaborative being sited in Clarkston (see Timeline, Figure 15). It is believed that Clarkston is a microcosm of what the Atlanta region, as a whole, will look like by the year 2020. Clarkston was selected as the home of the collaborative because of its rich diversity. There is a diversity of age groups, ethnic and racial groups, faith institutions, and housing stock, as well as opportunities for health status improvement. The Center of Applied Research in Anthropology of Georgia State University estimates that more than 87,000 non-U.S. native people resided in DeKalb County in 1997, accounting for more than 30 separate ethnic groups. The population of Census tract 220.02 that surrounds the City of Clarkston and makes up the greater Clarkston community was 12,447 in 2000, with a diversity demonstrated by the fact that 85.3 percent of the population is of races other than white.

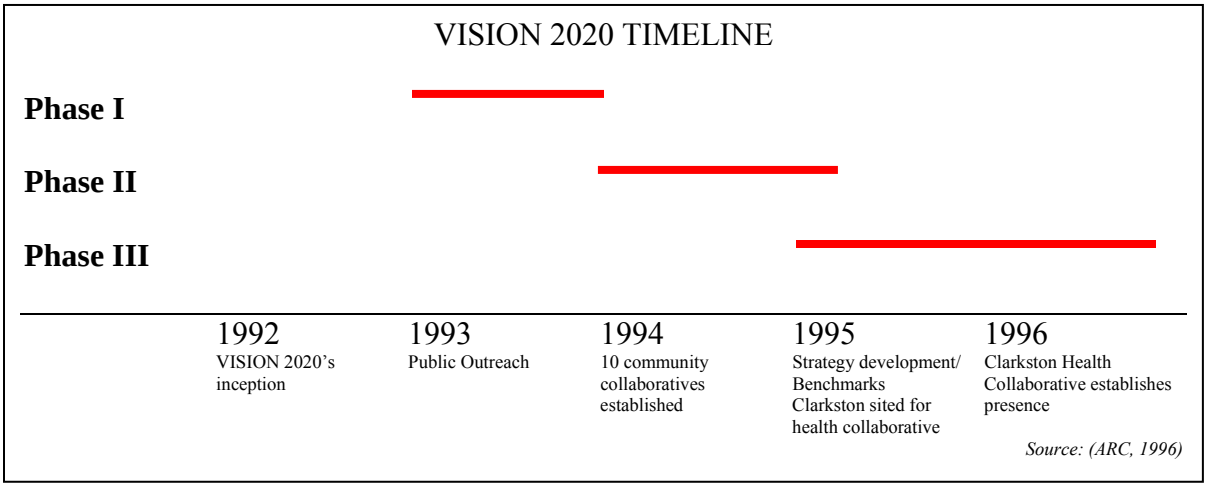

Figure 15. Timeline of VISION 2020, Establishing the Clarkston Health Collaborative

The work committee decided that several organizations should participate in a collaborative effort to assume responsibility for carrying out the research demonstration project. The Atlanta Regional Commission, as the official planning body for the ten-county region, agreed to assume the responsibility for overall coordination of the project and provide a public presence. The DeKalb County Board of Health agreed to supervise the day-to-day activities of the project and to be the direct link to the City of Clarkston. Emory University's schools of public health and nursing and Georgia State University's school of nursing agreed to participate as active partners in various aspects of the research and Georgia State University's new Institute on Health Policy agreed to assist in interpreting and distributing the results, acting as the link to policy development (Atlanta Regional Commission, 1996).[8]

The Present. Today, nearly 14 years after its inception, what is now known officially as the "Clarkston Health Collaborative" continues to promote sustainable, community-led change

[8] At some point, between the inception of the research demonstration project, an unreported set of circumstances occurred, which might have been shifts in funding, shifts in focus, changes in partner agencies, and consequently little of the original formality and structure of the health collaborative remains.

by facilitating a community-based, resident-driven process that looks at ways of empowering residents to improve the overall health of the population.

As noted above, the Clarkston community is comprised of sizeable and growing immigrant and refugee populations. As one measure of the diversity in the community, Clarkston High School has identified over 55 different nationalities among its student body and 21 languages are spoken at the school. Recently released data from the U.S. Bureau of the Census (United States Census, 2000) further substantiates the diversity of Clarkston's population: 4,025 blacks, 1,406 whites, 909 Asians, 333 Hispanics, 8 Native Americans, 3 Pacific Islanders, and 695 of other races. By far, the largest enclaves of Somalis, Ethiopians, Afghanis, Bosnians, Iraqis, and Sudanese that have settled in the metro Atlanta area over the past ten to 15 years have resettled in Clarkston (Georgia Department of Human Resources, 2007).[9] Other refugee and immigrant groups include persons from Latin and South American and Southeast Asian regions. In addition, they represent countries such as Eritrea, Pakistan, and India. This diversity is a result of several local agencies that receive funding from the U.S. Department of Health and Human Services through the Office of Refugee Resettlement. These agencies facilitate resettlement by providing case management and social services to refugee populations resettled in the Clarkston area.

Broadening of the mission. Diversity does not foster unity unless efforts are made by community members from different backgrounds to come together to know each other. The

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[9] The Refugee Resettlement Program is a federally-funded program that provides cash assistance, medical assistance, health screening, and social services to refugees. A refugee, as defined by the Refugee Act of 1980, is a person who is outside of and unable or unwilling to avail himself/herself of the protection of the home country because of persecution or fear of persecution on account of race, religion, nationality, membership in a particular social group, or political opinion (Georgia Department of Human Resources, 2007).

collaborative's initial focus on clinical health and access to healthcare has evolved into a broader definition of health associated with community wholeness and wellness. In 1999, the collaborative adopted the World Health Organization's definition of health: "a dynamic state of complete physical, mental, spiritual, and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1998). While this includes quality healthcare and access, there are a myriad of non-health related issues, based on this definition that are discussed and addressed by the health collaborative.

