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Oportunidades a través de la colaboración
A Membership Evaluation of the Hispanic Health Coalition of Georgia

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This project was made possible by the Rollins School of Public Health, Emory University, and the Hispanic Health Coalition of Georgia (HHCGa). The HHCGa was founded in 1990, by a small group of dedicated health and social service workers. Today, nearly 20 years later, the HHCGa promotes health equity for all Latinos through empowerment, education, and advocacy, so that all Latino, regardless of their immigration status, have the opportunity to receive culturally and linguistically appropriate healthcare.

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Abstract

Oportunidades a través de la colaboración:
A Membership Evaluation of the Hispanic Health Coalition of Georgia

By Natasha Tatiana Ludwig-Barron

Latinos are the largest minority group in the U.S., accounting for 46.3% of the country's growth over the last ten years. During this period, Georgia's Latino population more than doubled and left many exposed to undesirable health determents, which have been associated with poor health outcomes. As a result, many healthcare institutions and staff are ill equipped, and provide less than adequate resources and services to Latinos.

Community health coalitions bring together diverse groups to collaborate on achieving a common goal; however, it is not clear what exactly makes them effective. Evaluations have focused on preventing or ameliorating disease (e.g. tobacco control),with the majority of studies focused on coalition formation. The Hispanic Health Coalition of Georgia (HHCGa), a group dedicated to achieving health equity for Latinos through empowerment, education, and advocacy. Guided by the Community Coalition Action Theory (CCAT), the purpose of this study was todetermine basic characteristics of the HHCGa: membership roles, contributing barriers and factors influencing member recruitment and involvement, perception of leadership and staff, coalition climate, desired communication processes, and coalition expectations. Key informant telephone interviews with five diverse members provided in-depth information on coalition history, membership roles, involvement and strategies used to engage members. An online survey was distributed through the HHCGa listserv and collected information on seven areas of interest. Interview findings categorized survey participants into: individual/organizational members, and leadership. Membership survey results showed the majority of the HHCGa are Latino, Fluent/Native Spanish-speakers, relatively new to the organization, and provided direct/continuum of care and educational services. Many members did not know their influence on coalition decision-making processes, but indicated networking and information sharing as reasons for involvement. Barriers included time constraints, work and other commitments, and members have an overall positive perception of the leadership and staff. The membership prefers weekly e-mail communication, with the majority being recruited via word-of-mouth. This data should be used as a precursor towards studies that intend to focus on membership evaluations, specifically for minority-focused health coalitions. Further evaluations should focus on HHCGa effectiveness in comparison with other minority-focused health coalitions, specifically, coalitions in post-development stages.

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Chapter 1:

Introduction

National Latino Demographics

Today, Latino's are the largest and fastest growing minority group in the United States, accounting for 50.5 million people in 2010, or 16.3% of the nation which consists of approximately 299 million people (US Census Bureau, 2010). From 2000 to 2010, the U.S. Latino population grew by 46.3% and accounted for over half of the nation's growth (US Census Bureau, 2010). For purposes of this study, we define Latino as being a person of Latin American decent (e.g. Mexican, Puerto Rican, Columbian, etc.), excluding Spanish or European decent, that identifies themselves as either first, second, or third generation Latino or Hispanic. This also includes those who identify as Chicano, Boricua, or hyphenated names (i.e. Mexican-American, Cuban-American, etc.). Latinos are comprised of several different ethnicities, with the majority of the U.S. Latinos being Mexican (66%), followed by Puerto Ricans (9%), Cubans (3.4%), Salvadorans (3.4%), Dominicans (2.8%), Central Americans (7.6%), South Americans (5.5%), and 7.7% of the Latino population self-identifying as "other" Latino ethnicities (US Census Bureau, 2000). On a national level, Mexicans comprise of approximately 7.3% of the total U.S. population in 2000, Puerto Ricans 1.2%, Cubans and Salvadorans 0.4% and a host of other Latin and South American ethnicities (US Census Bureau, 2000). Comparing demographics from all four regions of the U.S., Latinos accounted for 24.3% of the population in the West, 11.6% in the South, 9.8% in the Northeast and 4.9% in the Midwest (Guzman, 2001). Furthermore, 43.5% of all Latinos live in the West and 32.8% live in the South, making up nearly three-quarters of all Latinos living in the U.S., indicating that the majority of Latino-focused resources should be

concentrated in Western and Southern states; however, this is not necessarily the case (Guzman, 2001).

The major distinguishing factor in Latino culture is communication via a language other than English, which is usually Spanish, but can also be a Portuguese or an indigenous dialect. There are 35 million U.S. residents, or 12% of the population, age 5 years and older that speak Spanish at home; however, a greater majority (69%) are bilingual in English and Spanish (US Census Bureau, 2010). Additionally, 9% of Latinos are monolingual Spanish speakers, 22% are monolingual English-speakers and 0.4% speak a language other than English or Spanish at home (US Census Bureau, 2007). Much has been published on the medical system's inability to reduce language barriers and it effects on health outcomes, adherence to consistent prevention screenings, non-compliance to medical treatment and/or advice, and most alarming, misdiagnosis (Flores, 2006; Timmins, 2010). Although, language is not always a hindering factor, when used to communication within family units and social networks, it can be a mediating and/or moderating factor for increasing positive health outcomes (Mulvaney-Day, Alegria, &Sribney, 2007).

There were reportedly, 10.5 million Latino family households in 2009 of which 66% consisted of a married couples and 41% consisted of a married couples with children (US Census Bureau, 2010). In 2002, more than a quarter (26.5%) of Latino family households consisted of five or more people, in comparison to only 10.8% of non-Hispanic white families having the same family unit size (Ramirez & de la Cruz, 2003). On average, Latino households consisted of 3.4 people, compared with 2.5 people in non-Hispanic White households (US Census Bureau, 2007). Latino family units, as well as extended friends and family support, have repeatedly been shown to increase self-reported physical and mental health outcomes (Mulvaney-Day, Alegria, &Sribney, 2007; Finch & Vega, 2003). When

developing future health programs and services for Latinos, a holistic approach that incorporates social network, including familial units, is necessary to achieve optimum health results.

The majority Latinos living in the U.S., prove to be relatively young in comparison to the national average and other demographic ethnicities/races for persons, with many Latinos being less than 18 years of age. While minors, under the age of 18 years of age, represent 25.7% of the U.S. population, nearly 35% of all Latinos living in the U.S. are under the age of 18 (Guzman, 2001). Furthermore, nearly 26% of children under the age of 5 years in the U.S. are Latino, indicating that many industries, including healthcare and education, will have to shift their future strategic planning to be more inclusive of Latinos (US Census Bureau, 2007). One plausible reason for having a younger demographic, is due to the lower median age among Latinos, 25.9 years, which is 13 years younger than the non-Hispanic White population, with a average age of 40.1 years (US Census Bureau, 2007). In addition, approximately 5% of Latinos were age 65 or older, compared with 15% of non-Hispanic Whites (US Census Bureau, 2007). This indicates that many Latinos are within their "prime" working age, in comparison with non-Hispanic Whites, and fall within prime childbearing years.

Though many Latinos are within their prime working age, with 69% age 16 and older working in the civilian labor force, an alarming 23.2% live in poverty (US Census Bureau, 2010). Latinos typically work in service occupations, construction, maintenance, production and material moving occupations, or "blue-collar" jobs, where non-Hispanic Whites tend to work in managerial, professional, sales and office occupations, or "white-collar" jobs (US Census Bureau, 2007). The median income for Latino households was approximately $36,000, which is less than three-quarters of the median income for non-Hispanic White

households, which was approximately $48,800 (US Census Bureau, 2007). As an outcome of working in low-wage occupations, nearly 30.7% of Latinos lack health insurance, which is a major barrier for receiving annual physical exams, used to identify health issues before they become severe concerns (US Census Bureau, 2010). Without health insurance, many Latinos are forced to use "wait and see" methods and typically receive care after an illness has progressed.

A limiting factor in high income attainment for Latinos the low prevalence of higher educational attainment. Approximately 62% of Latinos age 25 and older were high school graduates and about 13% had a bachelor's degree or more education, in comparison with non-Hispanic whites age 25 years and older, with 89% achieving a high school education and about 30% who had earned a bachelor's degree or higher education (US Census Bureau, 2007). This low college attendance rate, translates into less Latinos being able to provide direct, professional and culturally relevant services to Latino communities. In 2010, there were 79,440 Latino chief executives; 48,720 Latino postsecondary teachers; and 50,866 Latino physicians and surgeons (US Census Bureau, 2010). Now, more than ever, there is a need to provide health programs and services to Latinos; however, this is limited number of Latinos professionals who can provide these services and very few academic institutions that provide cultural competency/humility trainings to educate their students.

Finally, approximately 47% of Latinos are foreign-born with the majority living in the Southwestern states; however, this number is probably much lower than the actual number as many undocumented Latinos do not complete the census form for fear of being deported or incarcerated. Birth place of origin is important when considering how to best deliver services to Latinos, when upwards of half of the Latino population are unfamiliar with the U.S. medical system. A need for low-literacy educational materials, linguistically

appropriate health prevention programs and services delivered by culturally competent professionals, will help reduce health barriers between Latino communities and the medical/health institutions.

Latino Demographics in Georgia

The State of Georgia ranked within the top five states to have major increases in Latinos/Hispanics, with estimates of upwards of a 300% increase from 2000-2006 (NCLR, 2005). Falling second to Arkansas as having highest national increase in Latinos, Georgia's Latino population more than doubled, revealing a 59.4% increase in population size from 2000-2010 (US Census Bureau, 2010). Like many immigrant populations, dependence on existing social networks and job opportunities, plays a major role when deciding on a location to settle. For this reason, more than half of the state's Latino population resides within the following six counties: Gwinnett (20.1%), Cobb (12.3%), DeKalb (9.8%), Fulton (7.9%) and Clayton (13.7%), all spanning approximately 60 miles or less from Metro Atlanta (NALEO, 2010). Of Latinos living in Georgia, more than half are foreign born (52%) and they comprise of approximately 4% of the state (Pew Hispanic Center, 2008). These recent findings have sparked concern, specifically in the medical community, as most health professionals have not had adequate training on how to provide culturally appropriate services to Latinos.

Georgia's Latino population, now representing 8.8% of the state, is comprised of a relatively younger demographic, similar to national data findings (Docktermanm& Velasco, 2010; Pew Hispanic Center, 2008). Latinos living in Georgia have a median age of 25 years and over one-third (37%) were age 18 years or younger. In comparison, the State's overall median age is 34.6 years with 25% of all non-Latinos being age 18 years or younger (US Census Bureau, 2010; Pew Hispanic Center, 2008). Considering ethnic/racial groups,

Georgia's African American/Black population shows a median age of 31 years and the non-Hispanic White population shows a median age of 38 years, exhibiting similar findings to national data and emphasizing the Healthy Migrant Theory (HMT) (Abraído-Lanza, Dohrenwend, Ng-Mak, & Turner, 1983). Specifically, the HMT postulates that migration is selective based upon individual-level characteristics (i.e. younger, healthier populations) that positively favor their ability to migrate (Abraído-Lanza, 1983; Pew Hispanic Center, 2008). The theory gives rationale for Latinos' younger age composition, optimal working age and reproductive age range (Pew Hispanic Center, 2008).

When considering Georgia's educational systems and work force, Latino K-12 students make up 10% of the state's students and, similar to national findings, Latino employment is comprised of blue-collar jobs in agricultural industries, factories, service occupations, construction, and maintenance (Pew Hispanic Center, 2008). Latino's have the lowest education attainment in comparison with adults ages 25 years and older who are non-Hispanic white and/or African American/Black. Approximately, 43% of Latinos age 25 years and older do not graduate high school or have a GED, compared with Georgia's non-Hispanic white population (12%) and African American/Black population (18%) (Pew Hispanic Center, 2008). Education levels typically translate into more opportunity (i.e. better jobs, higher pay, better benefits, high quality of living, etc.) This translates into Latino's having the lowest median annual income, approximately $19,349, compared with the Non-Hispanic white population, who earn $32,588, and the African American/Black population who earn $25,460 (Docktermanm& Velasco, 2010). In addition, many Latinos/Hispanics under the age of 17 years live in poverty, approximately 31%, which is the same in for the African American/Black population, but is quite different for the non-Hispanic white population under the age of 17 years, where approximately 10% live in poverty (Pew

Hispanic Center, 2008; Docktermanm & Velasco, 2010). The poverty gap only intensifies with age,with approximately 20% of Latinos, age 18-64 years, living in poverty compared with Georgia's African American/Black population, 14%, and Non-Hispanic White population, 3% (Pew Hispanic Center, 2008; Docktermanm & Velasco, 2010). Lack of education, low-income levels, and high poverty rates are all indicators that influence health outcomes.

Access to Healthcare Leads toLatino Health Disparities

The growth of the Latino population in Georgia has brought attention to the challenges that this community faces. Compared to other racial/ethnic groups in Georgia, Latinos experience greater language barriers and are the less likely to have health insurance (The Kaiser Family Foundation, 2003; US Census Bureau, 2010). Coupled with increasing anti-immigrant sentiment throughout the country, Latinos face overwhelming challenges in accessing basic healthcare services. In general, low socioeconomic factors (e.g., education, employment, and poverty), poor lifestyle behaviors (e.g., physical activity and alcohol intake), poor social environment (e.g., educational and economic opportunities, discrimination, and neighborhood and work conditions), and less access to preventive health-care services (e.g., cancer screening and vaccination) all contribute to racial/ethnic health disparities (Williams, Neighbors, & Jackson, 2003).

Latino health disparities include barriers faced when attempting to access the healthcare system, including structural, institutional, and cultural barriers. Structural barriers include the following: 1) policies that restrict many legal immigrants' access to government-sponsored programs such as Medicaid and the State Children's Health Insurance Program (SCHIP); 2) fear of being considered a public charge if government services are used; and 3) anti-immigrant legislation that seeks to prohibit undocumented immigrants' access to critical

public health services(NCLR, 2008). Institutional barriers include hours of operation that are not compatible with patients' work schedules and lack of Spanish-speaking staff or interpreters (NCLR, 2008). Finally, cultural barriers include limited English proficiency (LEP), lack of knowledge of the U.S. healthcare system, and differing health beliefs (NCLR, 2008). Though these barriers are not unique to Latinos, given the large number ofLatino immigrants in the state, this group is more likely than other racial and ethnic groups to face these and other challenges.

When it comes to health risk indicators, lack of health insurance can often predict poorer health outcomes in a population because it creates substantial barriers to obtaining timely and appropriate medical care (The Kaiser Family Foundation, 2003). Without health insurance, patients are more likely to postpone medical care, go without necessary medical treatments and go without prescription medicines (The Kaiser Family Foundation, 2003). The principal reason that so many Latinos lack health insurance is that employers often do not offer it as a benefit (NCLR, 2008). Latinos are principally concentratedin the service industry, which is less likely to provide health insurance as a benefit (US Census Bureau, 2010; Pew Hispanic Center, 2008). Only 4% of Latinos in Georgia have employer-sponsored health insurance compared to 10% of Latinos nationally (The Kaiser Family Foundation, 2003). Lack of medical care often translates into individuals utilizing tertiary medical services to solve their health issues, which is less cost effective compared to using primary or even secondary prevention measures (WHO, 2010). In Georgia, approximately 25% of U.S. born and 71% of foreign born Latinos do not have insurance, compared to 22% of African American/Blacks and 14% of Non-Hispanic Whites (Livingston, Minushkin, & Cohn, 2008). More than 43% of elderly Latinos did not have health insurance, despite their participation in the labor force (Pew Hispanic Center, 2008). Additionally, when

employers offer insurance, Latinos often do not understandthe policies, the information is not presented in their predominate language or they believe that the premiums are too high and choose not to participate (The Kaiser Family Foundation, 2003; NCLR, 2008).

Furthermore, the lack of bilingual and bicultural providers throughout Georgia provides an additional barrier when accessing the healthcare system. Recent studies indicate that the Latino pediatrician-to-child ratio is expected to decrease from 17 Latino pediatricians per 100,000 children, to nine per 100,000 by 2025 (NCLR, 2008). In 2006, approximately 2.3% of nonfederal physicians were Latino, and between 2003 and 2004 only eight Hispanics graduated from Georgia's medical schools (NCLR, 2008). The importance of racial and ethnic diversity among physicians and medical staff has been associated with higher satisfaction ratings and higher health outcomes (NCLR, 2008; Timmins, 2010). The limited supply of bilingual and bicultural healthcare professionals widens the linguistic and cultural gap, which contributes to a system in which Latinos and the healthcare professionals who treat them are unable to communicate effectively (Timmins, 2010). A recent surveillance study of Georgia clinics indicated that several locations refuse to serve non-English-speaking Hispanics unless there is an interpreter available, which creates considerable controversy in who can and cannot access professional healthcare services (NCLR, 2008).

An additional barrier to accessing care is lack of transportation, and unfortunately, Georgia's public transportation infrastructure is limited. The city of Atlanta provides light rail and bus service; however, the majority of Latinos live in areas where public transportation is sparse (Soler, 2000). Bus lines often offer limited service at inconvenient hours, which is a significant barrier to healthcare access for Latinos own a form of transportation, which is especially true for migrant workers. In a needs assessment

conducted by Children's Healthcare of Atlanta, most parents reported driving their own car or taking a taxicab when their children needed to see a physician (Soler, 2000). Having services located in close proximity to a public transportation system is a critical component of extending services to the Latino community.

In addition to not knowing the language, many Latinos lack knowledge of how the U.S. health care system operates (NCLR, 2008). More often than not, Latino immigrants do not understand the concept of insurance since many Latin American countries provide subsidized healthcare, sponsored by the local government. Also, mixed messages about services provided to undocumented Latinos most definitely contribute to immigrants' reluctance to apply for or use services, even though they or their children may be eligible to receive low or no cost healthcare services (The Kaiser Family Foundation, 2003). Many Latinos are confused about how to access care, do not know where to go to receive services nor do they know where to find educational aides to navigate through the healthcare system (NCLR, 2008). A recent needs assessment indicated that Latinos lacked access to basic health information, with more than eight out of ten Latino parents said they did not know where to find health education materials in Spanish (Soler, 2000). Despite not having access to linguistically appropriate health information, Latinos living in Georgia have a desire to learn and should have the opportunity to be informed of their healthcare options.

Since 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) has restricted many undocumented immigrants from accessing government-funded programs (NCLR, 2008). Medicaid and SCHIP are two of the many targeted programs which instituted a five-year bar to services for immigrants who entered the country without the correct paperwork after the passage of PRWORA (NCLR, 2008). Despite the fact that immigrants pay taxes to support the U.S. medical system, they are denied access

during a period in which they are most vulnerable and working to establish themselves in a new country (NCLR, 2008). In addition, PRWORA created unease and caused immigrants to be labeled as a public burden, thus, further stigmatizing Latinos (NCLR, 2006). Within the Latino community, PRWORA established a sense of fear and distrust of local medical institutions.

Unfortunately, policy and government entities are seen as major contributors to the Latino community's poor socioeconomic environment, leading to unfavorable health outcomes. Low educational attainment, contributes to the disproportionate amount of Latinos, versus non-Hispanic whites, working in lower salaried service occupations (Ramirez & de la Cruz, 2003). In several public health studies, higher incomes were associated with increased access to medical care, enabled people to afford better housing and live in safer neighborhoods, and increased the opportunities to engage in health-promoting behaviors (Williams, Neighbors, & Jackson, 2003). In 2002, 21.4% of Latinos were living at or below the poverty line, compared with 7.8% of non-Hispanic whites, and of the 17.7% of Latino children living the U.S., 30.4% were living in poverty (Ramirez & de la Cruz, 2003). Finally, lower-income Latinos were also more likely than non-Hispanic whites to be exposed to urban violence contributing to lower health outcomes and living standards.

One of the more recent health findings, the Latino Paradox or Epidemiological Paradox, associates diminished health outcomes with time spent living in the U.S. (Hayes-Bautista, 2002; Abraído-Lanza, Chao, & Flórez, 2009). The longer Latinos live in the U.S. and adapt U.S. lifestyle behaviors (i.e., sedentary behaviors, eating less nutritious foods, etc.), the worse their health outcomes become (Hayes-Bautista, 2002). Length of stay in the U.S. was also associated with a greater likelihood of high alcohol intake, smoking and a high BMI (Abraído-Lanza, Chao, & Flórez, 2009). Previous studies indicate, foreign-born Latinos

have longer life-expectancies, deliver less low-birth weight babies and have a lower infant mortality rate than do Latinos born in the U.S. (Hayes-Bautista, 2002; Morales, Lara, Kington, Valdez, & Escarce, 2002). Nearly, 75% of Latinos were U.S. citizens, either through birth (approximately 61%) or naturalization (approximately 11%) and it is estimated approximately 28% of Latinos were foreign born and had not become U.S. citizens (Pew Hispanic Center, 2008). As Latinos become U.S. citizens and gain more opportunities to access healthcare services, there is a considerable trade-off for less favorable health outcomes.

In addition, being able to understand the health messages and having the ability to communicate with healthcare professionals can determine one's medical outcomes. Patients, particularly Latinos, who face language barriers can have deleterious health outcomes; are less likely than others to utilize professional medical services; are dependent on tertiary prevention (i.e., emergency room care); and have an increased risk of non-adherence to medical advice (Flores, et al., 2003; Flores, 2005). An estimated 49.6 million Americans or 18.7% of U.S. residents speak a language other than English at home; 22.3 million, or 8.4%, have limited English proficiency (LEP), speaking English less than "very well," according to self-ratings (Flores, 2006). Between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million, a 47% increase, and the number with of individuals with LEP grew by 7.3 million, a 53% increase (Flores, 2006). Predictably, in Georgia where Latino communities are increasing, an estimated 84% of residents indicated they speak a language other than English at home(Livingston, Minushkin, & Cohn, 2008).

Now more than ever, there is an unprecedented need for more public health research focusing on Latinos, so that programs and services can better address their healthcare

needs. Up until recently, research has heavily focused on quantitative research methods; however, there has been a shift in the public health methodology, from predominately quantitative studies to a mixed methods approach of combining qualitative methods, which serves to interpret the relevance, nature, and underlying framework of a research question.