The purpose of the Clarkston Health Collaborative is to catalyze and facilitate the development of true dialogue and understanding among diverse individuals and groups so that they can create the conditions that foster health and well-being. This VISION 2020 collaborative continues to develop and implement specific action plans to carry out the long-range initiative originally envisioned (Atlanta Regional Commission, 1996).

How the Clarkston Health Collaborative Operates

Participation. The Clarkston Health Collaborative mailing list has reached nearly 350 people and monthly meetings still involve key community stakeholders, including residents, Clarkston city government officials, and DeKalb County Board of Health staff. At regular monthly meetings (i.e., every fourth Tuesday) at the same time and location (i.e., 6:30 p.m. to 8 p.m. at the Clarkston Community Center), from 20 to 50 people convene to discuss issues important to Clarkston's health and well-being. As part of this gathering, the collaborative is host to not only residents, but also to business owners, health care providers, representatives from resettlement agencies, faith institutions, and from the Atlanta Regional Commission. At least one-third of regular participants are residents in the Clarkston community. It is a voluntary organization with no formal membership requirements or financial obligation. It is an open-

discussion forum, where participants are encouraged to bring issues that are important to broad community well-being. Although active participation is not a requirement of membership, it is strongly encouraged.

Leadership. Due to the early leadership of the Board of Health and the mayor of Clarkston, the work of the Clarkston Health Collaborative is steeped in community mobilization through health promotion, community empowerment, and social action. However, the forum has no formal, hierarchical structure. There is no president, board of directors, or standing committee structure. Although there are committees called "community action committees" that are broadly defined (i.e., health and wellness, political affairs and economic development, community-building and special events, and education and service learning), they are essentially ad hoc and are mobilized or changed based on emerging issues. The focus of the collaborative is on improving the overall wellness of the community, regardless of the issue. This goal is realized through facilitation of the dialogue by one or more members of the coalition. The facilitator is responsible for opening the meeting, reviewing the minutes from the previous meeting, and guiding the conversation on the current topic. Topics of discussion are decided by the membership at the beginning of the calendar year, and as community issues of concern arise. According to the original agreement, staff from the DeKalb County Board of Health continues to provide general support to the coalition through compiling and mailing of minutes and agendas, as well as meeting reminders.

Decision Making. The Clarkston Health Collaborative employs a shared or collaborative decision making style where all participants have an equal opportunity for input on topics of discussion. Specifically, the collaborative uses a problem-posing, action-producing process that includes active listening and reflection to assist members in identifying issues that are most

important. This is a fully participatory model whose premise is to develop the community's competencies around self-assessment and self-discovery. This community-based action is fueled by generative themes in the community, or those issues around which significant numbers of people are concerned. In this Freirian process of community action (Freire, 1970), the community is asked, or asks itself, "What are our biggest problems and why are they occurring?" This allows assessment of and reflection on these issues. The next question, "What needs to be done?" facilitates decision making. The final question, "Who will do it?" moves residents from contemplation and decision to action by identifying community assets and resources available to address the issue.

Communication. Meeting minutes are distributed monthly by both postal mail and electronic mail prior to the next scheduled coalition meeting. Communication with coalition members is also strengthened through monthly electronic meeting reminders and an electronic newsletter of current community events, called the Collaborative E-News. Periodic calls are made to members to request updates on contact information. All electronic communications offer the option to be removed from the contact list, as well as encouraging forwarding and sharing of information. Members who are unable to make the monthly meetings participate by reviewing meeting minutes or other forms of communication, and via information sharing.

Collaborative Results: Health Promotion, Empowerment, and Social Change

Participation Benefits and Sense of Community. The benefits of participation in the Clarkston Health Collaborative appear to be far reaching. Although previously unmeasured, the primary focus is to build a sense of community where needs are identified and social resources (internal and external to the community) to meet those needs can be mobilized, resulting in health promotion, empowerment, and social change.

Through resource mobilization, the collaborative offers the intangible resource of organizing and thereby bridges gaps for gaining access to tangible resources, a key to moving from discontent to social change. As a result, the collaborative is not a topic-based coalition (e.g., HIV, substance abuse, or family and child welfare). Instead, over the years members have discussed and addressed many issues of social concern, from housing conditions, to improving the cultural sensitivity of law enforcement, to safe routes to school, to improving the built environment, to female genital circumcision, to racial profiling, to gentrification. Resulting actions include, but are not limited to, developing a medical and a business resource guide, administering needs-based surveys, conducting trainings on varied topics (e.g., cultural sensitivity, recycling, and pedestrian safety), organizing community festivals, and sponsoring voter registration drives, just to name a few. These efforts work to increase community connectedness and a general sense of community.

The mission of the Clarkston Health Collaborative is to establish a platform for community development in order to facilitate meaningful dialogue among diverse individuals and groups so that they may effectively pursue their interests and talents in creating the conditions that foster healthy people in healthy communities. The pursuit of these interests and talents are benefits of participating in the coalition.

Health promotion through resource mobilization. The Clarkston Health Collaborative is essentially a wellness coalition in which a platform is established to allow community-generated issues to be discussed and addressed. According to Wolff (2001b) in his practitioner's guide to coalitions that are successful, some coalitions set out broad agendas and can easily become distracted by emerging crises and numerous side issues. He notes that still other single-issue coalitions become so narrowly focused on their topic that they ignore the very contextual and

environmental issues that impact them (Wolff, 2001b). The health collaborative strikes a balance between these two extremes in that it sets clear goals and objectives on broad issues affecting the single issue of community health and wellness.