Importance of Latino Health Coalitions

Traditionally, health coalitions form out of cause or need to prevent or lessen the burden of a particular disease (e.g., tobacco use, cancer, cardiovascular disease, etc.); however, many of the coalitions do not focus their attention on one particular minority group (The Community Guide, 2010). Coalitions that have represented minority groups (e.g., African Americans, Latinos, etc.) are typically found in policy work surrounding themes of civil rights, social justice and/or human rights; however, many health focused coalitions cite that cultural competence and relevance are key components in developing effective coalitions (Depke & Onitilo, 2011; Foster-Fishman, Berkowitz, Lounsbury, Jacobson, & Allen, 2001). Furthermore, several studies have shown how the knowledgeable use of cultural approaches and strategies such as rituals, celebrations, affirmations, communal meals, music, art, dance, proverbs, and language can help create a spirit of confidence, cooperation and collaboration (Kennon & Jackson, 2002). A national study by the Department of Health and Human Services (DHHS), Human Resources and Services Administration (HRSA) deemed that culturally competency "works" to improve patient health outcomes (2001). Several Latino health intervention studies support this evidence and indicate that when Latinos are provided medical care in culturally and linguistically appropriate manner, they adhere to professional medical advice, have a positive experience with the healthcare service provider and they are more empowered to lead a healthful life (HRSA, 2001).

Recently, there has been a major push towards the Patient Centered Care Model, which promotes care that considers a patients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles (Stewart, 2001; Mead & Bower, 2002). The model advocates for patients and their loved ones to be an integral part and collaborators of the medical team who makes clinical decisions based on academic and professional experience (Stewart, 2001; Mead & Bower, 2002). It is a holistic way of treating a patient and not the particular disease, but more importantly, it empowers patients to make important decisions regarding self-care and monitoring (Stewart, 2001; Mead & Bower, 2002). Patient-centered care ensures that transitions between providers, departments, and healthcare settings are respectful, coordinated, and efficient (Stewart, 2001; Mead & Bower, 2002). In addition, when care is patient centered, unneeded and unwanted services can be reduced, which improves the cost-effectiveness surrounding a patient's care (Stewart, 2001; Mead & Bower, 2002). This multi-faceted approach involves the collaboration of organizations that can work together and identify best practices and systematic improvements that enable patient-centered care in three areas:

1. Involving patients and families in the design of care
2. Reliably meeting patient's needs and preferences
3. Informed shared decision-making

It is the underlying factors and conditions, which are most recognizable in when analyzing Latino health through minority focused coalitions versus disease-focused interventions. The patient centered care approach, although it was unintentional, has guided the vision and mission of the Hispanic Health Coalition of Georgia.

Hispanic Health Coalition of Georgia

The Hispanic Health Coalition of Georgia, Inc. (HHCGa) is one of the few nonprofit organizations dedicated to promoting health and social change in Latino communities throughout Georgia. The collaborative provides a professional platform for networking and connecting like-minded organizations, companies, institutions and individuals in Georgia to establish relationships and to dedicate themselves to serving Latinos in Georgia, through leadership, education, advocacy and service. Moreover, Georgia has the second fastest-growing Latino population of any state in the nation, and the HHCGa recognizes the urgent need for awareness and providing quality healthcare services to Latino communities.

Since 1990, HHCGa has been proactive in addressing the critical needs within the Latino community and is solution-driven, by coordinating resources for Spanish-speaking clients from all sectors of health and human services in Georgia. Their program activities focus on strengthening Georgia-based healthcare organizations by bringing awareness to the need of culturally and linguistically appropriate, professional healthcare services, advocating improving access to quality healthcare services, providing health promotion/education initiatives in the Latino community and promoting new policies that protect the rights of Latinos for better health. They aim to empower the Latino community to achieve optimum health and wellbeing, which in turn, improves the future for all citizens of Georgia.

The HHCGa recently transitioned a new executive board on June 2009, a new President was elected to serve a two-year term, and in Summer 2010, a new Executive Director and Program Coordinator were hired. Their mutual decision to assess and evaluate the current membership as a quality assurance measure and provide suggestions on how to improve recruitment and retention was identified as a priority.

Problem Statement

Up until recently, most coalitions located in the southern U.S. have focused on providing solutions to disease-specific issues, social determinants of health and/or policy changes; however, the HHCGa, aims to solve some of the most devastating health issues for a particular minority group, Latinos, living in the South. To date, the HHCGa has undergone two internal process evaluations since it launch in 1993, but has not had opportunity to evaluate its membership.

Since their incorporation in 2001, the Coalition's vision and mission has gradually shifted from a purely networking organization for Latino-serving organizations to come together to learn of reliable services, to an action-oriented coalition. The HHCGa has made several strides in policy amendments and proposals that serve to benefit Latino health. Within the past five years, some of their greatest accomplishments include bringing together over 100 stakeholders (i.e. business, researchers, media experts, healthcare providers, politicians, etc.), ensuring medical facilities were using certified medical translators and working with vitality departments to ensure that Latino newborns were assigned the correct names on their birth certificates. Many of the HHCGa leadership would like to know how they might better serve the needs of its members, while continuing to foster a unified mission.

Purpose

The purpose of this study is to evaluate the functioning of the Hispanic Health Coalition of Georgia (HHCGA) and identify its internal strengths and weaknesses using an online survey development software program. In order gain depth and perspective, the survey was distributed to active and inactive members, plus all staff and leadership positions,

to understand how perspectives differ across the groups. Feedback from survey responses will (1) help guide strategic marketing plans to recruit new prospective coalition members, (2) provide a retention plan to keep current members engaged in HHCGA's activities' and (3) provide direction on making the coalition more efficient and effective, including the revitalization of the three-year strategic goals. Like many other community coalition-focused studies, the use of member satisfaction and participation will aid in intermediate measures of coalition effectiveness (Kegler, Steckler, Malek, & McLeroy, 1998). In addition, this membership evaluation, based on perceptions and attitudes toward the HHCGa's operations and processes, membership engagement, leadership/staffing, organizational climate and diversity/culture will allow for informed coalition modifications. All constructs, with the exception of the diversity and culture construct, have been previous identified in previous coalition evaluation research and The Community Coalition Action Theory.

Theoretical Framework: The Community Coalition Action Theory (CCAT)

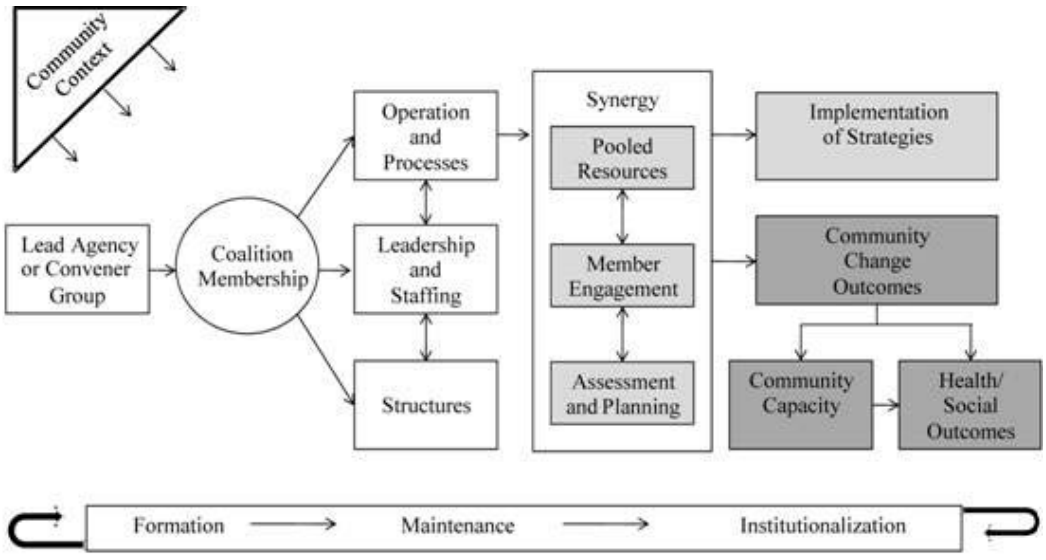
As an action oriented partnership, a coalition usually focuses on preventing or diminishing a community problem by analyzing the problem; gathering data and assessing needs; developing an action plan with identified solutions; implementing solutions; achieving outcomes; and creating social change (Butterfoss & Kegler, 2002). It is one of only a few comprehensive coalition theories posed in the literature that comprehensively addresses the key components of community coalitions through their precise stages of development. CCAT hinges on the definition of community coalitions, a specific type of coalition, that consists of "a group of individuals representing diverse organizations, factions, or constituencies within the community who agree to work together to achieve a common goal"(Butterfoss & Kegler, 2002, p. 157).

The CCAT is comprised of fourteen major constructs and 23 propositions, which

relate-back to the various constructs. The constructs and propositions provide an underlying framework for understanding the processes, structures, and outcomes experienced by effective community coalitions, depicted in Figure 1. For the purposes of this study, the CCAT will provide a roadmap for maintaining an effective coalition and will provide a basis for evaluating coalition effectiveness for the HHCGa.

Much of a coalitions success is formulated in Construct 1, the Stages of Development, which is broken down into two propositions. The first proposition states that coalition building tends to be cyclical and unique to each coalition, based upon situation and need. The three stages include (1) formation, (2) maintenance, and (3) institutionalization. While these names have slight variations from study to study, the majority agree that common activities occur over the lifespan of a coalition, including recruiting, mobilizing

Figure 1: The Community Coalition Action Theory (CCAT)



Source: Toward a Comprehensive Understanding of Community Coalitions, Butterfoss & Kegler, 2002.

members, establishing organizational structure, building capacity, planning for action, implementation of strategies, evaluating outcomes, and institutionalizing strategies

(Butterfoss & Kegler, 2002). The second proposition, states that at each stage, specific factors enhance coalition function and progression to the next stage (Butterfoss & Kegler, 2002).

During coalition formation, or Stage 1, a convener or lead agency brings together a core group of organizations that will then recruit the initial members. Leaders and staff are identified and structural elements such as committees, rules, and operating procedures are developed (Butterfoss & Kegler, 2002). Generally, this stage demonstrates that participation is enhanced when members feel benefits of participation outweigh costs (Rogers, Howard-Pitney, Feighery, Altman, Endres, & Roeseler, 1993; Butterfoss & Kegler, 2002). Key factors in the formation stage include resources exchanged by potential members that lead to inter-organizational collaboration, payoffs for coalition members, and adequate size of a core group (Butterfoss & Kegler, 2002). In addition, a concise and clear mission, vision or purpose seems to be a key element of successful formation (Butterfoss, Goodman, & Wandersman, 1993). The process of formation is most notably influenced by community context, history, leadership, membership, structure, and processesto name a few characteristics(Butterfoss & Kegler, 2002). Comparisons of other coalition evaluations located in the South, found that trust, politics, history of collaboration, geography, and community readiness can greatly influence coalition formation (Butterfoss, Lachance, & Orians, 2006). Also, leadership characteristics including a strong administrative and management infrastructure, existing community relationships, and understanding and support for coalition efforts, were all found to be important to formation and intermediate outcomes (Butterfoss, Lachance, & Orians, 2006). Coalition processes such as frequent, productive communication, member influence in decision-making, and conflict resolution were seen as catalytic factors for intermediate outcome achievement (Butterfoss, Lachance,

& Orians, 2006). Effective structural characteristics were found to be formalized rules, roles, structures, and procedures (e.g., steering committees, subcommittees, rules of operation, by laws, policy statements, mission statements, written goals and objectives, regular meetings with agendas, clear communication, etc.) (Butterfoss, Lachance, & Orians, 2006). Finally, core members of a coalition, or the *veteranos,* were seen as key instruments to a coalition's initial success, in addition to member experience(s), commitment, diversity, and lack of conflict (Butterfoss, Lachance, & Orians, 2006).

During Stage 2 of coalition development, otherwise known as coalition maintenance, characteristics of success have most notably included sustaining member involvement and recruitment of new members, implementing competent processes and concrete action(s), acquiring member and external resources, and identifying positive results (Butterfoss & Kegler, 2002). Identifying factors that contribute to the implementation and maintenance of coalitions including degree of formality, leader and member characteristics, organizational climate, and relationships with external supports (Butterfoss, Goodman, & Wandersman, 1993). Several additional factors have been shown to enhance implementation, which are analyzed based on the number of activities completed (i.e., coalition vision, skilled staff with time to work on activities, frequent and productive communication, cohesion and/or sense of belonging, and complexity of coalition structure (Kegler, Steckler, Malek, & McLeroy, 1998). More specifically, 12 measures in the CCAT include items around leadership, decision-making, communication, conflict, benefits and costs, organizational climate, staffing, capacity building, member profile, recruitment pattern, organizational structure, and community capacity. Barriers to successful implementation include staff turnover, staff lacking community organization skills, dependence on state-level staff during planning, and lack of member input into action plan (Kegler, Steckler, Malek, & McLeroy, 1998). Also,

previous works suggest that members can be satisfied and actively involved but not accomplishing meaningful change or established goals (Kegler, Steckler, Malek, & McLeroy, 1998).

Finally, Stage 3, or the institutionalization stage is important for long-term sustainability of programmatic interventions and of the coalition itself. Included in this stage is building community capacity to solve new challenges that arise (Butterfoss & Kegler, 2002). Sustainability should be viewed as a global, dynamic process that does not imply a static program and should start early in the project's development (Butterfoss & Kegler, 2002; Bracht, et al., 1994). It encompasses several aspects or strategies including maintaining the benefits of the program over time, resource development and maintaining a funded infrastructure as key to sustaining activities and outcomes and building community capacity (Bracht, et al., 1994). Community entities, funding agencies, and broader society have cause for concern when program termination occurs at the point of termination of funding rather than when objectives have been achieved (Kegler, Steckler, Malek, & McLeroy, 1998). Most programs require significant costs to move them from theory to reality, and are perceived as a poor usage of resources when final outcomes are not achieved. Unfortunately, these effects can have long-lasting effects as program staff, community coalition members and the broader community can demonstrate a loss of trust and support for future program implementation when programs are terminated inappropriately (Bracht, et al., 1994).

Research Questions

The following questions were developed in collaboration with the HHCGa and guided the evaluation:

1. What are the basic characteristics of the HHCGa (i.e., age, ethnicity, language preference, educational attainment, service offered to the Latino/Hispanic Community, etc.)
2. What role do members play in the coalition?
3. What are the barriers and factors that contribute to member recruitment and involvement?
4. What is the perception of the leadership, staff and overall coalition cohesion?
5. What is the preferred method of communication?
6. What are the expectations of the membership and to what extent have those expectations been met?

Assumptions

Prior to this study, an evaluability assessment had not been conducted on the Hispanic Health Coalition of Georgia, and it was assumed that the HHCGa was capable of undergoing a membership evaluation. It was assumed that members, or participants of this study, were willing to provide honest and accurate responses based on their prior experiences with the HHCGa. More broadly, it is assumed that entities within Georgia (e.g., residents, organizations, political stakeholders, etc.), see the value and need to support coalitions that aim to ameliorate Latino health issues given Georgia's historical context of racial segregation, conservative views and unsettled ruminants stemming from the Civil Rights Movement. Thus, we are assuming that there are no external forces influencing membership involvement, or lack there of.

Definition of Terms

- Active member – An individual who has attended or contributed to at least one HHCGa event in the last year or if they have paid their annual membership dues.
- Capacity building – Knowledge and skills transferred to coalition members and their organizations through technical assistance and training, and the inter-organizational linkages created through the coalition (Kegler, Steckler, Malek, & McLeroy, 1998).
- Coalition – An action oriented, collective partnership usually focusing on prevention or ameliorating a community problem by analyzing the problem; gathering data and assessing need; developing an action plan with identified solutions; implementing solutions; achieving outcomes; and creating social change (Butterfoss & Kegler, 2002)
- Coalition satisfaction – A dimension of membership engagement, satisfaction refers to coalition members' fulfillment of needs and expectations.
- Cohesion – As it refers to organizational climate, a coalition's ability to unite and ensure a sentiment of togetherness is felt between all group.
- Communication – The activity of conveying information between the coalition's internal and external groups (i.e. leadership, staff, membership, and general public).
- Community Coalition Action Theory (CCAT) – An evidence-based theory, comprised of 14 constructs and 23 propositions, provides an underlying framework for understanding the processes, structures, and outcomes experienced by effective community coalitions (Butterfoss & Kegler, 2002).

- Decision-making – The role that coalition members play in offering opinions, solutions and strategies to the coalition.
- Diversity – The inclusion of multiple groups (i.e., cultures, ethnicity and/or racial groups, healthcare services, education, expertise, health professions, etc.).
- Ethnic minority (simplified "minority") – According the CDC's Office of Minority Health & Health Disparities, racial and ethnic minority populations are defined as American Indian and Alaska Native, Asian, black or African American, Hispanic or Latino, and Native Hawaiian and Other Pacific Islander (CDC, 2009).
- Hispanic – Term coined by the federal government in the 1970's to represent Latinos, and used interchangeably with the term "Latino" in the U.S. It is most often used in federal demographic reports, and typically seen as more institutional, conservative and external to the community.
- Latino - a person of Latin American decent (e.g. Mexican, Puerto Rican, Columbian, etc.), excluding Spanish or European decent, that identifies themselves as either first, second, or third generation Latino or Hispanic. This would also include those who identify as Chicano, Boricua, or hyphenated names (i.e., Mexican-American, Cuban-American, etc.) This term will be used throughout the study. Currently, this seems to be the preferred choice of many advocates as it denotes stronger ties to Latin American and indigenous ancestry and less of an emphasis on Spanish, or European, colonization.
- Leadership & Staffing – This refers to the HHCGa collection of Board Members (11) and staff-members (2) which organize the coalition's structure and are

responsible for coalition processes (i.e., communication, decision making, etc.) that keep coalition members engaged and satisfied (Butterfoss & Kegler, 2002).

- Non-active member – An individual that has not attended or contributed to the at least one event or cause in the last year, have not paid their membership dues, and/or deems their status to be "in-active."
- Membership engagement–The process by which members are empowered and develop a sense of belonging to a coalition. Evaluation techniques focus questions on the memberships' satisfaction, participation and commitment (Butterfoss & Kegler, 2002).
- Membership involvement – Extent and ways that members participate on the coalition (i.e., activities, meetings, etc.) In CCAT, involvement is synonymous with participation, and is applied to membership engagement.
- Patient Centered Medical Home - A health care setting that facilitates partnerships between individual patients, their personal physicians, and when appropriate, the patient's family and/or caregivers. Comprised of six different standards, including six must pass elements, which can result in one of three levels of recognition (Nutting, Miller, Crabtree, Jaen, Stewart, & Stange, 2009).
- Undocumented Immigrant - This term describes the immigration status of people who do not have the federal documentation to show they are legally entitled to work, visit or live the U.S. Some Latinos say this term more accurately describes people who are in the U.S. illegally because the word points out that they are undocumented, but does not dehumanize them in the manner that terms like "aliens" and "illegals" do (NAHJ, 2011).

- Underinsured – When someone finds that their insurance does not cover all of the necessary medical expenses, and as a result must pay an out-of-pocket difference. This sub-population is vastly growing as insurance becomes more expensive and employers can no longer afford full-coverage medical plans for their employees (Schoen, Collins, Kriss, & Dotty, 2008)

Chapter 2:

Literature Review

A membership evaluation was conducted on the Hispanic Health Coalition of Georgia, the only coalition that specifically addresses the healthcare needs of the Latino community. This section reviews Latino social, environmental and institutional determinants of health as it pertains to the Southern United States, with an emphasis on the leading causes of death for Latinos. In addition, we will discuss action-driven, community-based health coalitions, including the benefits and challenges they face, as they compare to other coalitions cited in the literature. Finally, the Community Coalition Action Theory (CCAT) serves as the theoretical framework which guided the evaluation.

Determinants of Latino Health

The WHO defines determinates of health as factors that combine together to affect the health of individuals and communities (WHO, 2011). These are categorized into three areas, which include social and economic environment, physical environment and individual characteristics and/or behaviors (WHO, 2011). Examples that have been widely studied include neighborhoods, the state of our environment, genetics, income level, education and intimate relationships with regards to health (WHO, 2011). This section will focus on socioeconomics and physical environment, as it pertains to Latino health.

The growth of Latinos, deemed the largest and most diverse minority group in the U.S., presents challenges and opportunities for health professionals, leaders and policy makers. Historically, it had been assumed that Latinos have some of the worst

health outcomes, similar to other ethically and racially diverse groups that fall in the lower socioeconomic range; however, evidence suggests that this is not always the case (Hayes-Bautista, 2002). The Latino Paradox, also referred to as the Hispanic Paradox or the Epidemiological Paradox, suggests that there is a correlation between Latinos' health and their generational status (i.e., first, second, third, etc.) (Hayes-Bautista, 2002; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). First generation immigrants, exhibit better health outcomes than expected, given their low socioeconomic status for infant mortality rates, low birth rates and all-causes mortality rates when controlling for age and gender across other racial/ethnic groups (Hayes-Bautista, 2002; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Latinos also live 2.5 years longer on average, compared with non-Hispanic whites (Hayes-Bautista, 2002). It is when Latinos become more acculturated with U.S. lifestyle behaviors, that they start to demonstrate poorer health outcomes (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007; Hayes-Bautista, 2002). Still overshadowing this positive health outlook are socioeconomic, health system and policy barriers, which disproportionately impact Latino health and wellbeing. When considering Latino health outcomes, it is important to consider both protective effects and areas that undermine Latino health.

Leading Causes of Death in Latinos

Heart disease and cancer are the major causes of death in both Latinos and non-Hispanic populations, with 26.9% of Latino men and 31.1% of Latina women dying from cardiovascular diseases (CVD) in 2010 (CDC, 2010; American Heart Association, 2010). Reports indicated that one in two Latino men, and one in three Latina women will receive a cancer diagnosis in their lifetime, accounting for 20% of Latino deaths overall and 13% of deaths in Latino children (American Cancer Society, 2009).

Unintentional injuries, both occupational and non-occupational, rank third for Latinos, higher than both the non-Hispanic white and African American/Black populations (CDC, 2010). The most common types of injury were from motor-vehicle accidents (MVA), pedestrian versus motor-vehicle collisions, bicycle versus motor-vehicle collisions, firearms, burns, falls, and pesticides (most notably experienced by migrant farmworkers) (CDC, 2010) The fourth leading cause of death for Latinos is stroke, which ranks third for the non-Hispanic populations, and affects 2.6% of Latinos over the age of 18 years (American Heart Association, 2010). Diabetes mellitus ranks fifth for Latinos, but ranks seventh for the U.S. general population, and affects 11% of Latinos age 18 years (CDC, 2010). Although diabetes as a primary cause of death is under-reported, there is a high correlation between CVD and diabetes (CDC, 2010). Approximately, 65% of deaths among people with diabetes are due to health disease and stroke (American Heart Association, 2010). In addition, chronic liver disease/cirrhosis, homicide, chronic lower respiratory disease(CLRD), influenza/pneumonia and perinatal conditions all rank within the top ten leading causes of death for Latinos (CDC, 2010).

Several studies have proven that health consequences do not occur in a vacuum, nor are they solely dependent on genetics that are passed down from generation to generation (WHO, 2011; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). More broadly, a persons' health is determined by their social determinants of health or the conditions in which people are born, grow, live, work and age (WHO, 2011). This includes the structural drivers and/or barriers of those conditions, which includes the distribution of power, money and resources (WHO, 2011). To adequately address Latino health, health coalitions must invest considerable time and effort into distinguishing specific needs, determinants of health and health consequences of their

target populations, if they aim to eliminate health disparities. Determinants of health are almost always multifaceted and inter-related, which means coalition action plans should be as well.

Impact of Social & Environmental Barriers

Research on the socioeconomic determinants of health, specifically in the United States, indicates that negative health outcomes are associated with low socioeconomic status (SES) and low educational attainment (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Both national and state data indicate that Latinos are more likely to be categorized as living in the lower SES bracket, than any other racial/ethnic group (US Census Bureau, 2007). Latinos are considered part of the "working poor," earning a median household income of $36,000 and 23.2% living at or below the poverty line (US Census Bureau, 2010). In 2007, U.S. born Latinos age 25 years and up held the lowest high school graduation rate, with 23.5% of the population having not attained a high school diploma or GED equivalency, compared with 14.4% of non-Hispanic Whites (U.S. Census Bureau, 2009). Among first generation Latinos age 25 and up, over half (50.7%) of the population did not attain their high school diploma or GED equivalency, holding lowest educational attainment of all foreign-born U.S. residents (U.S. Census Bureau, 2009). Although, Latinos posses some the most unfavorable health factors, like low SES and low educational attainment, an additional factor seems to determine whether or not poor health outcomes seen.

Several studies have concluded that among first generation Latinos, the correlations between socioeconomic and health outcomes appear attenuated; however, this relationship begins to become more evident for second and third generation Latinos (Hayes-Bautista, 2002). Over the last 30 years, first generation Latinos (i.e., foreign-

born) have contributed to 45% of the Latino population growth, while second generation Latinos (i.e., U.S.-born Latinos of immigrant parents) contributed 25% to the population's growth (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Taking into consideration the average age of the Latino population is 25.9 years, statistical analyses predict that by 2020, second generation Latinos will surpass the first generation Latinos' population size (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007; US Census Bureau, 2007). This highlights the socioeconomic concern for poor health outcomes found in second generation Latinos, for both healthcare professionals and political stakeholders.

In addition to individual and family level characteristics, evidence suggests that residential segregation and poor neighborhood environments have an effect on health outcomes (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Moreover, individuals that live in better physical and socioeconomic environments are more likely to have positive health outcomes (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). In relation to neighborhood environment, non-Hispanic whites have an advantage in comparison with Latino and African-American communities (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Residential segregation in predominately African American communities have been widely documented since the Civil Rights Movement of the 1950's, and though there are fewer studies that examine the same effects in Latino communities, evidence suggests that Latino isolation and clustering effects are present (Orfield & Lee, 2005). Nationally, metropolitan areas with the largest increases in Latino communities, between 1980 and 2000, generally experience segregation and isolation (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Often times, studies use public school systems to indicate the presence of racial segregation, isolation and poverty levels in the surrounding community. Particularly in the South, studies show that African Americans and Latinos

comprise of more the 90% of the student population in extreme poverty (Orfield & Lee, 2005). In addition, four out of every five Latino students in the South attend a school that is predominately Latino and in extreme poverty, an indication of community segregation and resource-poor settings (Orfield & Lee, 2005).

Though it is not a certain, one possible characteristic that might lead to isolation of predominately Latino communities are language barriers faced by monolingual, Spanish-speakers and/or those who speak an indigenous language. While 48% of first generation Latinos live in predominately Latino neighborhoods, 39% of second generation Latinos live in such neighborhoods (Pew Hispanic Center, 2008). Only 25% of monolingual-English speaking Latinos live in predominately Latino neighborhoods, versus 53% of monolingual-Spanish speaking Latinos and 45% of bilingual Latinos tend to live in predominately Latino neighborhoods (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Language barriers are associated with community segregation, poor communication between the health service providers, poor satisfaction of the healthcare experience and poor overall health outcomes as many Latinos will try to avoid clinics, until the situation becomes dyer (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Although this segregation pattern seems to favor first generation Latinos' health outcomes, this is not the case for second generation Latinos, who tend to have higher rates of diabetes, cardiovascular disease, hypertension, cancer and several other poor health outcomes (Hayes-Bautista, 2002).

Impact of Policy & Institutional Barriers

Just as social and environmental factors hinder the health of Latinos, so can institutionalized factors, particularly when looking at the U.S. healthcare system and governing policies that make decisions for public health. Individuals with lower

educational levels and lower income levels are found to have lower access to health insurance (US Census Bureau, 2010; The Kaiser Family Foundation, 2003). Latinos who earn less than $30,000 annually are over four times likely to not have health insurance compared with those who earn more than $50,000 annually (Pew Hispanic Center, 2008). In addition, insurance trends of non-coverage and under-coverage among Latinos, is associated with country of origin, citizenship status, language and geographic location (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). First generation, monolingual Spanish-speaking and non-citizens are less likely to have access to health insurance, and forgo many of the primary prevention screenings that aim to detect illnesses before they become serve health concerns (The Kaiser Family Foundation, 2003).

In the U.S., health insurance is imperative in order to cover the rising cost of healthcare; however, it is estimated that Latinos make-up approximately one-third of U.S.'s uninsured (NCLR, 2008). Insurance coverage is also influenced by geographical location of Latino communities, which is indicative of the surrounding labor markets, availability of employers who offer insurance coverage, eligibility for public insurance, charity care and viability of the local safety-net (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). When it comes to U.S. born, Latino children with undocumented parents, they are far less likely to be insured when compared with their counterparts whose parents are U.S. born, despite having the same eligibility for health programs and services (NCLR, 2008). Currently, there is a five-year minimum on naturalized Latinos, before they can begin to receive Medicaid/CHIP coverage, which has lead to lower levels of coverage among Latino immigrants (15.5%) and higher risks of poor health outcomes (NCLR, 2008). Finally, when Latinos, the largest growing population, are

uninsured or underinsured, they are less likely to have a patient-centered medical home, meaning they are less likely to receive regular healthcare that meets the basic standards of adequacy for primary and secondary care services(NCLR, 2005). This is a national concern since, Latinos risk exasperating medical conditions that would otherwise be prevented through primary medical screenings, and can potentially be transferred others (NCLR, 2005).

Those who are able to access the healthcare system must also face language and cultural barriers in medical institutions, which have been shown to adversely affect health outcomes (Timmins, 2010; Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Latinos are less likely to comprehend critical health information for prevention and disease management, have problems understanding insurance coverage options, and are under-represented in the health professional and educational workforce (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007; NCLR, 2005). For example, 49% Spanish-dominate speakers, compared with 16% of bilingual and 8% English-dominate speakers reported having difficulties communicating with healthcare providers because of language barriers (Timmins, 2010). Essentially, language, citizenship status and lack of health insurance coverage place greater barriers to accessing care for Latinos and their children. This suggests that the national health objectives should include proactive solutions (i.e., bilingual communication, health insurance options, etc.), so that everyone residing in the U.S., regardless of immigration status, can receive the healthcare they deserve.

Additionally, within the Latino population there are several distinct, sub-populations, each with very different cultural practices (i.e., shared beliefs, norms and values). One of the major difficulties faced by first generation Latinos is the Western medical approach with emphasizes the concept of disease and treatment of an illness,

versus many positive cultural factors used in the Latino community which take a holistic approach to health and wellness (Hayes-Bautista, 2002). Uncompromising practices used in medical institutions throughout the U.S. have a negative impact on patient satisfaction, compliance and overall health outcomes, especially when it comes to Latino health (Snowden & Yamada, 2005). Contributing to the communication barriers and cultural humility, is the fact that Latinos are under-represented in health professional schools, the lack of formal cultural competency and/or humility curriculum in training programs and the lack of compliance with federal regulations (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Title VI, Prohibition against National Origin Discrimination as it Affects Persons with Limited English Proficiency (LEP), requires government funded programs or services to ensure meaningful access to health and social services to persons with LEP (DHHS, 2011). Many Latinos, especially first generation Latinos, continue to face language and cultural barriers because their healthcare provider(s) do not speak their native language, lack medically trained interpreters and do not take cultural practices or spirituality into consideration when trying to navigate patients into a good health standing (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007).

Considering all health barriers, the most effective way alter health barriers, and thus altering health outcomes, would be to set public policies in place that benefit the health of Latinos. Public policy plays a critical role in the distribution of national, state and local resources, which create incentive and disincentive for Latinos to access the U.S. healthcare system (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). Though first generation Latinos have better health outcomes than U.S. born Latinos, public policies that hinder recent immigrants from preventative services, at a time when they may need services the most, threaten the health of Latinos' and their subsequent generations (The

Kaiser Family Foundation, 2003).

One example of policy effecting Latino health based on immigration status, is seen in the 1996 Responsibility and Work Opportunity Reconciliation Act (Berk, Schur, Chavez, & Frankel, 2000). For the first time in U.S. history, policy deemed citizenship as a criterion for determining eligibility for federally fund health programs, Medicaid and the State Children's health Insurance Program (SCHIP) (Berk, Schur, Chavez, & Frankel, 2000). Prior to this policy change, lawful permanent residents (LPR's) were eligible for Medicaid on the same basis if they met financial and other eligibility requirements (Berk, Schur, Chavez, & Frankel, 2000). After the policy was passed, legal immigrants entering the U.S. after August 1996 were required to wait five years before they were deemed eligible to participant in any public health service options (Berk, Schur, Chavez, & Frankel, 2000). While states were given the option to use state funds to supplement the costs, many did not have the budget to do so, including the State of Georgia (Stone, Viruell-Fuentes, & Acevedo-Garcia, 2007). In addition, only a handful of states use part of their SCHIP funds to provide prenatal care to expecting mothers, regardless of immigration status (Berk, Schur, Chavez, & Frankel, 2000). Unfortunately, this leaves many pregnant women with the decision to forgo medical care until they deliver their child. Emergency treatment is available to all individuals in the U.S., regardless of immigration status under the Emergency Medicaid and the Emergency Medical Treatment and Labor Act (EMTALA); however, this system does not have the capacity to serve large volumes of patients and is often overwhelmed by non-emergency related care (Berk, Schur, Chavez, & Frankel, 2000). To prevent the over utilization of emergency room visits and improvement of health outcomes for the uninsured, policy makers should re-consider appropriating funds to federal and/or state funded medical

services. The restrictions to publicly funded healthcare disproportionately impacts the health and wellbeing of children, expecting mothers and their families.

Indicative to Latino health outcomes, are the underlying determinates of health that are environmentally, socially and institutionally constructed. If public health professionals are to address the gradient of diminishing Latino health as they stay in the U.S., a collaborative, multidisciplinary approach should taken. Like many marginalized causes that are not federally funded, local communities are left to formulate solutions with limited resources. Thus, many local entities have created forums to address a common cause, using collective resources. In this case, local health-specialist address the increasing healthcare needs of Latino patients in the Metro-Atlanta Area. They collectively call themselves the Hispanic Health Coalition of Georgia.

Coalition Types Across the U.S.

Community coalitions serve as prominent mechanisms for building local capacities to address health and social concerns and have been defined in two ways. The first, is an organization of individuals representing diverse organizations, factions or constituencies, who agree to work together in order to achieve a common goal (Feighery and Rogers, 1990), and the second, is an organization of diverse interest groups that combine their human and material resources to effect a specific change the members are unable to bring about independently (Butterfoss, Goodman, & Wandersman, 1993). Though an agreement has not been reached over a definition to describe a coalition, experts do agree on a few essential characteristics. Recent definitions of coalitions characterize coalitions as formal, multi-purpose and long-term alliances, with a shared purpose usually amounting in a social or ethical issue (Butterfoss & Kegler, 2002). They must maintain a structure, focusing on specific goals external to the coalition and

commit to recruiting member organizations with diverse talents and resources (Butterfoss & Kegler, 2002). Coalition members collaborate not only on behalf of the organization they represent, but also advocate on behalf of the coalition itself (Butterfoss, Goodman, & Wandersman, 1993). A recent emphasis shows effectiveness of coalitions as multi-purpose alliances, with more than one set of goals and they promote multiple level interventions (e.g., policy change, resource development and ecological change)(Kegler, Steckler, Malek, & McLeroy, 1998). In addition, coalitions must withstand conflict and overcome barriers, especially in hard economic times (Butterfoss & Kegler, 2002). Thus, coalitions must be durable, especially when coalitions commit to changing health outcomes as a goal, because of their long-term commitment to a cause and effect a large population.

Categorization of coalitions can be through 1) membership types, 2) patterns of formation, 3) types of functions and 4) structures that allow coalitions to maintain functionality(Butterfoss, Goodman, & Wandersman, 1993). Categorization based on membership can be seen as grassroots-based, professional groups, and community-based groups (Feighery & Rodgers, 1990). In comparison, professional coalitions form either in a time of crisis, or as a long-term strategy to increase their power and influence (Feighery & Rodgers, 1990). An example of this can be seen in the 1990's, when the American Cancer Society, American Heart Association and American Lung Association came together to form he Tobacco Free America Coalition (Feighery & Rodgers, 1990). Finally, community-based coalitions represent a heterogeneous mix of both professional and grassroots leaders and typically have their own separate funding (Feighery & Rodgers, 1990).

Often times coalitions form out of a response to an opportunity or threat, thus, some coalitions are categorized according to their formation pattern (Butterfoss, Goodman, & Wandersman, 1993). Several opportunities may rise in response to a funding opportunity, where others might form out of perceived adversity or opposition (Butterfoss, Goodman, & Wandersman, 1993). An example of the coalition formation out of adversity was seen prior to the Civil Right and Chicano Movements, where groups of individuals unified to fight opposition of unfair and unjust policies in the U.S. government. After the opportunity or crisis is over, member organizations with differing scopes of work may find it difficult to continue working together and will often disband (Butterfoss, Goodman, & Wandersman, 1993).

In addition, coalitions are comprised of diverse units and can be categorized based on their complex functionality that serves their membership. Typical functions include one or more of the following: information and resource sharing, networking, technical assistance, self-regulation, planning and coordination of services and advocacy (Butterfoss, Goodman, & Wandersman, 1993; Feighery & Rodgers, 1990). The functionality of a coalition is based upon the need and common goals of the group and typically frames organizational structures, the final categorization for coalitions.

Organizational structures are typically defined as organization-set coalitions, network coalitions, and action-set coalitions (Butterfoss, Goodman, & Wandersman, 1993). The organization-set coalitions are comprised of groups of cooperative organizations that provide resources or services under an over-arching, or "umbrella," organization (i.e., United Way) (Butterfoss, Goodman, & Wandersman, 1993). Network coalitions are comprised of organizations with a common purpose and/or service goals that target a particular type of clientele or population (Butterfoss, Goodman, &

Wandersman, 1993). Finally, action-set coalitions are issue specific and *ad hoc* in nature (Butterfoss, Goodman, & Wandersman, 1993). They bring together organizations, businesses and individuals that may not have previously been in the same network to accomplish a specific purpose or to develop a common identity (Butterfoss, Goodman, & Wandersman, 1993).

Health promotion coalitions are unified, heterogeneous forces that are driven towards finding solutions towards a common goal. Though they are categorized differently, for different funders, reports, and communication purposes; they come together to fulfill planning, coordinating and advocacy functions for their communities. Though many of the coalitions tend to focus their attention on disease interventions or prevention strategies, several might find population based health practices a more thorough way to address health concerns.

Coalition Trends in the Literature

Though coalitions are a relatively new phenomenon to public health, there have been extensive studies to prove their effectiveness and justify the need for additional support (Feighery & Rodgers, 1990; CDC, 2007; Zakocs & Edwards, 2006). Many of these studies have focused their attention towards the formation, or initial stage of coalition development, but have rarely evaluated the maintenance and institutionalization stages (Feighery & Rodgers, 1990; Zakocs & Edwards, 2006). In addition, even fewer studies have evaluated population specific coalitions. Many of the studies have focused their attention towards specific diseases (e.g., cardiovascular disease, cancer, HIV/AIDS, asthma, etc.) (Butterfoss, et al., 2006; Yancy, et al., 2011; Clark, et al., 2009), advocating to alter policies or instutionalized regulations (e.g., smoking bans, immigration reform, unionized benefits, abortion law reform, etc.) (Clark, et al., 2010), changing social norms

(e.g., smoking, drinking or breastfeeding) (Johnson, Myers, Webber, Boris, He, & Brewer, 2009; Frances, 2008) and environmental sustainability (e.g., walkability of urban areas, increasing community green spaces, increasing healthy food outlets in low income neighborhoods, etc.) (Levenstein, 2009; Srinivasan, O'Fallon, & Dearry, 2003), to name a few.

Thus, many coalitions utilize a traditional "diseased-centered" medical model, which focuses on a diminishing the burden of a particular disease. This theoretical framework stems from traditional medical teachings that places physicians as the primary decision makers for almost all treatments, based on clinical experience and data from various research studies (Mead & Bower, 2002). In comparison, the "patient-centered model" has been proven to be a more effective approach, by empowering patients to become active participants in their own care and receive services designed to focus on their individual needs and preferences, in addition to the advice and counsel of health professionals (Mead & Bower, 2002). Though there is little to no empirical evidence to support this connection between patient-centered care and minority-specific coalitions, a more recent descriptive study looked at underlying characteristics, with considerable attention given to cultural uniqueness. Promotion of this type of coalition evaluation could set the foundation for further research on minority-specific coalition effectiveness as it pertains to populations, rather than a disease (Aguilar, Abesamis-Mendoza, Ursua, Divino, Cadag, & Gavin, 2010).

The evaluation on a minority-specific coalition from New York, focused on the formation of a Filipino-based health coalition. Though the target audience was different, many of the findings can be applied to Latino-focused health coalitions, like the HHCGa (Aguilar, Abesamis-Mendoza, Ursua, Divino, Cadag, & Gavin, 2010). Particularly useful

are the suggestions that 1) leadership should have an established trust within the community, 2) having intergenerational membership can provide organizational diversity, structure and sustainability, 3) addressing diversity within the community can foster inclusiveness and active participation, 4) allowing individual members (not necessarily associated with an organization) to be part of the coalition can additional perspectives, 5) allowing all members to participate in discussions and decision-making processes and 6) planning periodic assessments to maintain coalition structure (Aguilar, Abesamis-Mendoza, Ursua, Divino, Cadag, & Gavin, 2010). Although, suggestions are applicable to many coalitions, they do not address the specific concern coalitions face during their later stages of development, particularly during maintenance and institutionalization.

Though the topic of coalition effectiveness has been researched for developing coalitions, very few studies have considered the effectiveness of coalitions during their maintenance phase, and even fewer studies have been conducted on minority-focused coalitions. Much like the patient-centered care model, the Hispanic Health Coalition of Georgia, aims to meet the needs of the Latino community through a holistic approach which considers cultural practices, personal beliefs, family dynamics, etc. prior to developing an action plan that alleviates a specific health issue.

Benefits of Coalitions

In a systematic review, coalitions were found to have seven main benefits. The first benefit includes enabling organizations to become included in new and broader issues without having the sole responsibility of managing or developing issues (Butterfoss, Goodman, & Wandersman, 1993). The second benefit is that by their collective nature, coalitions are able to develop widespread support for issues, actions or unmet needs (Butterfoss, Goodman, & Wandersman, 1993). The third benefit is that

coalitions are able to maximize their resources and power through joint action, also referred to as increasing the "critical mass" beyond what any one individual or organization could achieve on its own (Butterfoss, Goodman, & Wandersman, 1993). Fourth, coalitions are collective units of small and large organizations, which in many cases have limited resources. By collectively joining forces and working towards a common goal, organizations prevent duplication of efforts (Butterfoss, Goodman, & Wandersman, 1993). Fifth, coalitions are able to mobilize more talents, resources and approaches to influence an issue than any single organization can achieve alone (Butterfoss, Goodman, & Wandersman, 1993). Sixth, coalitions have the advantage of including multiple disciplines, by recruiting participants from diverse backgrounds and professional expertise (i.e., political, business, human service, social, religious, etc.) (Butterfoss, Goodman, & Wandersman, 1993). Finally, the seventh advantage of coalitions is that they can be flexible to accommodate the different participants involved in the coalition (Butterfoss, Goodman, & Wandersman, 1993).

In addition, successful coalitions have a common thread that bridges their success, which is their ability to remain action focused (CDC, 2007). Some of these actions include keeping the issues coalitions work towards public, educating policy makers and/or advocating for policy change, providing expertise through coalition diversity, promoting community buy-in, enhancing community involvement, amplifying state resources and making sure community needs are met (CDC, 2007). Collectively, coalitions pride themselves as being cost-effective by bringing together multiple disciplines under one roof to achieve common, well thought out goals (CDC, 2007).

Challenges of Coalitions

Coalitions also meet challenging circumstances in which they risk losing autonomy, competitive edge and/or control. These challenges have occurred over conflicting goals and/or methods, lack of resources (i.e., time, money, status, data, etc.) or encountering delays in solving identified problems (Butterfoss, 2007). Though challenges are inevitable in any organization, evaluation processes can help prevent most challenges from occurring.

The CDC has identified six common challenges faced by coalitions. The first challenge is when coalitions have *vague expectations* of members or members that are complacent, not invested, lack autonomy and/or uninvolved (CDC, 2007; Feighery & Rogers, 1990). Coalitions that have this issue often lose momentum and cohesion, which is why it is important for coalitions to develop goals and objectives in the beginning, developmental stages. The second issue involves lack of coalition identity (CDC, 2007). Again, this can be prevented in the developmental phase. Those that chose to alter identity and/or purpose risk losing participants. Thirdly, coalitions that lack key stakeholders and leaders or have inadequate participant diversity (i.e., too much of one group represented) typically have trouble finding the support they need to move forward (CDC, 2007; Feighery & Rodgers, 1990). The third most common issue, is when coalitions find themselves moving away from their objectives or established goals, but can be fixed during a coalition's maintenance phase (CDC, 2007). Fourth is typically a political stance on issues that are not supported by all participants because of their tax status or the issue at hand (CDC, 2007). Finally, the inability of coalitions to present a united voice can lead poor communication, both internally and in the public, which can often be avoided by identifying a clear mission and scope of work (CDC, 2007).