While referring to health promotion through resource mobilization, it is important to note that the Clarkston Health Collaborative has no treasury or regular funding source. In its early years, the ARC provided financial resources. From 2001 to 2003, funding was received via a grant from the Joseph B. Whitehead Foundation to provide community empowerment and leadership development trainings in the Clarkston community. Essentially, lay leaders in the refugee community were trained to listen in their respective ethnic communities for important concerns and facilitate local action toward solving their own problems. The DeKalb County Board of Health served as the fiscal agent for these dollars. No other funding has been raised or received to support coalition functions.

Empowerment. The collaborative's focus has been on how social issues disproportionately affect marginalized communities in Clarkston, including youth, women, minorities, and the poor. For example, through the work of the collaborative, a summer youth employment program called "Photovoice" was created for Clarkston High School students[10]. The program gives youth an opportunity to express through photography how they view the "health" of their community. The community needs identified through the Photovoice projects in 2000, 2001, and 2003 resulted in: (1) the establishment of a Photovoice Club at the high school, (2) the school being designated an official site of Hands On Atlanta, the nation's largest community-based volunteer service organization that helps individuals, families, and community

[10] In 1992, Dr. Caroline Wang, along with Dr. Mary Ann Burris, created what is now known as "Photovoice" as a way to enable women living in the remote countryside of Yunnan Province, China, to successfully influence the policies and programs that affected them. The Photovoice methodology has been adopted as a tool for assessing grassroots needs and assets, and for evaluation by diverse populations nationally and internationally (Wang, 2005).

and corporate groups find flexible volunteer opportunities at more than 500 community-based agencies and schools throughout Atlanta, (3) the initiation of a Clarkston clean-up and recycling program, and (4) a commitment from local elected officials and the DeKalb County school board to improve conditions in and around the high school and community.

Social Resources. This process of engagement has lead to many action solutions to identified problems in the community, including: facilitating the distribution of small community capacity grants; Transformation for Health workshops to train community leaders to listen within their respective spheres and facilitate action; assisting in the transforming of an old school into a community and cultural arts meeting place (now known as the Clarkston Community Center), and many others. It is the combination of member participation, leadership, and shared decision making that helps to mobilize resources toward action. As a result, a greater sense of community and community well-being is realized.

The collaborative focuses on empowerment of marginalized groups (e.g., minorities, women, children, the poor, refugees, homeless, etc.) through social action and social and environmental justice. For example, the collaborative coordinated an initiative to improve poor and dilapidated housing and apartment complexes causing sub-standard living conditions for refugees and immigrants in Clarkston. A contingent of nearly 50 people, including a housing code enforcement officer, residents, elected officials, and police, gathered at a landlord's office one morning demanding change. Shortly thereafter, the complex was remodeled and thus, conditions were dramatically improved. As a follow-up the collaborative authored and presented a prototype anti-retaliatory law to the county commission and state legislature that would prevent landlords from retaliating against tenants who report poor housing conditions.

Efforts such as this continue today, over a decade after the coalition's initiation and largely independent of those entities that banded together to establish it. Currently, in addition to local residents, the agencies that actively participate in the collaborative include:

- Bridging the Gap
- Christ Community A.M.E. Church
- City of Clarkston elected officials
- Clarkston Baptist Church
- Clarkston City government
- Clarkston Community Center
- Clarkston United Methodist Church
- Coalition of Concerned Africans
- DeKalb County Board of Health
- DeKalb Public Library
- Georgia Department of Human Resources
- Georgia Mutual Assistance Consortium
- Global Health Action
- Jewish Family & Career Services
- Oakhurst Medical Center
- Refugee Family Services
- Refugee Women's Network
- Somali Community Organization

The Clarkston envisioned is a vibrant, sustainable community where empowered people reach their full potential for health and well-being. This effort prepares community leaders to listen within their own community for those issues that evoke strong feelings. People are thus empowered to move forward with their own action solutions to address emerging and existing social issues.

APPENDIX B. Clarkston Health Collaborative Member Survey (Quantitative)

Version 1: Online
Version 2: Mailed

Purpose
The purpose of this survey is to find out how the Clarkston Health Collaborative as a community coalition, has sustained its efforts and what factors foster member participation (past and current), as well as member's commitment to the work of the group. The findings will help provide insight into improving the effectiveness of the coalition and the planning and implementation of similar coalitions in other communities.

Confidentiality
All of the information you provide was kept strictly confidential. Your responses will be combined with the responses of others in the Clarkston Health Collaborative. The information from the coalition may be summarized and reported back. Neither your name, nor any personal information or identifiers was revealed in any published reports of this research. I ACCEPT/REJECT

Instructions (online)
You can answer most of the questions by clicking on the response-category that represents your response. The survey takes approximately **20 minutes** to complete. If you have questions about the survey, please call: Dr. James Emshoff at 404-651-2029.

Instructions (hard copy)
You can answer most of the questions by filling in or circling the response-category that represents your response. The survey takes approximately **20 minutes** to complete. If you have questions about the survey, please call: Dr. James Emshoff at 404-651-2029.

◉ Brief follow-up interviews was conducted in a few weeks. There is the possibility that you can participate in an interview. Please click here (or check here) if you would like to be contacted for an interview.

Background: the first set of questions is about your involvement (or participation) in the Clarkston Health Collaborative.