Evaluating Coalitions

The underlying foundation of a coalition is strength lies in membership, partners, diversity and resources, which are embedded in two levels of the coalition, their inward work and their outward work (Butterfoss, 2007). A coalition's inward or internal work refers to the processes that build, nurture and maintain the coalition, where a coalition's outward or external work refers to their task-oriented behaviors set out to achieve coalition goals (Butterfoss, 2007). Evaluation processes, take both internal and external work into consideration, but often define their scope and focus on one of the two levels that make up the coalition. Until recently, there have been very few published coalition evaluations that focus on coalitions who serve the health needs of a particular minority group. Most of the health coalition evaluations have focused on specific diseases, prevention programs, policies, and/or health environment changes that aim to reduce the burden of a particular public health problem.

Coalition and partnership evaluations are necessary for three main reasons 1) to show that a particular coalition is making a difference and achieving outcomes, 2) to show accountability to the outward community, funding agencies and stakeholders and 3) to build community awareness and support (Butterfoss & Kegler, 2002). There are generally three levels of coalition evaluation (Butterfoss & Francisco, 2004). Level 1, the primary focus of the HHCGa Evaluation, evaluates the internal processes and focuses on coalition effectiveness. Level 2, evaluates the impact from one or two coalition programs or services provided by the coalition. And Level 3 evaluates overall changes in environment, policies and practices and/or changes in health or social status. Such studies measuring outward or external outcomes can be more difficult, thus, many studies focus their attention on measuring processes that build and sustain strong

coalitions (Butterfoss & Kegler, 2002). As an essential component of coalition evaluation, the membership evaluations monitor both internal and external components as they are perceived by the members and leadership.

Coalition Evaluation Measures

The measures of the HHCGa Membership Evaluation stem from the constructs defined in the Community Coalition Action Theory (CCAT) and previous reviews of coalition evaluation measurement tools,in addition to areas of cultural inclusion and diversity (Butterfoss & Kegler, 2002; Granner & Sharpe, 2004). An extensive review of coalition evaluation measurement tools suggests that optimal results are obtained by developing items through an overarching, theoretical framework, setting evaluation objectives based on project needs and developing tools with proven validity and reliability (Granner & Sharpe, 2004). Also, a systematic review on coalition effectiveness revealed that coalitions that enact a formal governance, encourage strong leadership , foster active participation of members, cultivate diverse memberships, promote collaborations among member agencies, and facilitate group cohesion may be more effective (Zakocs & Edwards, 2006). After careful consideration, the following constructs will serve as an underlying framework for the membership evaluation: coalition membership and involvement, operations and processes, leadership and staffing, and member engagement.

Coalition Membership. The first proposition states that coalition formation typically begins by the recruitment of a core group of committed individuals that share a common interest (Butterfoss & Kegler, 2002). Evidence suggests that previous experience with a specific health topic and coalition processes increases member commitment (Butterfoss

& Kegler, 2002). In addition, flexibility to allow members to participate at varying levels of intensity was essential for volunteer-driven coalitions (Butterfoss & Kegler, 2002).

The second proposition states that effectiveness is increased when the core group expands to include a broad constituency representative of the diversity found in the community, both professionally and ethnically (Butterfoss & Kegler, 2002). This includes the recruitment of community gatekeepers, parties interested in the topic and a diverse group of organizations, business and policy makers, etc. so that collectively, the group can develop solutions that would otherwise not have been achievable through individual efforts (Butterfoss & Kegler, 2002). Creating an environment that fosters diversity, which increases the range of expertise, perspectives, and backgrounds, will enable more options for achieving success (Butterfoss & Kegler, 2002).

Operations & Processes. The five propositions, based on the assumption that effective internal functioning is necessary for progress, encompass this construct. Three propositions outline themes of open and frequent communication among staff and members, shared and formalized decision-making, conflict management, fostering positive relationships among members, and member perception that benefits outweigh the cost(s) of participation (Butterfoss & Kegler, 2002). In addition, organizational climate is beneficial for increased member engagement and perceived accomplishments (Kegler, Steckler, Malek, & McLeroy, 1998). If all components are achieved through a coalition, the results indicate that the members report having positive outcomes including increase member satisfaction, commitment and empowerment (Butterfoss & Kegler, 2002).

Leadership & Staffing. An evaluation study by Mizrahi and Rosenthal, indicated that participants rated competent leadership as the second most important characteristic,

next to commitment, and is linked to member satisfaction and participation (2001). In addition, a strong leadership can influence the success of collaborative partnership. Without strong leadership and adequate staffing, collations cannot move beyond the initial steps of formation (Butterfoss & Kegler, 2002). Specifically, two propositions state that a strong leadership team and skilled, paid staff both improve coalition functioning, pooling of resources, engagement and effective assessment and planning (Butterfoss & Kegler, 2002). Leadership and staff competency are associated with member satisfaction and perceptions of team efficiency, which is suspected to lead to overall team effectiveness (Granner & Sharpe, 2004). Adequate staffing, with low staff turn-over, and adequate time to dedicate to coalition activities improves intermediate outcomes and member satisfaction (Butterfoss & Kegler, 2002). Coalition leadership dedicated to a clear and shared vision are able to support group ideas, planning efforts, practice democratic decision-making processes, and encourage networking and information sharing (Butterfoss & Kegler, 2002). Indicators of perceived empowerment included expectations of members for positive outcomes and commitment to the group (Butterfoss & Kegler, 2002).

Member Engagement. This construct supports the notion that collaborative synergy is generated through successful engagement of diverse coalition members (Butterfoss & Kegler, 2002). The proposition indicates that satisfied and committed members will participate more fully in and outside the coalition meetings and activities (Butterfoss & Kegler, 2002). Several factors are known to enhance engagement, one of which involves maximizing member benefits and reducing costs of participation (Butterfoss & Kegler, 2002). Also, members who have real influence in and control processes within the coalition are more willing to become engaged in coalition activities, and more

importantly, are able to talk about their experience with others to increase recruitment efforts (Butterfoss & Kegler, 2002).

Chapter 3:

Methodology

This study was one of the first membership evaluations for the Hispanic Health Coalition was founded in 1990 and was incorporated in 2000. Nearly twenty years later, the organization decided to renew and restore its foundation during the Latino Health Summit on February 27-28, 2009. Together, Latino-serving health professionals, community advocates, educators and general community members identified the key issues, prioritized them, established strategic goals and began creating action plans that were to be completed over the next three years. This forum provided a platform for revamping the HHCGa mission and vision, which serves as a recruitment tool to external audiences and provides directionality for internal members. The strategic goals are to be revisited and revamped every three years, with the next planning session planned for mid-year 2011.

The purpose of this study was to identify internal strengths and weaknesses in the Hispanic Health Coalition of Georgia (HHCGa) through key informant telephone interviews and an on-line survey. Emory University Institutional Review Board (IRB), was notified of the study, which was classified as a quality improvement project and did not need further review (Appendix A). Participants were invited to participate through personal e-mails, the HHCGa Newsletter and announcements at two HHCGa Quarterly Meetings. The survey took approximately 15 – 20 minutes to complete, and included both open- and closed-response items. The on-line survey tool was generated through SurveyMonkey.com. Feedback from survey responses will help to: 1) guide strategic marketing plans to recruit new prospective coalition members, 2) provide a retention plan to keep current members

engaged in HHCGa's activities' and 3) provide direction on making the coalition more efficient and effective, including the revitalization of the three-year strategic goals.

Participants and Sampling

The evaluation included 27 participates who were either active/inactive individual members, organizational members, board members, or staff. In order to qualify to participate, individuals must have attended at least one HHCGa Quarterly Meeting or event in the past. All participants have or have had an interest, either personally or professionally, in Latino health issues. The non-probability, convenience sample included Atlanta residents with diverse backgrounds, both ethnically/racially and professionally, that provide services to Latino clientele. An exception was made for students and individual members that had attended at least one Quarterly Meeting and/or HHCGa sponsored event as eligibility criteria. Members were notified via an announcement during two Quarterly Meetings, over the two HHCGa e-Newsletters and via personalized e-mails generated from sign-in sheets. The HHCGa listserv included over 400 organizations, companies, institutions and individuals that have attended one or more of the HHCGa's functions, speaking engagements and/or have paid membership dues.

Recruitment started inNovember 2010 for key informant interviews, and continued until February 2011. Key informants were selected using the following criteria: length of time with the coalition, role within the coalition and date of initial recruitment. The criterion was conveyed to the President of the Executive Board, and a list of 9 possible candidates was generated. Attempts to contact key informants ceased after three voicemails and three e-mails were sent, with no response.

Membership recruitment stared in January 2011 and ended in March 2011. Signup sheets were circulated during the November 2010 and January 2011 Quarterly Meetings, and

allowed participants to provide their contact info, preferred mode of communication and the most appropriate time to reach them (if applicable). Within a few days participants received a follow-up e-mail with a link to the online survey, and special accommodations were made for those who did not have access to a computer and/or preferred to take the survey over the phone. All members and leadership were invited to participate via an e-mail invitation with a hyperlink to access the online survey.(Appendix B) All board members were asked to complete the survey during their Monthly Board Meeting in February and March 2011.

Research Design and Procedures

Key informant telephone interviews were conducted prior to the membership survey distribution, and guided the development of the online survey tool. The aim was to interview 4-8 members of the coalition with varying experiences (i.e., roles within the coalition, length of time with the coalition and date of initial recruitment, overall positive/negative perceptions of the coalition) to gain historical background on the processes and structures within the HHCGa. In addition, it allowed informants to openly respond to construct areas using their own, internal terminology, which was incorporated into the online survey. Participant responses were tape-recorded using a digital recorder, and notes were taken throughout the telephone survey in the event that the recorder ceased to function. Once the interviews were transcribed, the recordings were destroyed and each participant was assigned a generic identification number, which could not be linked to the participant's identity. Response saturation was reached after interviewing 5 participants, and helped inform the online membership survey.

Coalition members volunteered to complete a 15-20 minute, one-time, cross-sectional online survey, which included both, closed and open-ended responses. Coalition members consisted of local entities, who provide research or services to the Latino

community and who have participated in one or more HHCGa functions and/or paid their membership dues. Participation was voluntary and all responses were kept confidential.

All surveys were tracked using a password protected Excel Sheet, to conceal participants' identity. Those who volunteered to complete the survey at the Quarterly Meeting were contacted within 3-5 business days via e-mail to complete a 15-20 minute online survey. The online survey consisted of several close-ended, fixed response questions and a few open-ended responses. Upon entering the online survey, participants were prompted to read a passive informed consent which notified participants that their responses would be kept confidential and could, in no way be associated with their identity, personal or organizational. Following the completion of the online survey, participants were eligible to enter an opportunity drawing to win a $50 gift card, in which case their preferred method of communication was entered into a database, with considerable attention given to ensuring names, and all other identifiable information could not be deciphered. At the end of the data collection phase, one participant was randomly selected from the opportunity drawing list and informed of their prize. The opportunity drawing was voluntary, and participants were able to opt out, or cancel, their participation at any time. The total burden of participation was approximately 15-20 minutes, which varied according to the participant's open-ended responses.

Following data collection, the survey responses were analyzed using SPSS and thematic analysis. The findings were presented to the HHCGa Board Members to help inform decisions on future strategic planning and were defended at the Rollins School of Public Health, Emory University on April 14, 2010.

Description of the Data Collection Measures by Instrument

This study employed two data collection instruments. The first instrument, a qualitative interview guide, was used to gather data from five key informants to help guide the development of the recruitment plan and the membership survey. (Appendix C & D) The second instrument, a combination of qualitative and quantitative survey items, was administered to the membership and leadership (i.e., board members and staff), via an online survey software program, SurveyMonkey.com. (Appendix E)

Key informant survey

The first group included five key informants, which helped guide the development of the online evaluation tool and provided background information on the HHCGa. Key informants were determined by the HHCGa President and based on the participant's availability, roles within the coalition, length of time with the coalition and date of initial recruitment. Appointments were set in advance and interviews were conducted over the phone. Permission to record the telephone calls was determined at the time of the interview, so that quotations could be extracted to support the findings. Also, hand written notes were taken during each interview to prevent unpredictable technical malfunctions of the digital recording device. The interviewees were a diverse mix of HHCGa leadership and general members, who were either active or inactive. The purpose of interviewing a diverse group of members and leaders was to gain perspective on the evaluation tool and to determine the best method for participant recruitment. Items on the survey instrument included retrospective questions that asked participants to recall events and scenarios that occurred in the past, as well as theoretical questions that asked participants to predict future events and/or decisions. The questions were guided by the major constructs from the Community

Coalition Action Theory, but also included specific questions pertaining to Latino health issues within the State of Georgia. The open responses allowed informants to develop their own thoughts and draw from their personal experiences, without the biases of a developed tool. Each interview varied from 45 minutes to approximately two hours, depending on the interviewees' experiences and perceptions.

Coalition Membership Survey

The Coalition membership survey was designed to elicit coalition members' opinions and perceptions of their involvement , decision-making influence, satisfaction, leadership and staffing, communication, organizational climate, diversity within the coalition, level of influence on selection of goals and activities, progress made toward their accomplishments and demographic questions. The 77-question, comprehensive survey contained a combination of closed and open-ended questions, which was adapted from the National Cancer Institute's Americans Stop Smoking Intervention Study (ASSIST), an evaluation focusing on policy change, with the goal of altering states' social, cultural, economic, and environmental factors that promote smoking (Kegler et al, 1998). The survey was approximately 15-20 minutes in length, depending on whether or not participants provided optional comments to the open-ended questions.

Piloting of the survey

A small group of four individuals volunteered to pilot test the survey, which uncovered several errors that were immediately corrected. The participants' responses were recorded as if they were actual survey participants, but were not included in the sample. The findings from the pilot sample helped determine comprehension of items, duplication of items, as well as items that needed to be omitted.

Evaluation Measures

Membership & Involvement. Membership and involvement was defined as the various means and frequency of a particular member's participation in HHCGa activities. Ten survey items were developed to measure the participant's service specialty, level of activity/engagement, length of membership, initial recruitment appeal, retention appeal and adherence to membership dues. To measure service specialty, members were asked to categorize themselves and/or their organization they represented as being: educational, communications/marketing, economic, religious, legal, direct healthcare provider, continuum of care organization, recreational, or other and which contained an open-field. All categories included examples of professions or services that might be offered by the organization. Directly following this question, the participant was asked to indicate whether or not they conduct research in the service area they identified with. Three items captured participants' self-reported level of activity by asking them to categorize themselves into one of four groups (i.e., not at all active, not very active, somewhat active and very active). Length of membership in the HHCGa was also divided into four categories (i.e., less than 1 year, 1-2 years, 3-4 years and 5 or more years). As part of the collaboration between the key informants and stakeholders, participants were asked to report how often they attended HHCGa Quarterly Meetings (i.e., zero, once, twice, three or four times a year).

Included in theMembership and Involvement section are open–ended questions that were designed to elicit participant perception and general opinions on previous events, initial recruitment appeal, and retention appeal. Regarding past event perceptions, participants were asked to recall all of the events they attended and then asked to indicate which one's stood out to them. The information was formatted as a skip-pattern question, so that if the participant had not attended an event, they could proceed to the next question. However, if

they had attended an event, they were given the opportunity to provide open responses and speak freely about how they experienced the events. Participants opinions of the qualities and/or benefits that attracted them into joining and staying engaged with the HHCGa, will serve as positive feedback for the coalition. Conversely, participants were able to provide barriers, or reasons, that have either hindered or terminated their involvement with the HHCGa. Finally, payment of membership dues was posed as a categorical response of, yes or no.

As part of the collaboration with the HHCGa, the Executive Director asked that the survey tool incorporate an open response field to gather additional information. The three questions were 1) *What does The Coalition mean to you*, 2) I*f you are with an organization, how might The Coalition contribute to your work?* And 3) *What other benefits would you like to receive from The Coalition?* The items provided supplemental information, and were critical for determining any unidentified themes that were not questioned.

Decision-Making. Member decision-making was defined as the role that members play in making important decisions for the coalition and in selecting coalition activities and priority areas. Members' perceived influence on making decision on behalf of the coalition was assessed using the following four items: 1) Setting goals and objectives, 2) Selecting coalition sponsored activities, 3) Setting the budget for coalition activities and 4) Deciding general coalition policies and actions. Respondents rated decision-making influence on a four-point Likert scale, from *no influence = 1* to *a lot of influence =4*. A separate item on the survey measured member perception of the groups that make the major decision for the coalition. Response choices included coalition members, committee members, committee chairpersons and/or staff.

Leadership & Staffing. Coalition leadership and staffing were defined concurrently for the purposes of this study, because many times the two were not mutually exclusive, with paid staff fulfilling many leadership functions, such as setting agendas and facilitating meetings. Together, coalition leaders and staff manage the structure through which coalitions accomplish their work and are responsible for coalition processes such as communication and decision-making that keeps members satisfied and committed to coalition efforts (CDC, 2007). Additionally, effective leadership and staffing hinges on the collective efforts of multiple individuals, with varying backgrounds and expertise, to make up the leadership of a coalition and is not based on the skill of one individual. Members' perception of leadership qualities and management skills were assessed using the following fifteen items: 1) making members feel welcome at meetings, 2) praise and recognition of the membership, 3) consideration of membership opinions and suggestions, 4) request specific tasks from the membership, 5) efforts made to get to know the membership, 6) share a clear vision and direction for the group, 7) recognizable in the Latino Community, 8) conflict-resolution skills, 9) characteristically controlling, 10) overall guidance, 11) respected within the coalition 12) overall competence, 13) responsiveness to criticism, 14) ability to work well with others and 15) availability for assistance. Respondents rated leadership and staffing on a five-point, Likert scale, from *strongly disagree = 1* to *strongly agree =5*. In addition, respondents had the opportunity to add additional comments in an open-field, at the end of the section.

Communication. Coalition communication was defined as the ability of an organization to exchange thoughts, opinions, or information through speech, writing or more modern electronic portals. The ability to communicate effectively, both internally and externally, serves to increase coalition satisfaction, commitment and implementation of strategies. Six survey items focused on communication, marketing and outreach efforts

within the HHCGa. The first, free response item brought forth information on participants' first experience and awareness of the HHCGa, which was expected to be different for each respondent. The subsequent three items referred to the respondents' opinions on preferred modes of communication, least preferred modes of communication and frequency of communication. Responses for modes of communication, were categorized and included the following: website, e-mail, letter, phone call and other, which was an open field. The respondents were also encouraged to provide additional modes of communication they would prefer to use. The frequency of communication was categorized as daily, weekly, monthly, quarterly, and other, which was a free response category. Finally, participants were encouraged to share their opinion about 1) the frequency of communication between members and the leadership/staff and 2) the frequency of communication between coalition members. Respondents rated the internal frequency of communication on a five-point, Likert scale, from *no communication at all = 1* to *very frequent communication =4,* and *I couldn't say=5*.

Coalition Satisfaction. Member satisfaction with the HHCGa was defined as overall membership fulfillment and gratification with the services provided. Using a five-point, Likert scale, from *very unsatisfied=1* to *very satisfied=5*, participants were asked to provide responses to eight coalition satisfaction items. The items included satisfaction with:1) the HHCGa's involvement in the Latino community, 2) recruitment efforts, 3) involvement in government advocacy efforts, 4) adherence to health promotion and education efforts, 5) promotion of local Latino resources and services, 6) agenda structure at Quarterly Meetings, 7) topics covered at the Quarterly Meetings, 8) professional development opportunities, 9) opportunities for members to take leadership roles, 10) activities selected by the HHCGa, 11) the result of the activities, 12) fundraisers selected by the HHCGa, and 13) the results of

the fundraisers. Finally, participants had the opportunity to elaborate on additional ways in which they were satisfied or unsatisfied with the coalition, through open response questions that asked 1) if there were any professional development opportunities or trainings of interest, 2) were there any specific health topicsthat were of interest, and 3) the last item allowed participants to add additional comments. Collaborative efforts allowed for the addition of one open ended item at the end of the survey, which asked "What are your [participants] expectations of The Coalition?" and whether or not these expectations have been met. This allowed for participants to bring out additional themes regarding Coalition Satisfaction.

Latino Representation, Diversity & Culture. The area of Latino representation, diversity and culture was a unique construct for the survey tools because of the HHCGa's unique approach to prevent and ameliorate disease prevalence and provide culturally appropriate services to Latinos. For the purposes of this study, culture was defined as the collective behaviors of a group that are typically considered to be the tradition and are transmitted from generation to generation. Four survey items collected data on participant opinions of whether or not they feel the HHCGa contains ethnic/racial diversity, cultural diversity, and professional diversity (i.e., metal health services, primary care, policy makers, etc.) The final open-ended question, allowed for participants to leave additional comments, regarding their perception of the HHCGa's culture and diversity.

Organizational Climate. This construct was broken down into coalition unity (or cohesion) and task focus. Coalition unity, or cohesion, was defined as the extent to which unity and closeness is felt between members. Task focus was defined as the extent in which the coalition engages in practical tasks. Seven Likert scales questions, with response choice options ranging from *strongly disagree = 1* to *strongly agree =5*, established particpants'

perception of the HHCGa unity felt within the membership. Statements included: 1) There is a feeling of unity within the coalition, 2) There is a strong emphasis on practical tasks, 3) There is not much group spirit, 4) There is a feeling of belonging, 5) There are not any concrete outcomes, 6) The membership feels close to one another and 7) Members work well together.

Mission & Vision. As a defining statement, coalitions should look to Mission and Vision statements that are both, clear and concise. Two dichotomous variables were measured (i.e. yes or no) to determine whether or not the membership agreed on the Mission and Vision of the coalition. Each statement was provided to the participant, then directly following the statement, they were asked whether or not they defined the work of the coalition. This allowed coalition leadership, the ability to identify an issue and make adjustments if the membership does not feel that they have accomplished their Missions or Vision. These statements changed half way through the study, so this data set was not analyzed.

Demographics. For comparison purposes, demographic information was captured to establish a profile of the membership (i.e. gender, age, race, education, Spanish proficiency, organizational information, etc.) The information was collected at the beginning and end of the survey.

Participant Protection

Responses provided in this survey are being used for a graduate level thesis. The protocol was submitted to IRB and received exempt status. Participants were told that their responses might be discussed in an academic setting and amongst the HHCGa staff and elected officials, but that confidentiality would remain throughout the study. The recordings produced during the key informant interviews, were destroyed once the information had

been entered into a database and a false name was attached to each transcript, which could not be linked to a participant's identity.

The online software program, which generated the membership survey, allowed for member participation to be completely confidential. Following the completion of the study, participants had the opportunity to enter a drawing to win a $50 gift card. One participant's e-mail was randomly selected and all participant information stored in the online database was destroyed soon thereafter. The raffle was voluntary and the participants could remove themselves at any time.

Informed, passive consent was obtained over the telephone prior to each key informant interview and prior to the administration of the online survey. (Appendix C) There is no direct benefit to the participant, and the assessment has contributed to the advancement of the Hispanic Health Coalition of Georgia and has provided them with vital information for future strategic planning. This study was voluntary and participants were not compensated for their time, instead participants who completed the online survey were eligible to enroll in an opportunity drawing to win a $50 gift card.

Data Analysis

Qualitative and quantitative data were collected and analyzed during this study. Qualitative data were obtained through the key informant interviews, using open-ended response items. Both qualitative and quantitative data were derived from the online membership evaluation tool. Out of the 77 items found on the membership evaluation tool, the majority contained fixed-response items(n=62) with a few open-ended response items (n=15). Data analysis methods for each data type are described in the section below.

Qualitative Data Analysis

Key informant interview data was completely qualitative, so that it could inform the development of the membership evaluation tool. Interviews were tape-recorded and interviewer notes were taken throughout the interviews. The interviews were played back, so that major themes could be captured for all constructs discussed. Themes were then compiled from all key informants across all constructs, and then used to help understand the coalition's history, development of the membership evaluation, and provide context to participant responses.

Membership evaluation data used a combination of qualitative and quantitative items. Of the 15 qualitative response items, all items were imported from SurveyMonkey.com, into a Microsoft Excel Spreadsheet and then transcribed into a Microsoft Word Document. One qualitative response asked for participant age; however, this item was re-categorized into age specific categories using 10-year increments. Nine of the items were coded according to theme and ordered according to frequency of theme within a response category. Tables were generated to depict the question at the top and corresponding themes below, with the frequency of the theme next to the response item. Three of the items were presented using exact quotes of all the participants, and two items included both thematic analysis and direct quotation, when there were not many reoccurring themes. The purpose of providing, supplemental information qualitative data, was to clarify additional perceptions and thoughts behind coalition leadership and staffing, coalition satisfaction, communication, and diversity /culture, some of which may not have been asked directly through quantitative survey items.

Quantitative Data Analysis

The quantitative responses were collected via SurveyMonkey.com, and imported via

an Excel Spreadsheet in Microsoft. All items were further imported into PASW (SPSS) Statistical Package Version 18. Descriptive statistics were reported in the form of frequencies. Unanswered items were left blank. Frequencies were run on each data item to determine data quality. Data cleansing occurred on open-responses, which allowed participants to elaborate and clarify their responses if the response was not provided. Typically, participant responses provided in the "other" category, was assigned to a response field if they fell within the definition, and if they feel outside of the definition, the response was left as other. For example, on the race/ethnicity item, participants were asked to self-report how they identify. Participants categorized themselves as "other", but then indicated that they were "Peruvian," was subsequently reclassified into the Latino/Chicano category. All scaled items were coded as they appeared on the questionnaire. Likert scale items, were collapsed into three point scales (e.g., strongly disagree and somewhat disagree, were collapsed into a "disagree category" and strongly agree and somewhat agree, were collapsed into an "agree category.") This was done to simplify reporting for the general public. Descriptive statistics were analyzed for demographic questions and each construct. A mean sample comparison t-test, separating the leadership from the membership, was run for Coalition Satisfaction and Coalition Unity. Also, a simple frequency comparison was made using the decision-making construct, looking at differences between the leadership and membership.

Finally, the survey questions pertaining to the HHCGa Mission and Vision were not analyzed because they changed mid-way through the data collection process and were not reported.

Limitations

This study is delimited in a few areas, the first being, that the survey tool does not cover all nine constructs used in the Community Coalition Action Theory (CCAT). In addition to the constructs outlined in the CCAT, an additional construct of Diversity and Culture was added, which has not be previously validated in the literature. The expectation of members to reflect or recall events many introduce participant bias. There was no sampling frame for the HHCGa coalition members, thus, convenience sampling was used, which brings in the possibility of selection bias. For the qualitative data analysis, one evaluator analyzed the data. Typically, two or more evaluators analyze the data separately, and then compare notes to determine if the data were interpreted similarly as a measure of quality control. With only one evaluator, segments of the data could have been misinterpreted or overlooked. Finally, of the two data collection techniques, the key informant interview and the membership survey may be biased due to the reliance on self-reported information.

Delimitations

The study did not examine Latino/Hispanic health outcomes in Georgia, because of time constraints and costs of conducting a large, state-wide evaluation. In addition, this study is the first of its kind for the HHCGa, which up until this point had not evaluated the membership. This data will be used as baseline data for years to come, but was not able to be compared with membership evaluation data from previous years. The scope of the study was to determine the current opinions for the HHCGa membership, and not look at HHCGa processes that might influence the members' opinions.

Chapter 4:

Results

This study utilized a mixed methodology for data collection, which comprised of qualitative telephone interviews of key informants and a cross-sectional on-line survey. The survey was provided to participants via, SurveyMonkey.com and all HHCGa members, staff and board members were invited to participate. The data contains information for HHCGa decision-makers, on their members' perceptions of engagement, roles within the coalition, recruitment, personal experiences and lessons learned. The data collection items were pulled from previous coalition evaluations that were driven by Community Coalition Action Theory (CCAT). The following constructs were considered in the instrument design: member involvement, decision-making influence, satisfaction, cohesion/unity, leadership, communication, mission and vision. Unlike many other coalitions that focus on a specific disease, policy or public health issue; the HHCGa addresses the issues of a particular medically underserved, minority group, so addition items pertaining to culture and diversity were added.

Key Informant Interview Results

At total of five key informant interviews were conducted with staff, board members and "inactive members" that held leadership roles. Interview durations lasted from 46 minutes to one hour and 55 minutes, depending on the interviewees' responses. One out of the five interviewees was conducted by a male, and professions of the interviewees varied with two participants working in direct healthcare, two working in continuum care services and one business professional. The interview guide contained constructs from the Community Coalition Action Theory (CCAT) as well as additional background information

that helped guide the membership survey development processes. The key informant interviews discussed the following topics: coalition history, leadership, member recruitment and retention, leadership opportunities, decision-making processes, communication, sustainability, satisfaction, representation, diversity and culture, accomplishments, challenges and purpose of conducting an evaluation.

Coalition History. All interviewee's identified the formation of the coalition as deriving from a basic need within the healthcare community in 1991. Several healthcare and social service professionals came together through the leadership and direction of Sister Barbara Harrington, as an informal networking organization with the sole purpose of sharing local bilingual health and social service information. Initially, meetings were small, with approximately 10 people representing organizations that provide culturally appropriate services to the Latino community. Nine years later, the Hispanic Health Coalition of Georgia developed a more formal structure with a governing body which included a president, vice president, secretary, registrar, and executive board with the purpose of gaining strength and switching the focus of the coalition from a networking organization, to an action driven organization. In 2002, the HHCGa was incorporated and became an official 501(c) 3. All positions and involvement was voluntary and there were no grants, awards or funding sources at the time. The first part-time position became available in 2009 when grant funds became available, with the sole purpose of obtaining grant funding.

Leadership. After the incorporation of the HHCGa, the governing body consisted of long-term members and those who volunteered for leadership positions, with a minimum two-year term for each position. The executive board positions were allocated via invitation only, and all governing positions are elected by the Board of Directors (BOD). The size of the board has fluctuated from 8-11 members over the years, but the appointment of a board

member currently happens through consensus and personal invitation of the BOD. In June 2009, the first Executive Director was hired on a part-time basis with the purpose of cultivating income development opportunities (e.g., grants, awards, donations, etc.). Today, the leadership consists of 11 Board of Directors, an Executive Board (e.g., President, Vice President, Treasurer, Secretary and Medical Director), a full-time Executive Director and a part-time Program Coordinator. There has been ambiguity in the past on who oversees the work of the leadership (i.e., Governing Bodies, Staff and Executive Board); however, there have been two internal evaluations to address this issue. It is without a doubt that the HHCGa leadership, most of which are volunteers, are devoted to Latino health causes and are actively trying to find solutions to achieve Latino health equity.

Member Recruitment &Retention. Meeting attendance grew over the years from having 10 attendees at the initial meetings, which doubled after the first 3-4 years, and then increased dramatically to upwards of 80 members after 10 years. The vast majority of the membership recruitment has happened at a grassroots level, via word-of-mouth and e-mail marketing. There were two types of members that were identified 1) individual members and 2) organization members, which are typically local business and/or organizations that serve Latino patrons. Organizations and businesses will send one or two representatives so that they may network, advertise services and report back any relevant information to their respective organizations.

One of the major marketing and recruitment events, mentioned by four out of the five interviewees as one of the HHCGa's greatest accomplishments, was the Latino Health Summit in 2009. The health awareness event was by invite only and allowed the HHCGa to gain access to over 100 of the state's most influential leaders, policy makers, businesses, health institutions, media outlets, funders, etc. for the purpose of putting Latin health issues

on everyone's agenda. The event built lasting relationships, collaborations and gained the much-needed support for the HHCGa Mission.

In addition to recruitment, the Latino Health Summit provided a forum for stakeholders to develop a strategic plan consisting of four strategic goals, action items and a timeline. All participants committed to one of the following goals of interest, which then became workgroups:

Goal 1: All Latinos in Georgia will have access to quality, culturally, and linguistically appropriate general and mental health care services.

Goal 2: To equip Latino individuals and organizations with the knowledge and the tools to advocate for themselves, as part of a broader advocacy community, working to achieve improved health outcomes and to reduce the stigma currently associated with immigrant families.

Goal 3: To identify and centralize existing health relevant resources and data that capture heterogeneity of the Latino communities.

Goal 4: Assure access to effective culturally relevant maternal/child health services through "Promatoras de Salud" and use of the medical home model.

Several of the workgroups followed through with their timeline and action items; however, many did not hold follow up meetings and did not accomplish their developed goal. For the workgroups that disbanded, or did not meet their goals, two of the interviewees felt this was not achieved because the workgroup's lack of guidance and/or leadership.

Communications. Currently, coalition quarterly meetings and bi-weekly newsletters are the primary activities and modes of communication that keep members engaged. The

quarterly meetings often bring together local resources, prominent speakers in the field of Latino health, networking between local organizations and professional development opportunities. At the October 2010 Quarterly Meeting, a representative from the Centers for Disease Control and Prevention presented national data findings on health disparities in the Latino community and a representative from the DeKalb County Department of Health provided local statistics on the Latino community. This specific quarterly meeting focused on education and provided members with the first bilingual Status of Health in DeKalb County Report 2010. At the January 2011 Quarterly Meeting, a hands-on workshop surrounding advocacy and how to speak with an elected official is one example of a professional development opportunity. Four out of the five interviewees mentioned that most of the educational opportunities and services that the HHCGa provides are during the Quarterly Meetings. In addition, the bi-weekly newsletter provides members with announcements on job opportunities, speaking engagements and service information (i.e., legal services, health screening services, ESL courses, etc.)

In the past, there have been several activities and events that have kept members engaged, some of which have included an Annual Networking Fair, Lunch & Learn conference calls, and Annual Fundraising Events. In addition, a Resource Manual was generated every 3-4 years, which included local Latino-serving organizations and the various services they provided. In order to advertise services and/or have access to the HHCGa Resources Guide, membership dues had to be paid in full. With the exception of the Annual Fundraising Event, most of the activities and resources have not been planned.

Leadership Opportunities. All interviewees indicated that there was not one clear path for members to become a part of the HHCGa's leadership, but that it is developedon a case-by-case basis and is often dependent on organizational needs. For example, the Executive

Board did not contain a member with a strong background in financial management. When this issue was identified, board members did an informal search to recruit a Financial Officer, who would provide pro-bono finance and tax expertise for the coalition.

When it comes to training the HHCGa leadership and conflict management, three interviewees mentioned a leadership retreat that involved the Governing Board, Executive Board and staff. The purpose was to reorganize the Mission and Vision, develop a three-year strategic plan and gain leadership skills through outcome measures provided from an internal evaluation. A consultant facilitated the retreat, and contributed expertise in coalition structure and maintenance, which was deemed helpful by all interviewees.

Decision-making Processes. All decision-making processes are required to go through the Board of Directors including grant writing approval, quarterly meeting speakers, events, fundraisers, budgeting, etc. Decisions made by the board typically happen through e-mail or online voting, with all board members votes having equal representation. All interviewees indicated that general members, do not have a say in setting the budget, goals, activities, policies, etc. for The HHCGa.

Though it is often a difficult topic, all interviewees mentioned they have personally been involved in at least one conflict with another member of the HHCGa, and a resolution was reached by putting the issue to a vote. Several of the conflicts were mentioned; however, identification of the conflict was not as important as how the conflict was handled. Though a voting system is typically the process taken to resolves a conflict, two interviewees mentioned that it would be helpful to have a "policy" on how to handle conflicts in the future.

Communication. The Board of Directors communicates, at minimum, on a monthly basis to ensure cohesion and completion of projects. The communication and outreach to

the membership occurs through a bi-weekly, electronic newsletter which is sent to all those who have signed up for the listserv. All communication between members happens voluntarily, but it was not known how often or which members communication outside of the Quarterly Meetings.

Sustainability. All interviewees mentioned and/or directed their attention to financial needs as a major contributing factor for the coalition's sustainability. The need to diversify funding sources (e.g., grants, corporate sponsorships, etc.) would help the coalition sustain programs, services and employees. Other areas that have helped sustain the activities and goals of the coalition include the hiring of a full-time Executive Director, making the organization visible to key stakeholders, continuing to host Quarterly Meetings, the development of the HHCGa Website, fundraising opportunities that generate funds and training opportunities of the BOD were a few of the suggestions provided by the interviewees. It is important to note that none of the interviewees thought the HHCGa could sustain itself for more than a couple of years, and as one interviewee mentioned that lack of security, "keeps him/her awake at night, thinking about how the HHCGa is going to continue."

Cultural & Diversity. All interviewees agreed that the HHCGa is ethnically and racially diverse; however, all of them also mentioned that the HHCGa lacked diversity of service organizations. One interviewee in particular felt that the HHCGa lacked cooperate representation, which could ultimately bring money into the organization. Other areas that were thought to be absent or lacking were refugee service centers, educational (K-12th grade) entities, attorneys, Latino healthcare providers, and consultants that will work pro-bono.

HHCGa Greatest Accomplishments. All interviewees mentioned the Latino Health Summit (2009) as being one of the greatest collaborative events because it brought together

many different decision-makers in Atlanta and identified a need. In addition, following were accomplishments mentioned by at least on interviewee:

- The coalition successfully intervened to prevent the closure of Grady Community Clinic, which provides medical services to majority, Latino medically underserved patients (n=1).
- In 2010, the advocacy workgroup collaborated on a project which mandates that medical facilities in the State of Georgia MUST provide medically trained interpreters for patients that speak a language other than English, and they cannot use a family members, spouses, friends, etc. to translate (n=2).
- Collaboration with the Office of Vital Records, to ensure that personnel are accurately trained to assign Latino names to birth certificate, to eliminate the possibility of errors as Latino names are not always confined to a one first, middle and last name (n=1).
- Diversidades cultural competency training in collaboration with the Morehouse School of Medicine, which provides health professional with hand-on education on how to services Latino patients (n=2).
- Bringing together multiple organizations to network, share resources and aim for solutions on providing culturally competent programs and services (n=2).

HHCGa Greatest Challenges. All interviewees mentioned that the attainment of funding or grant money was the greatest challenge for the HHCGa. Without financial stability, it was determined that it would be hard to grow the organization and expand on programs and services. In addition, one interviewee mentioned that it is difficult to implement change within the organization because some members are hesitate to transition from a strictly networking organization to an action driven, advocacy organization. Like

many volunteer driven organizations, one of the interviewees felt that decisions made by the leadership were not always made in the best interest of the HHCGa, but were based on alternative agendas. In the past, many of the challenges within the leadership were due to the expanding leadership and the hiring of staff, without the discussion of management protocol and "who answers to who," as mentioned by two interviewees. At this point, the interviewees mentioned, that this issue has been resolved.

Purpose of the Membership Evaluation. All interviews were supportive of the membership evaluation and hope to use the results to determine the desired benefits members deem rewarding, to gain overall perception of the coalition from the outside community, and to help guide strategic planning efforts. One interviewee mentioned that the information from the evaluation will help guide a membership benefits package, that will be created in the future, and indentify ways in which the leadership can get members more involved.

Coalition Member Survey Results

All respondents of the coalition membership survey were individual members, organizational members, board members or staff. The respondents were majority female, with less than a 20% male response rate and one member who identifies as a gender other than male or female. The majority of the respondents were Latino/Chicano (76.9%) and native Spanish-speakers (65.4%). Participants' ages ranged from 26 to 68 years of age, with the average age of participants being 47.5 years. Regardless of the participants' ethnicity/race, none one considered their Spanish language ability to be less than "Elementary." Participants indicated that they had a high level of educational attainment, with at least some college education, but the majority indicated that they held a Master's or Doctorate level degree (53.8%). The response rate of the membership was 62.9%, which

included both individual and organizational members, and 37% for the leadership, which included both staff and board members. Of those participants that represent an organization, the three most popular service(s) that organizational members provide are direct healthcare services (22.5%, n=9), continuum of care services (22.5%) and educational services (22.5%). Examples of direct healthcare services included those provided by primary care physicians, physician assistants, nurses and mental health providers. Continuum of care examples included services provided by social workers, public health professionals, lay community health workers, etc. Educational services included ESL courses, continuing education, citizenship courses, self-help, public schools, colleges, technical schools, etc. Detailed demographic information is provided in Table 1.

Data from the coalition member survey will be presented in the following order: (A) Membership & Involvement, (B) Decision-making, (C) Leadership & Staffing, (D) Communication, (E) Coalition Satisfaction, (F) Diversity & Culture and (G) Organizational Climate (i.e. cohesion/unity). Originally, two items inquired about the perceptions of the HHCGa Coalition's Mission and Vision statements; however, in February 2011, the Mission and Vision statements underwent revisions and were completely altered. The information provided from these questions is considered irrelevant at this time, and will not be discussed.

Membership & Involvement

Of the ten items that covered the topic of membership and involvement, 27 participants responded to the closed-ended questions, while 26 participants answered the open-ended questions. Approximately half the respondents (54.8%) classified their level of activity within the HHCGa as "Somewhat" to "Very Active" and many of respondents

Table 1: Membership Evaluation of the HHCGa, Demographic Information

	N	(%)
Gender		
Male	5	(19.2%)
Female	20	(76.9%)
Other	1	(3.8%)
Age		
20-29 years	2	(7.7%)
30-39 years	6	(23.1%)
40-49 years	6	(23.1%)
50-59 years	7	(26.9%)
≥ 60 years	5	(19.2%)
Ethnicity/Race		
Non-Hispanic White	3	(11.5%)
African	2	(7.7%)
American/Black	20	(76.9%)
Latino/Chicano	0	(0%)
Asian/Pacific Islander	0	(0%)
Native American	1	(3.8%)
Other		
Spanish Language Ability		
Elementary	2	(7.7%)
Intermediate	2	(7.7%)
Advanced	2	(7.7%)
Fluent	3	(11.5%)
Native	17	(65.4%)
Educational Attainment		
Some College	2	(7.7%)
College Graduate	6	(23.1%)
Some Graduate School	4	(15.4%)
Master's Degree	9	(34.6%)
Doctorate Degree	5	(19.2%)
Affiliation		
Individual Member	5	(18.5%)
Organization Member	12	(44.4%)
Board/Staff	10	(37.0%)

*Data excludes missing values or incomplete responses

	N	(%)
Level of Activity		
Not At All	3	(9.7%)
Not Very Active	7	(22.6%)
Somewhat Active	8	(25.8%)
Very Active	9	(29.0%)
Length of Time Involved		
< 1 Year	5	(18.5%)
1-2 Years	6	(22.2%)
3-4 Years	7	(25.9%)
≤5 Years	9	(33.3%)
Attendance at Quarterly Coalition Meetings		
0 Times/Yr	4	(14.8%)
1 Time/Yr	5	(18.5%)
2 Times/Yr	4	(14.8%)
3 Times/Yr	9	(33.3%)
4 Times/Yr	5	(18.5%)
Reason for Involvement		
Represents an org.	22	(50.0%)
Personal interest	19	(43.5%)
Career Opportunities	1	(2.3%)
Student	0	(0%)
Other	2	(4.5%)
Services Provided by Member Organizations		
Educational	9	(22.5%)
Communication	2	(5.0%)
Economic	1	(2.5%)
Religious	0	(0%)
Legal	1	(2.5%)
Direct Healthcare	9	(22.5%)
Continuum of Care	9	(22.5%)
Recreational Services	2	(5.0%)
Social Services	5	(12.5%)
Other	2	(5.0%)

were relatively new to the coalition, with an involvement of 2 years or less (40.7%). Self-reported attendance of at least half of the quarterly meetings (i.e., 3 or more meetings) was approximately half of the participants (51.8%). Approximately half of the participants that indicated their reason for involvement was to represent an organization that provides services to Latino patrons (50.0%), and the second most common reason for participation was because participants had a personal interest in Latino health (43.5%). Several of the participants indicated that they have not attended an HHCGa-sponsored event, or they have only attended one event (22.2%); however, the majority of the participants have attended one to four events (59.3%). When asked which events the members would consider attending again, the most popular responses included fundraising events, advocacy trainings and coalition meetings. Several of the members elaborated on the specific topics and/or speakers they enjoyed hearing about (e.g. CDC Presentation and DeKalb County Public Health Report.) All results are presented in Table 2.