1. How many months/years have you been (or were you) involved with the coalition? _____months _____ years
2. Do you live in a community served by your coalition? (Choose one) YES NO

3. A community coalition may have members who come from many different community sectors. From the following list of sectors, please check the **one** that best describes the sector whose viewpoint you offer to this coalition. **(Hays et al., 2000)**

☐ 1. Resident	☐ 7. Government (city, county, state, federal)	☐ 13. Grassroots Organization
☐ 2. Higher education	☐ 8. Parent group	☐ 14. Non-profit (CBO, NGO)

☐ 3. Social Services	☐ 9. Youth	☐ 15. Media
☐ 4. Public housing	☐ 10. Faith community	☐ 16. Recreation
☐ 5. Law Enforcement	☐ 11. Health/Healthcare	☐ 17. Education
☐ 6. Business	☐ 12. Cooperative Extension Service	☐ 18. Resettlement Agency

4. Since there is no formalized recruitment process, of the factors listed, which do you feel attract attendees to the Clarkston Health Collaborative?

   A. Topics B. Forum structure C. Guest Speakers D. Other attendees E. Leadership

   F. Others (please specify) _____

Participation: the next set of questions asks about your involvement (or participation) in the Clarkston Health Collaborative in a year. Please rate how often **YOU** usually played these roles in the coalition. **(Hays et al., 2000)**

	Never	Rarely	Sometimes	Often	Always
1. Attended regular coalition meetings (not including sub-committee or special meetings)	1 (0)	2 (1-3)	3 (4-6)	4 (7-9)	5 (10-11)
2. Made comments, expressed ideas at meetings	1	2	3	4	5
3. Served as a member of a committee	1	2	3	4	5
4. Helped organize coalition-sponsored activities (other than meetings)	1	2	3	4	5
5. Chaired a committee	1	2	3	4	5
6. Served as a coalition facilitator, guest speaker	1	2	3	4	5
7. I contributed knowledge to the coalition	1	2	3	4	5
8. I contributed expertise to the coalition	1	2	3	4	5
9. I worked with the coalition to change policies and practices in community institutions	1	2	3	4	5

10. If you attended less than 4 meetings, or indicated your participation as “rarely” or “never”, please describe the primary barrier to coalition participation.

(Kumpfer, 2005)

1. Didn’t know about the meetings
2. Didn’t have time to attend the meetings
3. Transportation
4. Distance
5. Time of day the meetings are held
6. Other: (please specify)_____

Commitment: Please indicate the degree to which each statement below describes your thoughts about commitment to the Clarkston Health Collaborative by choosing a number to the right of each statement. If you have trouble deciding, choose the answer that describes your feelings most of the time. **(Kumpfer et al., 1993)**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. I really care about the future of this coalition	1	2	3	4	5
2. I am proud to tell others that I am/was a part of this coalition	1	2	3	4	5
3. I feel strongly committed to this coalition	1	2	3	4	5

Leadership: the next set of statements is about the facilitator of your coalition. Please consider each statement, and then choose the answer that comes closest to expressing your feelings. If you have trouble deciding, choose the answer that describes your feelings most of the time.

The **facilitator(s)/leader(s)** of your coalition. . .

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. is very effective overall **(Hays et al., 2000)**	1	2	3	4	5
2. encourages and explores all points of view	1	2	3	4	5
3. is knowledgeable about the issues the coalition is seeking to address	1	2	3	4	5
4. is able to reduce or resolve turf issues among member organizations and community	1	2	3	4	5

agencies					
5. effectively manages conflict and channels it toward the coalition's goals	1	2	3	4	5
6. is knowledgeable about problems and issues across the community	1	2	3	4	5
7. is effective at advocating the coalition's perspective with community leaders and decision makers	1	2	3	4	5
8. makes you feel welcome at meetings **(Kegler et al., 1998)**	1	2	3	4	5
9. gives praise and recognition at meetings	1	2	3	4	5
10. intentionally seeks out your views	1	2	3	4	5
11. asks you to assist with specific tasks	1	2	3	4	5
12. makes an effort to get to know members	1	2	3	4	5
13. has a clear vision for the coalition	1	2	3	4	5
14. is respected in your community	1	2	3	4	5
15. is skillful in resolving conflict	1	2	3	4	5
16. develops other leaders	1	2	3	4	5

Sense of Community: Please indicate the degree to which each statement below describes the way your coalition/collaborative works by choosing a number to the right of each statement. If you have trouble deciding, choose the answer that describes your feelings most of the time.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Coalition members share a common vision for our community **(Hays et al., 2000)**	1	2	3	4	5
2. There is a feeling of unity and cohesion in this coalition **(Kegler et al., 1998)**	1	2	3	4	5
3. There is not much group spirit among members of this coalition (REVSCR)	1	2	3	4	5

4. There is a strong feeling of belonging in this coalition	1	2	3	4	5
5. Members of this coalition feel close to each other	1	2	3	4	5

Satisfaction: Please indicate the degree to which each statement below describes your level of satisfaction with how your coalition/collaborative works by choosing a number to the right of each statement. Indicate the extent to which you are satisfied with…

	Very Dissatisfied	Dissatisfied	Neither Satisfied nor dissatisfied	Mostly Satisfied	Very Satisfied
1. the way the coalition utilizes the assets (resources, knowledge, skills, abilities, etc.) that I bring to the coalition **(Kumpfer, 2005)**	1	2	3	4	5
2. the overall experience as a coalition member/participant	1	2	3	4	5
3. the amount of influence you have in major decisions **(Kumpfer et al., 1993)**	1	2	3	4	5
4. the coalition facilitator	1	2	3	4	5
5. the amount of discussion at meetings	1	2	3	4	5
6. the types of activities planned by the coalition	1	2	3	4	5
7. the planning process used by the coalition	1	2	3	4	5
8. the overall work of this coalition	1	2	3	4	5

Resources: Please indicate the extent to which you agree with each statement below that describes the way your coalition/collaborative works. If you have trouble deciding, choose the answer that describes your feelings <u>most</u> of the time.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. The Coalition mobilizes the assets (resources, knowledge, etc.) that are <u>available</u> in the community. **(Kumpfer, 2005)**	1	2	3	4	5