When asked to recall some of the qualities and/or benefits that attracted the members into becoming involved with the HHCGa, the most common response was to network with other Latinos or Latino-serving organizations, followed by an interest in gaining addition information and/or resources, having the opportunity to highlight their organizations' programs and/or services (n=6), and learning about other Latino-based programs and/or services, see Table 3. One participant described

Table 2: Events members would attend a second time.

- Quarterly meetings (5)
  - CDC Presentation
  - DeKalb County Public Health Report
- Fundraising Events (4)
  - Annual Fundraiser
- Advocacy training (3)
- Committee meetings
- Speakers event (2)
- Social events
- Board meetings
- Education events and/or activities (i.e., Health Fairs, workshops, lunch & learn)

their reasons for joining the coalition the following way:

> *"Leadership, passion for making a difference. Sense of accomplishment by pursuing the opportunity to assist an organization."*

Table 3: Why members joined the coalition.

- Networking with Latinos or Latino serving organizations (11)
- Gain resources & information (7)
- Opportunity to highlight my program/organization (6)
- Learning about new programs, services & causes (4)
- Education (3)
- Requested by employer (2)
- Reputation of the HHCGa (2)
- Interest in decreasing health disparities (2)
- Professional development opportunities
- Advocacy activities
- Improvement of Latino health services
- Latino awareness/public presence
- Job Opportunities

Participants indicated the reason for staying engaged in the HHCGa is to network, to gain addition information and/or resources, and because the HHCGa has a dedicated leadership. (Appendix F, Table 1) When asked to indicate reasons for not becoming more involved, participants' most commonly cited that they faced time constraints, work interference or limitations, they had other commitment or obligations or they had scheduling conflicts. (Appendix F, Table 1) In addition, most of the respondents indicated that they pay their annual dues (70.4%).

To supplement these finding, respondents were asked to report what the HHCGa means to them. (Appendix F, Table2) There were two negative comments and 15 positive comments that highlight the uniqueness of the HHCGa, its mission and expectations regarding outcomes that the respondents hope to accomplish. One participant described their personal feelings of what the HHCGa meant to them in the following statement:

> *"Group of individuals and organizations that come together to educate each other, network and advocate for Latino communities to have health equity."*

Yet another participant indicated that their experience and involvement with the HHCGa was because they are the "only" coalition that engages the Hispanic/Latino

Community. Respondents were also given the opportunity to voice how the HHCGa might contribute to their specific organization's scope of work. Twelve participants indicated that the HHCGa could increase advocacy, education, networking, collaboration/information sharing between organizations, availability/support, training (e.g., cultural competency), capacity building and grant/funding opportunities. (Appendix F, Table 3) In addition, participants provided the following information on additional benefits they wanted to received from the HHCGa: advocacy, training, education, access to bilingual (electronic) resources, and additional opportunities in volunteering, professional development, mentoring, jobs, networking, grant/funding, marketing their organization's services and client referrals. (Appendix F, Table 4).

B. Decision-Making

Decision-making items were completed by respondents using a five-point Likert Scale, but were condensed into the following three categories for simplicity: *No Influence to Not Much Influence*, *Some Influence to A Lot of Influence*, and *I Don't Know*. There were 27 respondents that completed all five items, and four that left all items blank.

Of the 27 respondents that completed the survey, the majority indicated that they "Did Not Know" who set the goals and objective for the HHCGa (44.4%) and approximately, one-third of the respondents indicated that the members had "Some to A lot" of influence (29.6%). When asked to indicate, who selected the activities for the HHCGa, the majority of the coalition indicated they "Did Not Know" (40.7%,) or that they had "Not Much to No Influence" (33.3%). Almost, half of the respondents indicated that they "Did Not Know" who set the budget for the coalition (48.1%) and the other majority indicated that they had "Not Much to No Influence" (40.7%). When asked how much influence coalition members have in deciding on coalition policies and actions, the majority

of the members indicated they "Did Not Know" (44.4%) or that they had "Not Much to No Influence" (37.0%). In addition, when asked to indicate which groups make the major decisions for the coalition, over three-fourths of the responses pointed to the HHCGa Board Members (77.8%). Results on membership influence on decision-making process are presented in Table 4.

TABLE 4: MEMBER INFLUENCE ON DECISION-MAKING

Type of Decision	Level of Influence		
	No Influence to Not Much Influence N (%)	Some Influence to A Lot of Influence N (%)	I don't know N (%)
Setting goals and objectives for The Coalition (n=27)	7 (25.9%)	8 (29.6%)	12 (44.4%)
Selecting activities for The Coalition (n=27)	9 (33.3%)	7 (25.9%)	11 (40.7%)
Setting the budget for The Coalition's activities (n=27)	11 (40.7%)	3 (11.1%)	13 (48.1%)
Deciding on general coalition policies and actions (n=27)	10 (37.0%)	5 (18.5%)	12 (44.4%)

In addition, a side-by-side comparison of the leadership and membership on opinions of coalition member influence on decision-making, indicated that the majority of the membership (>80%) did not think that they were able to influence any of the categories (i.e., setting goals and objectives, selecting activities, setting the budget, etc.) Conversely, a large majority of the leadership indicated that the membership did not have much influence on making decisions for the coalition (>55%). Comparison results are presented in Table 5.

C. Leadership & Staffing

On items that refer to the respondents' perceptions of leadership and staffing, 27 respondents completed the survey responses and 4 did not. For reporting purposes, a five-point Likert Scale was collapsed into the following three categories: *Disagree* (previously, Strongly Disagree and Somewhat Disagree), *Neutral,* and *Agree* (previously, Strongly Agree and Somewhat agree).

Table 5: A Comparison HHCGa Leadership & Members Opinions on Decision-Making Influence

Type of Decision	Leadership[1]			Membership[2]		
	No Influence to Not Much Influence N (%)	Some Influence to A Lot of Influence N (%)	I don't know N (%)	No Influence to Not Much Influence N (%)	Some Influence to A Lot of Influence N (%)	I don't know N (%)
Setting goals and objectives for The Coalition (n=27)	4 (57.1%)	4 (50.0%)	2 (16.7%)	3 (42.9%)	4 (50.0%)	10 (83.3%)
Selecting activities for The Coalition (n=27)	5 (55.6%)	3 (42.9%)	2 (18.2%)	4 (44.4%)	4 (57.1%)	9 (81.8%)
Setting the budget for The Coalition's activities (n=27)	7 (63.6%)	1 (33.3%)	2 (15.4%)	4 (36.4%)	2 (66.7%)	11 (84.6%)
Deciding on general coalition policies and actions (n=27)	7 (70.0%)	1 (20.0%)	2 (16.7%)	3 (30.0%)	4 (80.0%)	10 (83.3%)

[1] Leadership: HHCGa Board Members & Staff
[2] Membership: HHCGa individual members & members representing an organization
* Denotes statistical trend of $p \leq 0.051$

A large majority of the respondents indicated that they feel welcomed by the leadership/staff at coalition meetings (77.7%) and felt that they received praise and recognition during the meetings (70.4%). Over half of the respondents indicated that the leadership/staff had a clear vision and direction for the coalition (66.6%) and that they are well known within the Latino community (59.2%). However, over half of the respondents indicated impartiality on whether or not the leadership or staff were skillful at resolving conflict (51.9%). When asked if the leadership/staff were too controlling, the majority of participants remained "Neutral" (44.4%); however, one-third indicated that they agreed with the statement (33.3%). The majority of the respondents indicated that the leadership/staff were respected by coalition members (70.4%) and that they were competent (59.2%). When asked if the leadership/staff responds well to criticism, over half responded with "Neutral" (59.2%) and over one-third acknowledged their agreement with the statement (37.0%), see Table 6.

Finally, respondents were encouraged to elaborate on ways that they felt the leadership could improve. One particular respondent indicated that they would like to become more involved and receive addition information the coalition in the statement below:

> *"I think that orientation sessions for new members would be very helpful in providing information regarding the Coalitions mission and purpose in the community. This would help new members become acquainted with the history of the Coalition and its current projects/programs, as well as ways to become more involved."*

Some of the other comments indicated that they would like more updates and mentoring opportunities. (Appendix F, Table 5)

TABLE 6: PERCEPTION OF LEADERSHIP/STAFF BY THE MEMBERS			
	Level of Agreement/Disagreement		
Leadership/Staff Actions	**Disagree N (%)**	**Neutral N (%)**	**Agree N (%)**
They make me feel welcome at meetings. (n=27)	1 (3.7%)	5 (18.5%)	**21 (77.7%)**
They give praise and recognition to members at meetings. (n=27)	0 (0%)	8 (29.6%)	**19 (70.4%)**
They intentionally seek out the member's opinions and suggestions. (n=27)	5 (18.5%)	9 (33.3%)	13 (48.1%)
They ask members to assist with specific tasks. (n=27)	5 (18.5%)	9 (33.3%)	13 (48.1%)
They make an effort to get to know members. (n=27)	5 (18.5%)	11 (40.7%)	11 (40.7%)
They have a clear vision and direction for The Coalition. (n=27)	3 (11.1%)	6 (22.2%)	**18 (66.6%)**
They are well known within the Latino Community. (n=27)	6 (22.2%)	5 (18.5%)	16 (59.2%)
They are skillful at resolving conflict. (n=27)	1 (3.7%)	14 (51.9%)	12 (44.4%)
They are too controlling of The Coalition. (n=27)	6 (22.2%)	12 (44.4%)	9 (33.3%)
They provide good guidance to The Coalition. (n=27)	1 (3.7%)	14 (51.9%)	12 (44.4%)
They are well respected by coalition members. (n=27)	1 (3.7%)	7 (25.9%)	**19 (70.4%)**
They are competent. (n=27)	1 (3.7%)	10 (37.0%)	16 (59.2%)
They respond well to criticism. (n=27)	2 (7.4%)	15 (55.5%)	10 (37.0%)
They work well with coalition members. (n=27)	2 (7.4%)	11 (40.7%)	14 (51.9%)
They are usually available for assistance. (n=27)	4 (14.8%)	12 (44.4%)	11 (40.7%)

D. Communication

Of the six items that considered internal and external communication processes, one was open-ended. There were 27 respondents that completed six items and four that did not complete the items. When asked to recall ways in which respondents heard of the HHCGa the majority indicated that they heard of the coalition via word-of-mouth (e.g. leadership recruitment, another professional/friend, co-worker or unspecified personal invite) (63.0%). Other common methods of recruitment were from the leadership (i.e., staff or board

member) (22.2%), another professional (22.2%), and from either a co-worker/employer (22.2%). (Table 7)

Table 7: Ways members heard about the coalition.

- Leadership (staff or board member) recruitment (6)
- Another professional/friend (6)
- Co-worker (3)
- Employer (3)
- Do not remember (2)
- Another agency (2)
- Personal invite (2)
- Media (2)
- Received an e-mail

When asked to express their preferred method of communication for meetings and events, the majority of respondents indicated they prefer e-mail the most (92.6%) and phone calls the least (37.0%). The other least preferred method of communication included social networks (e.g., Facebook, Twitter, etc.) (22.2%), which showed the same response rate as e-mail (22.2%). When asked how often respondents would prefer to hear from the HHCGa, the majority indicated either weekly (48.1%) or monthly (37.0%). Finally, Table 8 indicates the respondents' perceptions of the internal and external communication, initially using a five-point Likert Scale and then collapsing the categories into the following: No to Infrequent Communication, Somewhat to Very Frequent Communication, and I Don't Know/Couldn't Say. Respondents were asked to consider the frequency of communication between members and the leadership, and responses showed little variation with 37.0% indicating somewhat to very frequent communication. When respondents were asked to consider the frequency of communication between the members, responses were split evenly across the categories (33.3%).

TABLE 8: COMMUNICATION BETWEEN GROUPS

	Frequency of Communication		
Groups	**No to Infrequent Communication N (%)**	**Somewhat to Very Frequent Communication N (%)**	**I don't know/Couldn't Say N (%)**
Between The Coalition members and staff/board members? (n=27)	9 (33.3%)	10 (37.0%)	8 (29.6%)
Between The Coalition members and other coalition members? (n=27)	9 (33.3%)	9 (33.3%)	9 (33.3%)

E. Coalition Satisfaction

Thirteen Likert Scale items and three open-ended responses assessed respondents overall satisfaction with the coalition. The five-category response items were collapsed into the following three categories for reporting purposes: *Very Unsatisfied to Unsatisfied*, *Neutral* and *Satisfied to Very Satisfied*. All responses are detailed in Table 9.

TABLE 9: COALITION SATISFACTION

	Level of Satisfaction		
Coalition Areas	**Very Unsatisfied to Unsatisfied N (%)**	**Neutral N (%)**	**Satisfied to Very Satisfied N (%)**
The Coalition's involvement in the Latino community. (n=26)	5 (18.5%)	9 (34.6%)	12 (46.2%)
The Coalition's efforts to recruit new members. (n=26)	7 (26.9%)	13 (50.0%)	6 (23.1%)
The Coalition's involvement with State and local policy and/or advocacy efforts. (n=26)	3 (11.5%)	13 (50.0%)	10 (38.5%)
The Coalition's adherence to health promotion and educational efforts. (n=26)	5 (18.5%)	7 (26.9%)	14 (53.8%)
The Coalition's promotion of Latino health resources and services. (n=26)	5 (18.5%)	6 (23.1%)	**15 (57.7%)**
The structure of the agenda at Quarterly Meetings. (n=26)	1 (3.8%)	10 (38.5%)	**15 (57.7%)**
Topics presented and discussed at the Quarterly Meetings. (n=26)	2 (7.7%)	7 (26.9%)	**17 (65.4%)**
Professional development opportunities (e.g. professional trainings, seminars, workshops, etc.) (n=26)	5 (18.5%)	13 (50.0%)	8 (30.8%)
Opportunities for coalition members to take leadership roles. (n=26)	8 (30.8%)	11 (42.3%)	7 (26.9%)
The activities selected by The Coalition. (n=26)	4 (15.4%)	11 (42.3%)	11 (42.3%)
The result of those activities selected by The Coalition. (n=26)	3 (11.5%)	14 (53.8%)	9 (34.6%)
The fundraisers selected by The Coalition. (n=26)	1 (3.8%)	15 (57.7%)	10 (38.5%)
The results of those fundraisers selected by The Coalition. (n=26)	0 (0%)	18 (69.2%)	8 (30.8%)

Respondents were asked to categorize their level of satisfaction of the HHCGa's involvement in the Latino community. When respondents were asked to categorize their level of satisfaction of adherence to health promotion and education, the common sentiment was positive (53.8%), in addition to the majority satisfaction for health resources and

services (57.7%). Regarding the structure and agenda of the coalition quarterly meetings, many of the respondents indicated a high level of satisfaction (57.7%), which was similar to the sentiment for topics presented at the meeting (65.4%). For professional development opportunities, most of the respondents indicated that they were neutral on the subject matter (50.0%) or satisfied to very satisfied (30.8%). The area with the most respondents indicating they were either very unsatisfied or unsatisfied, was on the opportunity for coalition members to take leadership roles (30.8%), with the majority indicating neutrality on the subject (42.3%).

When the roles of the respondents were dichotomized into leadership and membership, and means were compared for each item to indentify significant differences of opinion of the four items. For coalition's adherence to health promotion and educational efforts, the level of satisfaction was significantly lower for members ($x=2.1$) than it was for the coalition's leadership ($x=3.1$) ($p=0.008$). Also, the coalition leadership had s significantly higher level of satisfaction ($x=3.4$) when it came to topics that were presented and discussed at Quarterly Meetings, verses the membership ($x=2.6$) ($p=0.047$). There seem to be a similar sentiment towards the activities selected and the result of those activities, with the majority of the membership indicating lower levels of satisfaction, $x=2.06$ ($p=0.042$) and $x=2.0$ ($p=0.013$), respectively. Details are listed in Table 10.

The open-ended responses gave respondents the opportunity to share particular topics of interest around the specific health topics of interest. Of the eight respondents, topics of particular interest included obesity, in both children and adults, and health disparity topics (Table 11). In addition, professional development opportunities and trainings of interest included: integrated health topics, continuing education credits for health professionals, leadership trainings, advocacy trainings, mental health trainings and

TAABLE 10: DIFFERENCES IN MEMBERSHIP & LEADERSHIP COALITION SATISFACTION

	Affiliation to HHCGa		
	Leadership[1]	Members[2]	
Coalition Areas	**N Mean (SD)**	**N Mean (SD)**	**P-Value**
The Coalition's involvement in the Latino community.	10 2.5 (0.85)	16 2.1 (0.96)	0.32
The Coalition's efforts to recruit new members.	10 2.1 (0.88)	16 1.88 (0.62)	0.45
The Coalition's involvement with State and local policy and/or advocacy efforts.	10 2.5 (0.71)	16 2.2 (0.98)	0.39
The Coalition's adherence to health promotion and educational efforts.	10 2.8 (0.79)	16 2.3 (1.18)	0.21
The Coalition's promotion of Latino health resources and services.	10 3.1 (0.57)	16 2.1 (1.15)	**0.008***
The structure of the agenda at Quarterly Meetings.	10 2.9 (0.74)	16 2.6 (0.89)	0.42
Topics presented and discussed at the Quarterly Meetings.	10 3.4 (0.70)	16 2.6 (1.02)	**0.047***
Professional development opportunities (e.g. professional trainings, seminars, workshops, etc.)	10 2.4 (1.07)	16 2.1 (1.02)	0.52
Opportunities for coalition members to take leadership roles.	10 2.2 (1.23)	16 1.94 (0.68)	0.55
The activities selected by The Coalition.	10 2.7 (0.82)	16 2.06 (0.68)	**0.042***
The result of those activities selected by The Coalition.	10 2.7 (0.82)	16 2.0 (0.52)	**0.013***
The fundraisers selected by The Coalition.	10 2.6 (0.52)	16 2.3 (0.68)	0.17
The results of those fundraisers selected by The Coalition.	10 2.7 (0.82)	16 2.3 (0.58)	0.15

[1] Leadership: HHCGa Board Members & Staff
[2] Membership: HHCGa individual members & members representing an organization
* Denotes statistical significance of ≤ 0.05

information on local resources. (Appendix F, Table 6). In addition, five respondents gave supplemental information on areas, which they perceived as being unsatisfactory. Several of the suggestions were towards Quarterly Meeting length and start time, plus, suggestions on additional resources. (Appendix F, Table 7).

Table 11: Health topics members would like to learn more about.

- Acculturation/assimilation and the impact on health outcomes
- Obesity (e.g., child vs. adult) (2)
- Chronic disease
- Violence
- Health disparities (2)
- State of Georgia's health agenda
- Continuing medical education
- Tuberculosis
- Mental health
- Health Reform
- Diabetes
- Georgia's Nutrition and Physical Activity Strategic Plan
- Healthy People 2020
- PartnerUp for Public Health (Georgia-based campaign)
- Vision impairment
- Hearing impairment

Additionally, respondents were asked to convey their expectations of the HHCGa, and whether or not they have been met. There were five positive comments, eight comments that were neither positive nor negative, and five negative comments expressing expectations had not been met. The positive comments included having the expectation of having a group to share resources with, networking, and learning about local activities; all of which were met. In comments that were neither positive nor negative, expectations were framed in the future-tense or specifically stated that the expectations were partially met or somewhat met. Expectations included updating the membership on local resources, customer referrals, education on Latino health-related topics, and that they expect that HHCGa will be the umbrella organization for all Latino health resources. Negative comments, in which expectations were not met, included the following: having the HHCGa as the Latino "go to" organization, allowing members to take part in setting the coalition's goals, using HHCGa to foster collaboration, etc. Detailed descriptions provided in Appendix F, Table 8.

F. Diversity & Culture

The addition construct of diversity and culture was added to framework, as the HHCGa is not a disease-focused coalition, but rather motive by a medically underserved, minority group. For this reason, three addition items were developed that looked at diversity of cultures (i.e., Mexican, Cuban, Columbia, etc.) and services (i.e., mental health, direct healthcare, education, etc.) within the coalition. In addition, respondents were asked to justify their response if they selected that the coalition was lacking in diversity. When asked if the HHCGa made up a wide array of Latino cultures, the majority of the respondents indicated their agreement (65.4%); however, the same amount of respondents indicated that they did not know or indicated their approval of the diversity and inclusiveness of various Latino sub-cultures (i.e. Central American, South American, indigenous cultures, etc.) (42.2%). When the diversity of the services provided by coalition members was considered, the majority of the respondents indicated they considered the group to be diverse (42.3%). Those who did not agree, indicated the specific services or stakeholders they thought were not present and could benefit the coalition. The following comment, identifies a board suggestion that would be beneficial across all services:

> *"The coalition needs to have bilingual communication, both written and/or verbal, so it can attract more individuals who are not English proficient"*

Additional suggestions for increasing diversity include providing more services or resources around mental health services for Latinos and the inclusion of local policy makers. (Appendix F, Table 9)

G. Organizational Climate

One indicator for the construct of organizational climate is to determine whether or not there is unity and/or cohesion felt by the members. Unity and/or cohesion was measured using a five-category Likert Scale, which was collapsed into the following three categories: Disagree, Neutral and Agree. Twenty-six responses were collected and five respondents chose not to participate.

Overall, respondents agree that there is a felling of unity and cohesions in the coalition (46.2%). This construct was further tested by asking if there is a strong emphasis on practical tasks within the HHCGa, which was split between those who were in agreement and those who were impartial to the question (38.5%). Many respondents indicated that they would disagree (30.8%) or they are neutral (50.0%) with the state that the coalition rarely has anything concrete to show for its efforts. When questioning group unity and closeness, the majority of respondents were in agreement (26.9%) or impartial (50.0%). This was similar to the finding that respondents indicated the members of the coalition work well together (38.5%) or they were impartial (50.0%). For addition information, see Table 12.

TABLE 12: COALITION UNITY

	Level of Agreement or Disagreement		
Areas of Unity and/or Cohesion	**Disagree N (%)**	**Neutral N (%)**	**Agree N (%)**
There is a feeling of unity and cohesion in the coalition. (n=26)	6 (23.1%)	8 (30.8%)	12 (46.2%)
There is a strong emphasis on practical tasks in The Coalition. (n=26)	6 (23.1%)	10 (38.5%)	10 (38.5%)
There is not much group spirit among members of The Coalition. (n=26)	9 (34.6%)	11 (42.3%)	6 (23.1%)
There is a feeling of belonging in The Coalition. (n=26)	6 (23.1%)	10 (38.5%)	10 (38.5%)
The Coalition rarely has anything concrete to show for its efforts. (n=26)	8 (30.8%)	13 (50.0%)	5 (18.5%)
Members of this coalition feel close to each other. (n=26)	6 (23.0%)	13 (50.0%)	7 (26.9%)
Members of The Coalition work well together. (n=26)	3 (11.5%)	13 (50.0%)	10 (38.5%)

When considering differences between the perception of coalition unity or cohesion, in the leadership and membership, there was no statistically significant findings for all items ($p>0.05$). (Appendix F, Table 10).

Chapter 5:

Conclusion, Implications& Recommendations

The purpose of the Membership Evaluation was to examine the internal strengths and weaknesses, as they are perceived through the opinions of the membership. Feedback from the evaluation would 1) help guide strategic marketing plans to recruit new prospective coalitions members, 2) provide a retention plan to keep current members engaged in HHCGa's activities' and 3) provide direction on the making the coalition more efficient and effective. In addition, evaluation aims to uncover the membership's expectations and needs so that the HHCGa can address some of the most common needs.

The HHCGa was establish in 1990 and incorporated in 2002, with the initial intention of bringing together health service providers to network and collaborate on projects that were culturally and linguistically appropriate for Metro-Atlanta's sprawling Latino community. Over the last 10 years, the HHCGa has expanded their membership from a conservative group of 10 Latino-serving organizations to a listserv of upwards of 300 individuals, that provide a substantial amount of services including media, advocacy, consulting, legal, social, recreational, educational, direct healthcare and continuum of care services. In addition to spreading their network and putting Latino health issues on the agenda of Atlanta' s most influential stakeholders, the HHCGa has helped ensure that all local medical facilities provide medically certified interpreters to all limited English proficient (LEP) patients. They have also partnered with the Morehouse School of Medicine on a cultural competency training for young physicians called *Diversidades*. In addition, they helped develop the regulations for vitally office personnel whom, in the past have documented Latino newborns' with the incorrect surnames.

Previously, HHCGa underwent two internal process evaluations with the help of outside consultants, where they revamped their Mission, Vision and Three-Year Strategic Plan. Prior to the U.S. Census 2010, there was no question as to who would be identified as the fastest growing minority group in Georgia. As patient demographics started to shift from predominately non-Hispanic white and African American/Black, healthcare services providers started seeking professional outlets that offered a network of local health, educational, social and legal resources to Latinos. Many of the organizations saw an opportunity in networking and collaborating with like-minded individuals, so that they could find ways to maximize their services and find the necessary medical service providers more efficiently. Early members mentioned that they made an effort to attend all HHCGa-sponsored events that fostered collaboration. The HHCGa recognizes that each individual, or organization, represents an entity that can help increase health access and services to a small community of Latinos within Georgia; however, collectively the group can have a larger impact on Latino health.

Key informant interviews, using qualitative methodology, were comprised of five individuals with varying levels of activity, leadership and participation with the HHCGa. The responses guided the development of the membership survey and increased survey instrument reliability, by drawing out the history of the HHCGa and constructs from the Community Coalition Action Theory (CCAT). Participants were able to give their personal accounts of the HHCGa evaluation and how this could negatively or positively influence member perceptions. The constructs included 1) coalition membership, 2) operations and processes, 3) leadership and staffing and 4) member engagement. Coalition membership included defining membership criteria, demographical information on services and programs provided to the Latino community, and barriers or facilitating elements that keep the

membership involved. Operations and processes included organizational climate (e.g. organizational cohesion or unity), internal and external communication, decision-making influence, internal conflict management, training opportunities and collaborative planning (e.g., budget, goals and activities). Member engagement is accomplished by members committing to the mission and goals of the coalition, high levels of participants both in and outside of coalition meetings and activities, and satisfaction with the work of the coalition (Butterfoss & Kegler, 2002). Member participation, involvement and satisfaction were all taken into consideration for member engagement. An additional theme of culture and diversity, which included both ethnic diversity and services provided by the organizations, was added to meet the needs of the unique population that HHCGa services.

The on-line membership survey provided both qualitative and quantitative components that were derived from the CCAT (e.g., membership and involvement, decision-making, leadership and staffing, communication, coalition satisfaction, diversity and culture, and organizational climate). The online survey tool included 64-fixed response and 14-open response items, which was made available to all members, executive board members and staff.

Conclusions

HHCGa classifies their affiliates as individual members, organizational members, Board of Directors, Executive Leadership Board and Staff, with the majority of the members self-indentifying as organizational members. Less than a quarter of the members were male (19.2%) and the majority identified as Latino/Chicanos (76.9%) with high Spanish-speaking abilities (76.9%). The majority have earned at least a college degree or more education (92.3%), and represent an organization (50.0%) with educational services, direct healthcare and continuum of care services being the top services provided to the Latino community.

At first glance, the organization is comprised of highly educated individuals with professional and grassroots-based membership, implying this is a "community-based" coalition (Butterfoss, Goodman, & Wandersman, 1993). Historically, the HHCGa served as a networking coalition, but has since re-labeled themselves and their mission to an "action-driven" coalition, which has been show to be a beneficial characteristic in uniting members and focusing on outcomes (Butterfoss, Goodman, & Wandersman, 1993). The diverse qualities of the HHCGa membership, provides additional opportunities for the group.

Overall, the members are not clear as to what decisions they are able to make for the coalition, although, there is a slight possibility that this is the result of having a fairly new membership. This is also recognizable by the leadership, though it might not have been clear to them prior to this evaluation. Allowing members to actively be part of decision-making processes will increase member engagement and lead to less member turnover. In other successful coalitions, the membership is not only entitled to receive services, but also carries to responsibility of contributing to the coalition (Kegler, Steckler, Malek, & McLeroy, 1998). Uncertainty of member roles is one of the major challenges noted in other studies on building effective coalitions (CDC, 2007). To address this concern, coalitions should communicate with their membership by first awknowledging the issue and then including members to derive at a solution. This will not only facilitate member engagement, but also provide a positive organizational climate.

Factors that contribute to coalition member recruitment and involvement include the opportunity to network with other Latino serving organizations, gaining resources and information on the Latino community and the opportunity to highlight member's organizational programs and services. The latter, can be attributed to the HHCGa's historical framework as a predominately networking organization. Organizational members

are interested in learning about the programs and services that other local organizations are providing, so that they may refer to them on a professional level. Members' ability to speak-openly about reasons for join and staying with the HHCGa were very similar in that they all revolved around networking, information sharing and education. Reasons for not wanting to become more involved were attributed to work, time constraints, other obligations or commitments and scheduling conflicts. One participant indicated that they were unsure how to become more involved, which can be addressed in the future. Other members attributed long, early morning meetings as not being conducive to their schedules.

Coalition satisfaction is a vital component of member retention. Areas that indicated a difference of opinion, where the leadership indicated a higher level of satisfaction in comparison with the membership, was on the topic of promotion of Latino health resources and services, topics presented and discussed at Quarterly Meetings, activity selection and, also, the result of those activities. Health promotion of Latino health resources and services was also one of the areas that attracted most members into the HHCGa. Assuming that these resources and services are not being provided at the level of satisfaction that is deemed acceptable by coalition members, could cause members to become less active. Also, there was a lower satisfaction on the topic and discussions presented at the coalition meetings, which was expected considering the lack of influence members have on choosing a topics and speakers. Finally, the coalition sponsored activities and the results of those activities did not receive high markings from the membership in comparison with the leadership ($p=0.042$ and $p=0.013$, respectively). These findings are important address to may enhance member participation in the future.

Leadership and staffing was an area of interest for the HHCGa leadership, which corresponded with one of the CCAT constructs. Members indicated that they were very

pleased with the how the leadership made them feel at meetings and that they were given recognition for their work, which is important for creating a positive organizational climate. Members also indicated that the leadership had a clear vision and direction for the organization. In addition, approximately four participants indicating that the dedication of the leadership was one of the reasons they continued to stay involved. This was supported by the majority of the participants, who indicated that the leadership is well respected in the Latino community. In a previous report, increasing the credibility of a coalition and increasing key leaders and stakeholders, generally increases coalition strength and unity. Continuing to promote quality leadership and staffing will ensure that the coalition continues to be successful.

An area of concern surrounds coalition unity among the membership, with over one-third of the participants indicating they felt this way. One of the barriers that many struggling coalition have had in common is the ability to present a united voice and reduced coalition synergy (or organizational climate) (CDC, 2007). Members were also neutral to the fact that the coalition members were close to one another and that the membership works well together. Again, this could also be influenced by the relatively new membership, but paired with the fact that members indicated that there was not much group spirit, moves it into an area of concern. After comparing the means of both the leadership and the membership, and not finding statistical significance ($p>0.005$) indicates that the leadership is aware of the breach in coalition member unity (Table 9). Frequency of communication between groups, members to member and member to staff, does not reveal one salient response. This could be a modifying factor, but additional evaluations should be conducted to determine this. To strengthen membership engagement and organizational climate, plans should be to address these concerns.

Many member communication preferences are via e-mail, which is a faster and more efficient mechanism for communication, with some of the least preferred methods being phone and social networks (i.e., Twitter, Facebook, etc.) This is interesting because in order to recruit young professionals it might be necessary to communicate via social network. It may be necessary to recruit one young professional to develop and maintain communications on a social media network, prior to recruitment of this specific audience. In addition, the majority of members said that they would like to receive weekly e-mails, which might also promote coalition synergy and community engagement between activities. Finally, most members indicated that they heard about the coalition via word of mouth (i.e., through the leadership, another professional or friend, co-worker and/or and an employer.) It seems that word-of-mouth communication is a powerful skill and an effective way to communicate to an external audience. Hosting workshops on how to give an elevator speech on the HHCGa and organizational members could help increase the quality of communication between members and externally, and provide an opportunity for professional skill development.

As part of the collaboration between the HHCGa, the leadership wanted to know what members are expecting out of their membership and whether or not those expectations have been met. Many of the comments were either positive or neutral in nature, indicating that their expectations are either being met or they are almost being met. Most of these comments revolved around resource sharing and communication. Some of the areas where expectations were not being met were in promotion of collaboration, the opportunity to work within the coalition and expecting the HHCGa to be the hub for all Latino health information. The negative comments were more likely to express that they wanted to network and be exposed to an outlet for information sharing. Historically, the HHCGa has

been a networking organization, and more recently decided to be an action-focused coalition. Seeing that some of the organizational members have not had their expectations met, in regards to networking and information sharing indicates this shift has not been communicated to the members. Addressing this in the near future can shift the expectations of the members.

Public Health Implications

Coalitions have become a popular approach to maximizing limited resources and mobilizing community member towards vital health goals; however, recruiting, retaining and motivating members can be challenging if the proposed plan of action is prolonged or challenged in anyway. Strategies employed by successful coalitions may be disseminated to similar coalitions and serve as a model plan in the future. In the case of the HHCGa, there has been a gradual shift from an organization, whose main purpose was to network and find local services that would be able to provide appropriate services to Latinos. Today, with the influences of new staff and a new 3-year strategic plan, the HHCGa is able to gradually shift from a predominately networking organization to an action-driven organization that relies on social capital and collective resources to make a larger public health impact. The HHCGa, uses the patient centered care approach of treating the patient, versus treating the disease. This approach is seen to work on an individual level, with the doctor-patient relationship in order to increase adherence to treatment plans, and it might possibly serve as a basis for broad public health problems. When coalitions take a holistic approach to solving problems within a specific community, are there benefits? This question is longitudinal in nature and would take a considerable amount of time to prove, but it is similar to the foundation of the HHCGa.

The HHCGa is the only Latino-serving health coalition in Georgia, and has overcome several barriers in trying to secure funding and staff, to increase coalition momentum in the community. An additional layer to these barriers is Georgia's historical context of segregation and its lasting climate post-Civil Rights Movement. As Latinos become the "new minority" in the Southeast, which was predominately African American and non-Hispanic white, there have been two common responses. The first response of the surrounding community, is that of support and understanding from other minority groups, which in many ways found justification that discrimination is a reality, and if anything has only intensified over the years, particularly towards Latinos. The second response is that of apprehension, as the Latino population increases, Latinos are portrayed in the media as a threat to job security, public services, taxes, public safely and cleanliness. According to the CCAT, *community context* is apparent and can heavily influence the livelihood of a coalition during any stage of development (Butterfoss & Kegler, 2002). Although the theme of advocacy was presented by several of the participants in the key informant interviews and on the membership evaluations, as ways to create big changes for Latinos in Georgia, the HHCGa cannot take a stance on many of the issues for fear of losing funding and their non-profit status. In addition, the HHCGa does not have a lead agency or convening group that they can rely on for technical assistance, financial or material support. Typically, a *lead agency* or *convening group* provides stability and adds to the overall sustainability of the coalition, so that the coalition can focus their attention on collective actions as decided by the partners (Butterfoss & Kegler, 2002). Emerged in a politically conservative community context, advocating on behalf of Latino political causes (e.g., immigration reform) has left several Latino community-based organizations without funding, thus, the HHCGa has strategically

eliminated all politically charged objective for fear that they will also be eliminated from all funding and will be forced to disband.

This disempowerment or restriction of activities is fundamentally challenging for the HHCGa, who has ambitious goals that are clearly conveyed in their Mission that they aim to empower and advocate for health equity in Latino communities. Though success is not explicitly influenced by the amount of funding received by a coalition, it is deemed a barrier when coalitions are not able to secure funding and can no longer carry out their mission.

Recommendations for the Hispanic Health Coalition of Georgia

The following recommendations are derived from the HHCGa Membership Evaluation 2011, with the goal of expressing ideas to improve current coalition activities, processes, etc.:

- **Actively target and recruit additional members from sectors that are under-represented in the HHCGa, to diversify coalition membership.** Data collected from the HHCGa Membership Evaluation indicated that the coalition could benefit from targeting its recruitment to improve community representation. The coalition should actively seek out groups that are under-represented in the coalition. According to the demographical information collected, those groups that are under-represented in the HHCGa are: business organizations (e.g. financial institutions, worksites, unions, etc.), faith-based organizations (e.g., churches, interfaith counseling centers, etc.), legal institutions (e.g., organizations that coordinate naturalization services, worker's compensation, human rights, criminal justice services, etc.) and recreational services (e.g. dance, sports, arts, book clubs, etc.). In addition, recruitment of young professionals early in their careers can benefit both the coalition and the individual. The individual

gains experience servicing their local Latino community, while the coalition increases sustainability and can provide outreach to an additional age group. Young professionals have recently received training from experts in their field and are typically technologically savvy. Formation of a new committee to address membership recruitment could be beneficial. The recent partnership with a student organization from the Rollins School of Public Health, HOLA (Health Organization of Latin America) has the potential to increase recruitment of additional student-run organizations, through a snowball recruitment-effect. This is possible when student organizations, through their already establish networks at Emory University, recruit additional interested parties.

- **Educate members on how they can become involved.** According to the data collected, over 40% of the membership have been with the organization for two years or less. Many of them seem unclear on how they can participant in activities, other than the Quarterly Meetings. Indentifying ways in which these new members can become more active within the coalition will allow them to feel connected and get a sense of shared purpose. Conversely, satisfied and committed members will participate more fully in the work of the coalition (Butterfoss & Kegler, 2002). Typically, members loose interest and become less involved because the coalition's expectations of the membership are vague or there is a lack of coalition identity, including ability to present a united voice (CDC, 2007).
- **Allowing members to become part of the decision-making processes.** The data revealed that the vast majority of members, over 80% of the participants, did not know if they possessed decision-making influence on setting the goals and objective, selecting activities, budgeting and general coalition policies. Part of this could be due to the fact that over 40% of them have been with the coalition for two years or less; however, more

than 50% of the leadership indicated that the general membership had little to no influence on decision-making. Coalitions that promote shared and formalized decision-making helps to create a positive organizational climate, to ensure that benefits outweigh costs, and stimulates collaborative synergy (Butterfoss & Kegler, 2002). This engagement could be with assuming leadership roles at meetings or serving on subcommittees. It can be accomplished by setting up a simple online survey account (i.e., SurveyMonkey.com, Zoomerang.com) to allow for members to vote on upcoming activities, speakers, educational topics of concern, etc. that they find interesting.

- **Providing more activities will allow members to gain a sense of belonging within the coalition.** Many of the participants expressed an interest in networking opportunities, trainings and professional development opportunities. The HHCGa was founded as a networking coalition, aimed at promoting partnerships of local organizations so that they may provide optimal healthcare services for the Latino community. Although the HHCGa is gradually shifting to become an action-driven coalition, it might be to the advantage of the coalition to still include networking opportunities, which does not have to take time away from the Quarterly Coalition Meetings. One key informant mentioned that the HHCGa used to provide a contact list of all the members and the services their organizations provide, but in order to be included on the resources list, all participants had to pay their annual membership dues. Another idea is to allow members to submit a brief application about themselves, services their organization provides and upcoming activities that are open to the public. During each Quarterly Meeting create a selection process, which allows one community organization to present for 20 minutes, with a closing remark of how coalitions members can get involved with the community organization. This would allow for one

organization's services to be highlighted, it allows coalition members to ask questions about the services they provide and promotes collaboration outside of the HHCGa. In addition, members requested additional trainings and professional development opportunities. Because many of the new coalition members many have limited experience working with Latinos, the HHCGa has the opportunity to set their services apart and brand themselves as the local go-to organization for Latino health services and training opportunities. With these professional development trainings, one possibility is to provide continuing education credits (CEC's) for health professionals, which would also allow the HHCGa to fulfill part of their Mission Statement.

- **Increase availability of Latino resources that are both culturally and linguistically appropriate.** Several participants indicated that they did not know where to go for bilingual health resources (i.e., mental health services, family support services). Another participant indicated that an electronic portal or website with fact sheets, local services, etc. would be helpful to him/her. As it stands, the website does not contain updated information and can use some renovations. As mentioned earlier, members seem very interested in the types of local services provided, specifically in the Metro-Atlanta Area. Creating a resources list with members who have paid their membership dues may be helpful for members who need additional resources. In addition to this, one coalition member asked that all resources provided be made available in bilingual (i.e., English/Spanish) formats.
- **Promote communication and collaboration between the members.** Facilitating collaboration and improved communication, creates a positive organizational climate for members, which will keep them satisfied with the coalition and increase their involvement. In addition, it promotes coalition unity and cohesion from within the

coalition and increases community capacity, which is when community members and organizations develop capacity and build social capital that can be applied to other health and social issues (Butterfoss & Kegler, 2002). Building community capacity, versus just looking at one activity or program, will have long-lasting effects for the Latino community. Open communication increases trust between members and is essential to the success of a coalition and its functions (Feighery & Rodgers, 1990). One idea is to revamp and revitalize the current HHCGa website to allow for further exchange between members. In addition, adding a discussion section tab, would allow for members to chat outside of HHCGa functions and activities and increase overall organizational climate.

- **Communicate plans to membership in a clear concise way.** The coalition has historically focused on networking; however, many of the key informants who occupied leadership positions indicated that they are shifting the coalition's focus to be that of an action-based, community coalition. This reclassification and intention, whether it is gradual or immediate, should be communicated down to the membership. Though it is easy to conceptualize, leadership members should also be aware that changing the focus of the coalition could alienate some of the organizations, depending on their scope of work. This typically happens when political issues are taken on as agenda items, and an organizational member has to refrain from activity because the organization that they represent has opted to remain neutral or completely opposes the political issue.
- **By collaborating with other Latino health coalitions, the HHCGa increases their potential to discover new possibilities.** Although there is a gap in the literature on Latino health coalitions, performing an internet search for "Hispanic Health Coalitions" and "Latino Health Coalitions," there are over a dozen coalitions that have similar

missions, in that they do not focus on one particular disease, but target Latino health issues from a more holistic approach. The following is a list of a few of the coalitions, with similar scopes, but they all seem to be at various stages of coalition development: Latino Health Coalition for a Healthy California, Nashville Latino Health Coalition (formation stage), Hispanic Health Coalition of Houston, TX, Chicago Hispanic Health Coalition, South Carolina Hispanic/Latino Health Coalition, Hispanic/Latino Health Coalition of Elkhart County, IN, Latino Health for All Coalition (University of Kansas). Collaboration with one or more of the groups increases the potential for information and resource sharing.

- **Continue to evaluate HHCGa activities, processes, and outcomes.** Although evaluations are typically the last component anyone considers when conducting an activity, they are usually one of the most vital. Evaluations should occur on a periodic basis, and allow coalitions to establish progress towards its goals and objectives (Feighery & Rodgers, 1990). They provide information and feedback on what's working, indentify areas, which may need to be improved or eliminated, and identify accomplishments (Feighery & Rodgers, 1990). In addition, evaluations have been noted to capture "spin-off" success, or unexpected accomplishment that were not planned for while outlining program goals and objectives, but can be just as important to reaching long-term outcomes. Several short-term activities that can be evaluated are the Quarterly Coalition Meetings, annual fundraisers, membership drives and trainings. This is important for coalition feedback, quality control, but also, accountability for funders to see that a program is meeting the needs of their members or accomplishing intended goals.

Implications for Future Research

- **Use of theoretical framework to guide investigations of community-based coalitions.** The idea behind using theoretical framework, like the CCAT, to guide coalition evaluations is the hope that the field can establish a systematic way to verify coalition effectiveness, in addition, to being able to replicate and disseminate best practices with similar coalitions. Much of the coalition evaluation research has covered on certain predictive measure that is reflected in the CCAT; however, acknowledging how these variables fit into the stages of change of coalition development is important to consider when crafting a comprehensive evaluation.
- **Necessary to conduct investigations of coalitions through the various stages of development and across coalition types.** Most of the academic literature points to coalition formation and development, rather than the latter stages of maintenance and institutionalization. This is unfortunate for those coalitions who are past their infancy stage but are in constant transition or oscillation between maintenance and institutionalization. In addition, it is important to evaluate different types of coalitions based on their scope of work (i.e. advocacy, disease prevention, minority focused, etc.) There have been quite a few studies on community-based coalitions; however, there have been very few on minority-focused coalitions and which it is unclear at this time on whether or not they are more than disease-prevention and promotion coalitions. Additional process, outcomes and impact evaluations will help us to answer this question.