2. The members of this coalition are representative of the varied groups/citizens of this community **(Hays et al., 2000)**	1	2	3	4	5
3. I exchanged information about such things as meetings or conferences, training opportunities, funding sources, community survey data, or programs with other partners in your coalition	1	2	3	4	5
4. I changed or altered my event dates, fundraising plans, or program activities for the mutual benefit of other coalition partners	1	2	3	4	5
5. I jointly planned and implemented programs with one or more coalition partners	1	2	3	4	5
6. I jointly sought new funding with one or more coalition partners for programs to serve a common goal	1	2	3	4	5

Empowerment/General Self-Efficacy Scale: listed below are a series of statements. Please indicate your responses to the statements using the following scale: **(Bosscher & Smit, 1998)**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. If something looks too complicated, I will not even bother to try it (REVSCR)	1	2	3	4	5
2. I avoid trying to learn new things when they look too difficult (REVSCR)	1	2	3	4	5
3. When trying to learn something new, I soon give up if I am not initially successful (REVSCR)	1	2	3	4	5
4. If I can't do a job the first time, I keep trying until I can	1	2	3	4	5
5. When I make plans, I am certain I can make them work	1	2	3	4	5

6. When I have something unpleasant to do, I stick to it until I finish	1	2	3	4	5
7. When I decide to do something, I go right to work on it	1	2	3	4	5
8. Failure just makes me try harder	1	2	3	4	5
9. When I set important goals for myself, I rarely achieve them (REVSCR)	1	2	3	4	5
10. I do not seem capable of dealing with most problems that come up in my life (REVSCR)	1	2	3	4	5
11. When unexpected problems occur, I don't handle them very well (REVSCR)	1	2	3	4	5
12. I feel insecure about my ability to do things (REVSCR)	1	2	3	4	5

Communication: We are interested in how you view communication within your coalition. Please choose the best response for each of the following statements. **(Butterfoss et al., 1996)**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. Communication among members of this coalition is clear	1	2	3	4	5
2. There is very little communication among coalition members (REVSCR)	1	2	3	4	5
3. The discussion and communication in this coalition is productive	1	2	3	4	5

4. Which of the methods of communication have been utilized most frequently by your coalition? **(Kumpfer et al., 1993)**
   a. Telephone calls
   b. Phone meetings

c. Letters
d. Formal presentations
e. Do not communicate outside of meetings

5. How important or unimportant to your coalition is each of the following ways of communication? **(Kegler et al., 1998)**

	Not at all important	Not very important	Somewhat important	Very important
1. Mailed and faxed written materials	1	2	3	4
2. Verbal reports at meetings	1	2	3	4
3. Group discussions at meetings	1	2	3	4
4. Talking outside of coalition meetings	1	2	3	4

Decision Making: Please indicate the degree to which you agree with the following statements. If you have trouble deciding, choose the answer that describes your feelings most of the time. **(Butterfoss et al., 1996)**

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
1. This is a decision making collaborative	1	2	3	4	5
2. Members are encouraged to speak their minds even if it means disagreeing with the majority	1	2	3	4	5
3. This coalition avoids open arguments and disagreements (REVSCR)	1	2	3	4	5
4. This coalition knows how to resolve conflicts	1	2	3	4	5

The collaborative members have a part in…**(Kegler et al., 1998)**

5. determining the policies and actions of the coalition	1	2	3	4	5
6. setting goals and objectives for the coalition	1	2	3	4	5
7. selecting coalition activities	1	2	3	4	5

Benefits: Below is a list of possible benefits you may or may not get from your involvement in the Clarkston Health Collaborative. Circle the response that describes how you are currently receiving each benefit as a result of the work you do with the coalition. **(Butterfoss et al., 1996)**

	Not at all a Benefit	Not very Much of a Benefit	Somewhat of a Benefit	Very Much of a Benefit
1. Learn new skills (public speaking, program planning)	1	2	3	4
2. Receive information about community services, events, county government, etc.	1	2	3	4
3. Provides an opportunity to improve the way I do my job	1	2	3	4
4. Provides a chance to explore new job opportunities	1	2	3	4
5. Gain support by working with other members of the community	1	2	3	4
6. Gain personal recognition and respect from others	1	2	3	4
7. Increase cooperation with members of other community agencies/groups	1	2	3	4
8. Support my agency/group's concerns and mission	1	2	3	4
9. Receive satisfaction by being involved in an important project	1	2	3	4
10. Fulfill sense of responsibility to contribute to the community	1	2	3	4
11. Make the community a safer place to live	1	2	3	4

Demographics. Finally, would you please answer a few background questions that will help us describe community coalition participants and analyze our results. Please check your response or fill in the appropriate number. **(Hays et al., 2000)**

1. Are you: ☐ Male ☐ Female

2. Education completed:

☐ some high school	☐ high school	☐ some college	☐ bachelor's degree	☐ some grad school	☐ graduate degree

3. Racial group:

☐ African American	☐ White	☐ Asian/ Pacific Islander	☐ Native American	☐ Latino	☐ Other

4. Country of Origin _____

5. Age group:

☐ 21-30	☐ 31-40	☐ 41-50	☐ 51-60	☐ 61-70	☐ 70+

*****THANK YOU FOR YOUR TIME AND ASSISTANCE****

Your feedback and input will help to improve the coalition. It is much appreciated.

APPENDIX C. Survey Item Source by Construct

Construct	Item (#)	Source	(α)
Participation (p2)	1-9 (9)	*Member Coalition Survey* (Hays, Hays, DeVille, & Mulhall, 2000)	α = .87
	10 (1)	*Community Key Leaders Survey* (Kumpfer, 2005)	NR*
Commitment (p3)	1-3 (3)	*Community Team Member Survey* (Kumpfer et al., 1993)	α = .93
Leadership (p3)	1-7 (7)	*Member Coalition Survey* (Hays, Hays, DeVille, & Mulhall, 2000)	α = .92
	8-15 (8)	*Member Survey: Project ASSIST Coalitions* (Kegler et al., 1998)	α = .86 (10 items)
Sense of Community (p4)	1 (1)	*Member Coalition Survey* (Hays, Hays, DeVille, & Mulhall, 2000)	NR
	2-5 (4)	*Member Survey: Project ASSIST Coalitions* (Kegler et al., 1998)	NR
Satisfaction (p5)	1-2 (2)	*Community Key Leaders Survey* (Kumpfer, 2005)	NR
	3-8 (6)	*Community Team Member Survey* (Kumpfer et al., 1993)	α = .91 (9 items)
Resources (p5)	1 (1)	*Community Key Leaders Survey* (Kumpfer, 2005)	NR
	2-6 (5)	*Member Coalition Survey* (Hays, Hays, DeVille, & Mulhall, 2000)	NR
Empowerment (p6)	1-12 (12)	*General Self-Efficacy Scale* (Bosscher & Smit, 1998)	α = .60
Communication (p7)	1-3 (3)	*Community Partnership Program Fighting Back Committee Survey* (Butterfoss, Goodman, & Wandersman, 1996)	NR
	4 (1)	*Community Team Member Survey* (Kumpfer et al., 1993)	NR
	5 (4)	*Member Survey: Project ASSIST Coalitions* (Kegler et al., 1998)	α = .87
Decision Making (p8)	2-4 (3)	*Community Partnership Program Fighting Back Committee Survey* (Butterfoss, Goodman, & Wandersman, 1996)	α = .47 (14 items)
	1, 5-7 (4)	*Member Survey: Project ASSIST Coalitions* (Kegler et al., 1998)	α = .84
Benefits (p9)	1-11 (11)	*Community Partnership Program Fighting Back Committee Survey* (Butterfoss, Goodman, & Wandersman, 1996)	α = .90 (14 items)
Demographics (p10)	1-5 (5)	*Member Coalition Survey* (Hays, Hays, DeVille, & Mulhall, 2000)	---
Total Items	**90**		

*NR = None Reported

APPENDIX D. Recruitment for Key Informant Interviews (through primary online survey)

Version 1: Online

◉ Brief follow-up interviews will be conducted in a few weeks. There is the possibility that you can participate in an interview (please click here if you want (i.e., consent) to be contacted for an interview).

If this response option is selected, the participant was directed to a separate screen where they were asked to type in their name and the best method with which to be contacted by an interviewer. *Note*: Participants who elected to be contacted for an interview were necessarily no longer anonymous. Specifically, information pertaining to their participation level and commitment was connected to their identity. They were informed that their names would be connected to their responses on those respective 16 questions.

Those identifying themselves as willing to participate (i.e., passive consent), the data from their survey responses was pre-screened on the following criteria:

According to their interview responses

1. High participation or
2. High commitment

If deemed eligible, active consent (Appendix H) was obtained at the phone interview. If neither of the criteria was met, the respondent was not contacted or interviewed.

APPENDIX E. Clarkston Health Collaborative Key Informant Protocol (Qualitative)

Interview Protocol
Project: Clarkston Health Collaborative assessment to understand member engagement through participation and commitment

Time of interview: Beginning _____ Ending _____
Date:
Place:
Interviewer:
Interviewee:

(Introduction of study and briefly describe project) ***"I'm going to be asking you questions about 8 areas of the coalition's functioning. Please answer to the best of your ability as they relate to your experience as a member of the Clarkston Health Collaborative. With your consent, I will be taking notes while you answer, as well as tape recording your responses. The interview should take about 30 min."***

Questions:

PARTICIPATION/PARTICIPATION BENEFITS Questions

1. What keeps (or kept) you participating?
2. Are there personal benefits to your participation in the coalition? If so, how do you think these personal benefits affect your participation overall?

COMMITMENT Question

3. Why do you care about the work of the coalition?

MEMBER SATISFACTION Questions

4. How do you think member satisfaction affects participation? How do you think it affects your commitment?

LEADERSHIP/SOCIAL RESOURCES Questions

5. How do you think leadership affects participation, commitment, and satisfaction?
6. How might coalition leadership facilitate the discovery of resources in the community (e.g., community assets, opportunities for collaboration, funding, training, data)?
7. How does the identification of these community resources affect participation?

DECISION-MAKING Questions

8. How does the way decisions are made (i.e., collaboratively or by consensus) affect: member participation, member commitment, and member satisfaction?
9. How does the way decisions are made benefit you?

COMMUNICATION Questions

10. How do you think communication within the coalition (among members) affects your participation?
11. How do you think communication affects member satisfaction?

SENSE OF COMMUNITY/EMPOWERMENT Questions *(Just a few more questions to go!)*

12. How does your personal "sense of community" affect your participation in the coalition?
13. How does this sense of community affect your ability to get involved and change things in your community?
14. How does this sense of personal control and effectiveness affect your participation in the coalition?

SUSTAINABILITY Questions

15. Overall, why do you think the coalition is still around nearly 14 years after it got started, when so many people and other efforts have ended long ago?
16. Of all the elements of the coalition we've discussed today (give them a listing), which do you feel have the most impact on member engagement (that is, the combination of participation and commitment)?

Closing Comments: Well, that covers my questions. Is there anything I've not asked about that you think is important for me to know about the coalition?

1. Thank individual for participating in this interview. It will greatly assist research and community.
2. Assure them of confidentiality of their responses and a potential for future contact if additional clarity is needed.
3. Get their mailing address and inform them that an incentive and a confidentiality statement will be sent to them for their records within a week.

Format Source: Creswell, 1997

APPENDIX F. Qualitative Data Analysis Codebook (Primary Themes)

CODEBOOK

(primary themes, *N*=6)

Study Variables	Primary Themes
1. PARTICIPATION	Discusses attending monthly meetings of the coalition, being involved in the discussion or playing active roles, and length of participation/membership in coalition.
2. COMMITMENT	Expresses a feeling of care or concern for, or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in informing others of membership.
3. MEMBER SATISFACTION	Expresses a general feeling that the coalition is/has been adequately meeting personal and community needs.
4. LEADERSHIP	Makes explicit statements about the people/agencies that help facilitate the convening, discussion, information-gathering, and action steps of the coalition.
5. SOCIAL RESOURCES	Discusses the community resources that are identified or manifested as a result of the coalition's work (e.g., community assets, opportunities for collaboration, funding, training, data).
6. DECISION MAKING	Discusses the way that the coalition arrives at decisions or actions (e.g., collaborative, in group, by consensus, etc.).
7. COMMUNICATION	Discusses the methods used to communicate key information (e.g., minutes, agendas), and/or whether communication among members and external to the coalition is productive.
8. SENSE OF COMMUNITY	Discusses an individual (or collective) sense of connection and belonging to the community, or a feeling of unity and cohesion in the coalition.
9. EMPOWERMENT	Discusses a level of individual sense of control either as a result of being involved in the coalition, personal motivation to do something to help improve the community.
10. PARTICIPATION BENEFITS	Discusses the personal benefits realized as a participant of the coalition (e.g., improved public speaking, improved the way they do their job, new job opportunity, networking, support from others in community, personal recognition and respect, satisfaction in being involved in an important initiative).
11. SUSTAINABILITY	Discusses continuing the functioning and/or work of the coalition irrespective of traditional support structures of grant funding, formal membership, dues, etc.

APPENDIX G. Qualitative Data Analysis Codebook (Sub-Themes for Significant Relationships)

CODEBOOK

(common sub-themes, *N*=6)

Significant Relationships	Common Sub-Themes	refs/sources
Hypothesis 1		
Leadership – Social Resources	Makes explicit statements about how leaders who help facilitate the convening, discussion, information-gathering, and action steps of the coalition ***facilitate/bring about*** community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work.	**4/4**
Social Resources – Participation	Discusses the community resources (e.g., community assets, opportunities for collaboration, funding, training, data) that are identified or manifested as a result of the coalition's work, ***as reasons why*** they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles, and length of participation/membership in coalition.	**5/5**
Hypothesis 5		
Decision Making – Member Satisfaction	Discusses how the coalition arrives at decisions or actions (e.g., collaborative, in group, by consensus, etc.) ***leads to*** a general feeling of approval of/contentment with the way the coalition is/has been meeting personal or community needs.	**8/5**
Member Satisfaction – Commitment	Expresses general feelings of approval that the coalition is/has been adequately meeting personal/community needs which ***leads to*** a feeling of care or concern for, or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Hypothesis 6		
Leadership – Member Satisfaction	Makes statements about how leaders who help facilitate the convening, discussion, information-gathering, and action steps of the coalition ***facilitate/bring about*** a general approval/conentment with the way the coalition is/has been meeting personal and community needs.	**8/6**
Member Satisfaction – Commitment	Expresses how a general approval/conentment with the way the coalition is/has been meeting personal/community needs ***has facilitated*** a feeling of care or concern for, or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Additional Relationships		
Leadership – Commitment	Makes statements about how leaders who help facilitate the convening, discussion, and action steps of the coalition ***facilitate/bring about*** a feeling of care or concern for, or commitment to the work of the coalition, a desire to see it continue into the future, and/or pride in membership.	**6/6**
Sense of Community – Participation	Discusses how an individual/or collective sense of connection and belonging to the community, or a feeling of unity and cohesion in the coalition ***as reasons why*** they are attending monthly meetings of the coalition, being involved in the discussion or playing active roles.	**9/6**

APPENDIX H. Informed Consent

Georgia State University
Department of Psychology
Informed Consent

Title: Understanding Member Engagement through Participation and Commitment in a Community-Based Health Coalition, 1994-2008: A Mixed-Methodological Study

Principal Investigator: James Emshoff, Ph.D.

I. Purpose:

You are invited to be in a study. The purpose of the study is to find out how the Clarkston Health Collaborative, as a community coalition, has stayed active for nearly 14 years. Also, what keeps people participating and staying committed to the work of the group.

You are being chosen because you are a current or former member of the coalition. A total of 100 people out of over 300 was chosen for this study. This survey will require about 20 minutes of your time.

II. Procedures:

You will complete a survey covering 12 areas of coalition activities. Your identity will not be known. We will not tell you everything about the study in advance. When the study is over, we will tell you everything. At that time you can choose if you want to let us use your information or not.

III. Risks:

You will not have any more risks than you would in a normal day of life.

IV. Benefits:

Being in this study may not benefit you directly. We hope to learn why people continue be in community coalitions.

V. Voluntary:

Completing this survey is voluntary. You do not have to be in this study. If you decide to be in the study and change your mind, you can stop at any time. You may skip questions. If you stop, you will not lose any benefits you may have been promised.

VI. Privacy:

We will keep your answers private. We will use numbers and not your name on your answers. Only evaluators will have access to the information you provide. It was stored in a secure computer at Georgia State University and may be used for future research purposes. This is a safe survey and responses cannot be viewed on the internet.

VII. Contact Persons:

If you have questions about this study call James Emshoff at 404-413-6270, jemshoff@gsu.edu. If you have concerns about your rights as a participant in this study, contact Susan Vogtner at 404-413-3513 or svogtner1@gsu.edu.

VIII. Copy of Consent Form to Subject:

We will give you a copy of this consent form to keep.

If you are willing to volunteer for this research and, and volunteer to be interviewed and audio-recorded, please sign below.

_____ _____
Participant Date

_____ _____
Principal Investigator or Researcher Obtaining Consent Date

APPENDIX I. Survey Announcement/Recruitment of Coalition Members (E-Mail)

Clarkston Health Collaborative Assessment
Information/Assistance Needed
October 2007

Dear Clarkston Health Collaborative Member:

We need your assistance! In order to achieve our goals of creating a healthier environment for Clarkston residents and those who work and play in Clarkston, we need to continually engage in efforts to determine how we may strengthen and improve our efforts.

This year we will evaluate the Clarkston Health Collaborative. Because Clarkston Health Collaborative is an important vehicle for grassroots initiatives in Clarkston, and it has never been assessed, it is important that a thorough assessment is carried out. Through this assessment we plan to determine how the coalition is doing, what is keeping people engaged, and the ways it may be improved.

The survey is easily accessed by clicking on the link below. This is a very convenient way to make sure we get feedback from as many coalition members as possible. We need to hear your voice! Your cooperation is greatly appreciated.

You do not have to be a part of this assessment. If you have any questions, please notify Jim Emshoff at 404-413-6270. Your participation will help us identify steps we can take to strengthen and improve the Clarkston Health Collaborative. Thank you for your help!

Here's the link!
http://www.surveymonkey.com/s.aspx?sm=UQU1mts8gYGod5t8yTho_2bw_3d_3d

Best regards,

APPENDIX J. Survey Announcement/Recruitment Cover Letter (for mailed survey)

Clarkston Health Collaborative Assessment
Information/Assistance Needed
October 2007

Dear Clarkston Health Collaborative Member:

As you know, this year we are evaluating the Clarkston Health Collaborative. One way that we are gathering information about the coalition is through a member survey. This survey is intended to get feedback from you, the members, to determine how the coalition is doing, what is keeping people engaged, and the ways it may be improved.

Many members are able to complete this survey online. However, we only had a mailing address for you. For this reason, we are mailing you the survey to ensure that everyone has an opportunity to participate.

Your opinions are important to us! Please take the time to complete the attached survey and sign the consent form and return both to us in the enclosed self-addressed, stamped envelope by November ___, 2007. If you have any questions about the assessment project or about the member survey, please notify Jim Emshoff at 404-413-6270.

Thank you for helping make the Clarkston Health Collaborative even stronger!

Best regards,

Enclosures
Informed Consent Form
Survey
Self-addressed stamped envelope

APPENDIX K. Member Survey Reminder Email/Reminder Postcard

MEMBER SURVEY - REMINDER

Subject: SEND IN YOUR MEMBER SURVEY

This is just a reminder about the assessment of the Clarkston Health Collaborative coalition. By now you should have received a Clarkston Health Collaborative Member Survey in the mail or by e-mail. Through the survey we want to know your opinions about how the coalition is doing and how it may be improved and ways to keep members engaged. The feedback that you provide on this survey was used to make Clarkston Health Collaborative even stronger! So PLEASE take a few moments to complete the survey and return it.

Thanks to all of you who have taken the time to complete the Clarkston Health Collaborative Member Survey.

If you haven't had a chance to fill out the survey, please do so by next Friday, November____2007. The online survey will close on November ____.

If you have not received the survey in the mail or need another copy, contact Jim Emshoff at 404-413-6270 or email him at jemshoff@gsu.edu.

Your participation is greatly appreciated!! Thanks for your continued support.

APPENDIX L. Key Informant Interview Phone Script/Screening

Clarkston Health Collaborative Assessment
Information/Assistance Needed

Hi. My name is _____. I am a graduate student in the Department of Psychology at Georgia State University.

As you know, this year we are evaluating the Clarkston Health Collaborative. One way that we was gathering information about the coalition is through a member survey and secondly, through interviews with particular coalition members.

As part of the initial survey, you were given the option to participate in an interview so that we could get more information about the Clarkston Health Collaborative coalition.

You have been selected because you volunteered and have an important perspective to share on how the coalition is doing, its member participation and commitment and ways it can improve.

How long have you been a member of the Clarkston Health Collaborative? _____ ($\geq$ 6 months)

I would like to schedule a time that is convenient for a brief interview. The interview was less than an hour (approximately 30 minutes). What is a good day, time and public location for us to meet?

The survey you completed mentioned this, but I want to remind you that I was recording your responses so that I don't miss important points. Is that okay? (Read through consent form and get verbal consent. Inform participant that they will need to sign form at phone interview).

Your participation is greatly appreciated and will help us identify steps we can take to strengthen and improve the Clarkston Health Collaborative. If you do not wish to be a part of this assessment or have any questions, please notify Jim Emshoff at 404-413-6270.

Thank you for your time and I'll see you at _____on the _____, 2008.

APPENDIX M. Post-Study Debriefing script

The following study was established for the purpose of determining what factors support the continued commitment to and participation in the Clarkston Health Collaborative. These factors are important in determining why the effort has been sustained for nearly 14 years, and why it continues to remain vital.

The information gained from this study was critical to community in shaping the future of the collaborative, its leadership, its communication channels, its resource development and so forth.

As part of this study, the coalition facilitator, Christopher Holliday is also a graduate student in the Department of Psychology at Georgia State University. As part of his doctoral degree, he will use data obtained from the survey as a partial fulfillment of his requirements to obtain this degree.

It was necessary to conceal his identity as a researcher in this study to assure that everyone would answer questions about coalition leadership and management that may relate directly to his abilities as honestly as possible without feeling they might offend him.

Your responses, as noted in your initial consent will remain anonymous. Your answers will not be connected to your responses.