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APPENDIX A

EMORY UNIVERSITY

Institutional Review Board

November 22, 2010

Natasha Ludwig-Barron
Emory University
Rollins School of Public Health
Atlanta, GA. 30322

RE: Determination: No IRB Review Required
Natasha Ludwig-Barron

Dear Ms. Ludwig-Barron:

Thank you for requesting a determination from our office about the above-referenced project. Based on our review of the materials you provided, we have determined that it does not require IRB review because it does not meet the definition(s) of "research" involving "human subjects" or the definition of "clinical investigation" as set forth in Emory policies and procedures and federal rules, if applicable. Specifically, in this project, you will be conducting a quality improvement project for The Hispanic Health Coalition of Georgia, Inc. In addition, the findings of this project will not be used to generate generalizable knowledge.

This determination could be affected by substantive changes in the study design, subject populations, or identifiability of data. If the project changes in any substantive way, please contact our office for clarification.

Thank you for consulting the IRB.

Sincerely,

Emily Sanders, BS
Education and QA Analyst Assistant
This letter has been digitally signed

APPENDIX B
Membership Evaluation of the Hispanic Health Coalition of Georgia 2011 Marketing Tool (Flyer)

APPENDIX C
Membership Evaluation of the Hispanic Health Coalition of Georgia 2011
Informed Consent

Title: An Organizational Assessment of the Hispanic Health Coalition of Georgia

Principle Investigator: Natasha Ludwig-Barron, MPH Candidate 2011 (Rollins School of Public Health, Emory University)

Purpose: You are invited to take part in a graduate level thesis project at Rollins School of Public Health, Emory University, in collaboration with the Hispanic Health Coalition of Georgia, which will be referred to as "The Coalition." The study aims to identify internal strengths and weaknesses of The Coalition via a one-time telephone survey completed by active and inactive members. Feedback from survey responses will (1) help guide strategic marketing plans to recruit new prospective coalition members, (2) provide a retention plan to keep current members engaged in The Coalition's activities and (3) provide direction on making the coalition more efficient and effective. All coalition members will be asked to complete a 15 – 20 minute telephone survey, that is comprised of both, fixed and open responses. The study finding will be available to The Coalition members and may be published pending academic approval. All responses that you provide will remain confidential, unless you say otherwise.

Procedures: This one time interview will take 20 minutes of your time, or less. This is completely voluntary, and if for any reason you would like cancel your participation you may. The questions are fixed and open-ended so that you can convey your personal opinions of The Coalition. I will be digitally recording and taking notes throughout the telephone survey. Your survey will be transcribed following the survey, and assigned a generic identification number, which will not be linked to your identity or the identity of the organization you represent.

All participants will be eligible to enter an opportunity drawing for a $50 gift card, in which case your preferred method of communication will be entered into a database, but will not be link to your identity. Following the data collection phase of this project, in February 2011, one participant will be selected at random and informed of their prize. I will be tape recording this interview, as well as recording notes, so that I may capture the entirety of your responses.

Risk, Discomfort and Inconveniences: Since we will be discussing mental health issues, specifically related to your diagnosis, some of the information may be uncomfortable to discuss. If you feel discomfort at anytime, please let me know and we can stop the interview, take a break or skip to the next question.

Confidentiality: Responses provided in this telephone interview will be used for academic purposes, the improvement of The Coalition and, pending approval, may be published in an academic journal. Therefore, your responses will be available to the public, but in no way will your identity be revealed. The recording of this interview will be destroyed once the

information has been transcribed and a false name will be attached to the transcripts, which will not be linked to your identity.

Contact Persons: Natasha Ludwig-Barron
MPH Candidate 2011
Rollins School of Public Health, Emory University
Ntludwi@emory.edu
(909) 241-8274

Dr. Ngoc-Cam ("Cam") Escoffery, PhD, MPH, CHES
Assistant Professor
Rollins School of Public Health, Emory University
cescoff@emory.edu
(404) 727-4201

It's Your Choice:

You are free to choose whether or not you want to take part in this interview. You can change your mind and stop at any time without penalty. This decision will not adversely affect your relationship with Emory. It will not affect any benefits you may receive outside of this project. It's your choice.

If you are willing to volunteer for this study, please say "yes" at this time, if not please say "no."

You do not give up any rights by agreeing to the term in this consent form. If you would like a copy of the informed consent form, one will be provided.

APPENDIX D
Membership Evaluation of the Hispanic Health Coalition of Georgia 2011
Key Informant Interview Guide

Date:
Time Start:
End Time:

Name of Person Interviewed:
Title and Function:
Agency/Organization:
Contact Information (phone/email):

Introduction

My name is Natasha Ludwig-Barron, and I am graduate student from Rollins School of Public Health in the department of Behavior Sciences and Health Education. As part of my final thesis project, I have been working with Hispanic Health Coalition of Georgia on conducting an organizational assessment. I understand that you have been quite involved with The Coalition, which is the reason that I would like to get your perspective on different facets of The Coalition and how it might have changed over time. Please understand that I am trying to get to know the organization as best I can and will use the information that you provide to help shape and frame the membership survey. There are no right or wrong answers to these questions, and any feedback you provide will be helpful.

Everything that we discuss today will be kept completely confidential; your name will not be associated with anything that you discuss with me, either in the final report or in any verbal reports I give, within or outside The Coalition. If you do not mind, I would like your permission to tape record this interview so that I can thoroughly document the information you provide. Is that all right with you? Thank you, lets go ahead and get started.

Purpose of the Interview – Questions you want Answered:

1. First, I would like to start out by getting to know you and your background. What is your professional degree or training in?
   - *What do you do full-time?*
   - *What is you background in (e.g., public health, advocacy, finance, etc.)*

2. Next, I would like to hear about your involvement with The Coalition. How would you describe your current involvement with The Coalition?
   - *How long have you been involved with the Coalition?*
   - *Have you held any leadership positions?*

3. I would like to switch gears a little and have you remember when you first joined The Coalition. Could you tell how you first got involved?

- *What first attracted you to The Coalition? Were you recruited? Did you see an advertisement?*
- *What is you level of involvement back then?*
- *How is the Coalition being marketed and/or how do people find out about The Coalition?*

4. Could you please tell us about your first impressions of the work The Coalition was trying to accomplish? Do you know why The Coalition was started?

- *What was the Mission, Vision and Goals of organization when you first started?*
- *What were the services The Coalition provided?*

5. How have the scope or the Mission, Vision and Goals of The Coalition changed over the years?

- Why did the scope change?
- Who was the driving force behind this change (e.g., members, leadership, etc.)

6. Have you worked with coalitions in the past?

- *What were some of the qualities that you liked about the coalition you were a part of?*
- *What were some of the qualities you would have changed?*

I'd like to talk about some of the facets that make up The Coalition, so the following questions will be concerning the formation/development of The Coalition, the membership involvement, decision making processes, services provided, training/education, conflict, sustainability and any closing remarks that you would like to add.

<u>Coalition Formation/Development</u>

7. Let's start with formation and development. In your opinion, what factors of staff, board members and members have shaped how The Coalition has evolved over time?

8. To the best of your knowledge, has there been a evaluation completed on processes or operations of The Coalition?

9. Do you feel that the Mission and goals of The Coalition are well defined?

Membership Involvement

10. The next set of questions concern the coalition members' involvement. What role(s) do you think the coalition members play in shaping The Coalition?

- *How are leadership positions determined?*
- *Do you feel there is a unity amongst the members?*

Decision Making Processes

11. Next we are going to talk about the decision-making processes within The Coalition. Who do you think makes the major decisions for The Coalition?

- *Who decides on budget, activities, goals and objectives?*
- *Has this position/person always made the major decisions for The Coalition?*
- *Have the decisions always been decided in this way?*
- *Can you think of a scenario in which a decision had to be made without consulting the membership or board? Was this a rare circumstance?*

Services Provided

12. Next we are going to discuss some of the services and benefits The Coalition provides. Can you list some of the services or benefits provided to the members?

- *Can you list some of the services or benefits provided to the general public?*
- *How often are some of these services provided?*

Training/Education

13. Lets talk about some of the trainings and education provided by The Coalition. In what ways does The Coalition educate or train coalition members? What topics or skills have been presented?

- *Were the trainings for credit or compensation?*
- *Were the trainings free?*
- *Were the trainings open to the public?*

Conflict Management

14. The next set of questions concerns conflict within The Coalition. Has there been any conflict between members and the leadership, either staff or board members?

- *Has there been conflict between any individuals in The Coalition? This includes conflict between board members, staff and/or general members.*
- *How were the conflicts handled?*
- *Would you say conflict is a common occurrence? If so, what is the reoccurring conflict?*

Sustainability

15. We are almost finished. The next question covers sustainability. What measures is The Coalition taking to ensure that sustainability so that The Coalition stays around for a long time?

Culture & Diversity

16. What would you say the majority of the membership consists of racially and ethnically?

- Do you think the membership is representative?
    - Racially/ethnically?
    - Membership services (e.g., healthcare providers, politicians, etc.)

General Questions

The last set of questions concern The Coalitions major accomplishments, challenges and opinions on future directions.

17. Lets start with what you think are The Coalition's greatest accomplishments, and why?

18. What have been The Coalition's greatest challenges, and why?

19. In what ways, if any, do you think The Coalition can be improved?

20. Are there any specific questions that you would like to know about The Coalition's membership? Any specific questions you would like to include on the membership survey? (If you would like to take a moment and get back to me on this question, you may do so.)

21. Do you feel the results of the membership survey will be useful?
- *How does The Coalition intend on using the results?*

22. To the best of your knowledge, has there been any other evaluations or assessments on The Coalition?
- *When? Where? Who? Why?*

Summary of Key Points – Most Important Questions and Answers from Interview Guide:

Summary Impressions of the Interviewee:

Comments – Interruptions, Physical Environment, etc

APPENDIX E

Membership Evaluation of the Hispanic Health Coalition of Georgia 2011
Membership Survey Tool

Hispanic Health Coalition of Georgia

1. Welcome/Bienvenidos!

The Hispanic Health Coalition of Georgia wants to hear from YOU!!

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Hispanic Health Coalition of Georgia

2. Informed Consent & Confidentiality

Title: A Membership Assessment of the Hispanic Health Coalition of Georgia

Principle Investigator: Natasha Ludwig-Barron, MPH Candidate 2011 (Rollins School of Public Health, Emory University)

Purpose: You are invited to take part in a graduate level thesis project at Rollins School of Public Health, Emory University, in collaboration with the Hispanic Health Coalition of Georgia, which will be referred to as "The Coalition." The study aims to identify internal strengths and weaknesses of The Coalition via a one-time web-based survey completed by active and inactive members. Feedback from survey responses will (1) help guide strategic marketing plans to recruit new prospective coalition members, (2) provide a retention plan to keep current members engaged in The Coalition's activities and (3) provide direction on making the coalition more efficient and effective.All coalition members will be asked to complete a 15 – 20 minute web-based survey, that is comprised of both, fixed and open responses. All responses that you provide will remain confidential, unless you say otherwise.

All participants will be eligible to enter an opportunity drawing for a $50 gift card, in which case your preferred method of communication will be entered into a database, but will not be link to your identity. Following the data collection phase of this project, in February 2011, one participant will be selected at random and informed of their prize.

Confidentiality: Responses provided in this telephone interview will be used for academic purposes, the improvement of The Coalition and, pending approval, may be published in an academic journal. Therefore, your responses will be available to the public, but in no way will your identity be revealed. The recording of this interview will be destroyed once the information has been transcribed and a false name will be attached to the transcripts, which will not be linked to your identity.

✱ **1. Do you agree to participant in this study?**

- ○ Yes
- ○ No

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Hispanic Health Coalition of Georgia

3. Tell me about yourself -

Note: All responses will be kept confidential. Information provided will be used for academic purposes and the improvement of The Hispanic Health Coalition of Georgia ("The Coalition").

✱ **1. Your involvement with The Coalition is best described as (check all that apply):**

- ☐ I represent an organization that provides services to the Latino community
- ☐ I have a personal interest in the Latino community
- ☐ I am looking for career opportunities
- ☐ I am student
- ☐ Other (please specify)

2. If you represent an organization, then what type of services do you provide? (choose all that apply)

- ☐ Educational (i.e. ELS courses, continuing education, citizenship courses, self-help, public schools, colleges and technical schools, etc.)
- ☐ Communication (i.e. TV, radio, newspaper, etc.)
- ☐ Economic (i.e. business, worksites, unions, etc.)
- ☐ Religious (i.e. church, interfaith counseling, etc.)
- ☐ Legal (i.e. naturalization, workers compensation, human rights, criminal justice, etc.)
- ☐ Direct Healthcare (i.e. primary care physician, physician assistance, nurse, etc.)
- ☐ Continuum of Care (i.e. social worker, public health, lay community health worker, etc.)
- ☐ Recreational Services (i.e. dance , sports, art, book club, etc.)
- ☐ Other (please specify)

✱ **3. Do you conduct research in the Latino community?**

- ○ Yes
- ○ No

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Hispanic Health Coalition of Georgia

4. Membership & Involvement

Please tell us about your membership and involvement with The Coalition.

✱ **1. Describe your level of activity in The Coalition. Do you consider yourself to be:**

- ○ Not at all active
- ○ Not very active
- ○ Somewhat Active
- ○ Very Active

✱ **2. I would describe my affiliation with The Coalition as being a:**

- ○ General Member (Individual)
- ○ General Member (Organization)
- ○ Board Member
- ○ Staff
- ○ Other (please specify)

✱ **3. How long have you been involved with The Coalition?**

- ○ Less than a year
- ○ 1-2 years
- ○ 3-4 years
- ○ 5+ years

✱ **4. On average, how often do you attend the quarterly coalition meetings?**

- ○ 0 times per year
- ○ Once a year
- ○ Twice a year
- ○ Three times a year
- ○ Four times a year

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Hispanic Health Coalition of Georgia

* **5. In the past, how many events have you attended that were sponsored by The Coalition?**
  - 0 events
  - 1-4 events
  - 5-8 events
  - 9-12 events
  - 13 or more events

Which specific events would you consider attending again?

* **6. Think back to why you joined The Coalition. Please explain some of the qualities and/or benefits that attracted you or your organization?**

* **7. Please explain some of the qualities and/or benefits that keep you involved.**

* **8. What typically prevents you from becoming more involved with The Coalition?**

* **9. Do you pay the annual membership dues?**
  - Yes
  - No

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Hispanic Health Coalition of Georgia

5. Decision-Making

The following section will ask you about your decision-making opportunities in The Coalition.

* **1. How much influence do coalition members have in making decisions for The Coalition in the following areas? (For each statement, indicate the level of influence from "no influence" to at "a lot of influence.")**

	No Influence	Not Much Influence	Some Influence	A Lot of Influence	I don't know
Setting goals and objectives for The Coalition					
Selecting activities for The Coalition					
Setting the budget for The Coalition's activities					
Deciding on general coalition policies and actions					

* **2. Which of the following groups makes the major decisions for the coalition? (Check all that apply.)**
  - All Coalition Members
  - Coalition Board Members
  - Coalition Staff
  - Other (please specify)

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Hispanic Health Coalition of Georgia

6. Leadership & Staffing

The following section asks you to consider the leadership, staff and elected board members of The Coalition.

* **1. Consider The Coalition Staff and Elected Board Members.**
For each statement, please choose your level of agreement or disagreement with the statement with 1=strongly disagree, 2=somewhat disagree, 3=neutral (neither disagree or agree), 4=somewhat agree and 5=strongly agree.

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
They make me feel welcome at meetings.					
They give praise and recognition to members at meetings.					
They intentionally seek out the member's opinions and suggestions.					
They ask members to assist with specific tasks.					
They make an effort to get to know members.					
They have a clear vision and direction for The Coalition.					
They are well known within the Latino Community.					
They are skillful at resolving conflict.					
They are too controlling of The Coalition.					
They provide good guidance to The Coalition.					
They are well respected by coalition members.					
They are competent.					
They respond well to					

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criticism.					
They work well with coalition members.					
They are usually available for assistance.					

2. Are they any additional comments you would like to add about the leadership, staff and/or elected board members in The Coalition?

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Hispanic Health Coalition of Georgia

7. Communication

The following section will ask you about communication within The Coalition.

✱ **1. How did you hear about The Coalition?**

✱ **2. How do you prefer to hear about meetings and events? (please choose one)**

- Website
- Email
- Letter
- Phone Call
- Social Network (e.g. Facebook, Twitter, etc.)
- Other (please specify)

✱ **3. What mode of communication do you prefer the least? (please choose one)**

- Website
- Email
- Letter
- Phone Call
- Social Network (e.g. Facebook, Twitter, etc.)
- Other (please specify)

✱ **4. How often would you prefer to hear from The Coalition?**

- Daily
- Weekly
- Monthly
- Quarterly
- Other (please specify)

Hispanic Health Coalition of Georgia

✱ **5. From what you've seen, what is the current frequency of communication between the following groups?**
Please rank each from 1=no communication at all, 2=infrequent communication, 3= somewhat frequent communication, 4=very frequent communication, and 5=I don't know/couldn't say.

	No Communication At All	Infrequent Communication	Somewhat Frequent Communication	Very Frequent Communication	I don't know/Couldn't Say
Between The Coalition members and staff/board members?					
Between The Coalition members and other coalition members?					

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8. Coalition Satisfaction

The next set of questions refers to your overall satisfaction with The Coalition.

✱ **1. How satisfied or dissatisfied are you with the following aspects of The Coalition and its activities? Please indicate your level of agreement from 1=very unsatisfied, 2=unsatisfied, 3= neutral (neither satisfied or unsatisfied), 4=satisfied and 5=very satisfied.**

	Very Unsatisfied	Unsatisfied	Neutral	Satisfied	Very Satisfied
The Coalition's involvement in the Latino community.					
The Coalition's efforts to recruit new members.					
The Coalition's involvement with State and local policy and/or advocacy efforts.					
The Coalition's adherence to health promotion and educational efforts.					
The Coalition's promotion of Latino health resources and services.					
The structure of the agenda at Quarterly Meetings.					
Topics presented and discussed at the Quarterly Meetings.					
Professional development opportunities (e.g. professional trainings, seminars, workshops, etc.)					
Opportunities for coalition members to take leadership roles.					
The activities selected by The Coalition.					
The result of those					

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activities selected by The Coalition.					
The fundraisers selected by The Coalition.					
The results of those fundraisers selected by The Coalition.					

2. Are there any professional development opportunities or trainings that are not currently being addressed that you would be interested in?

3. Are there any specific health topics that you would be most interested in learning about?

4. Is there anything you would like to add regarding areas where you may be satisfied or dissatisfied with The Coalition?

Hispanic Health Coalition of Georgia

9. Diversity & Culture

The next set of questions refers to how representative and diverse The Coalition is of different sub-cultures within the Hispanic/Latino community. In other words, are South American, Central American, North American and Caribbean cultures represented in The Coalition? This section also asks about the diversity of service sectors involved in The Coalition.

✱ **1. Do you feel that The Coalition members are diverse and represent a wide array of Hispanic/Latino cultures?**

- Yes
- No
- I don't know

✱ **2. Is the Coalition representative and inclusive of most Hispanic/Latino sub-cultures? For example, peoples of Caribbean, Central American, South American, North American, indigenous, meztiso, etc., decent.**

- Yes
- No
- I don't know

If "No," what cultures or Latino sub-groups do you think need to be involved in The Coalition that are not currently?

✱ **3. Do you think The Coalition is representative of the different health services and/or agencies? For example, mental health services, primary care, policy makers, health educators, etc.**

- Yes
- No
- I don't know

If "No," which services and/or agencies do you think are under-represented in The Coalition?

4. Would you like to provide additional comments regarding The Coalition's diversity of cultures and/or services?

Hispanic Health Coalition of Georgia

10. Coalition Unity

We are almost finished at this point. The next section asks you to recall factors that pertain to The Coalition's unity and togetherness.

✱ **1. How much do you agree or disagree with the following statements about The Coalition? Please indicate your level of agreement with the following statements with 1=strongly disagree, 2=somewhat disagree, 3=neutral (neither disagree or agree), 4=somewhat agree and 5=strongly agree.**

	Strongly Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Strongly Agree
There is a feeling of unity and cohesion in the coalition.					
There is a strong emphasis on practical tasks in The Coalition.					
There is not much group spirit among members of The Coalition.					
There is a feeling of belonging in The Coalition.					
The Coalition rarely has anything concrete to show for its efforts.					
Members of this coalition feel close to each other.					
Members of The Coalition work well together.					

Hispanic Health Coalition of Georgia

11. Implementation of Mission & Vision

The next section asks for you opinions on the Mission and Vision Statements of The Coalition.

✱ **1. In your opinion, does the mission define the work of The Coalition?**

"The Mission of The Coalition is to promote health policies in Georgia that improve access to health services for all Hispanic/Latino children and adults."

- Yes
- No

✱ **2. Does the vision define the work of The Coalition?**

"The Vision is to be the acknowledged policy leader in Georgia for building health equity for Hispanic/Latinos and for promoting collaborations with stakeholders supporting under-served communities."

- Yes
- No

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12.

Please provide short responses to the following questions. All responses will help us meet your needs as a member.

1. What does The Coalition mean to you?

2. What are your expectations of The Coalition? Have these expectation been met?

3. If you are with an organization, how might The Coalition contribute to your work?

4. What other benefits would you like to receive from The Coalition?

Hispanic Health Coalition of Georgia

13. Demographics

The final set of questions is based on demographics.

✱ **1. What is your gender?**

- Female
- Male
- Other

✱ **2. What is your age?**

✱ **3. What is your ethnicity?**

- White (Non-Hispanic)
- Black/African-American (Non-Hispanic)
- Latino/Chicano
- Asian/Pacific Islander
- Native American
- Other (please specify)

✱ **4. How would you categorized your level of Spanish-speaking skills. (Select one option.)**

- None/Very Little
- Elementary
- Intermediate
- Advanced
- Fluent
- Native

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✱ **5. Please indicate your highest level of educational attainment.**

- Less than high school
- High school graduate/GED
- Vocational Schooling or Associates Degree, beyond high school
- Some college
- College graduate
- Some graduate-level education
- Master's Degree
- Doctoral degree or professional degree and beyond (Ph.D., M.D., J.D., etc

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Hispanic Health Coalition of Georgia

14. Finished!

This completes the survey. Thank you for your time and commitment to the Hispanic Health Coalition of Georgia!! We look forward to seeing you soon.

Please enter your e-mail address below to be entered in the drawing for a chance to win your $50 gift card.

For questions regarding the survey and/or results please contact:
NLudwigBarron@gmail.com

Gracias!!

1. Enter e-mail address to be entered to win a $50 gift card. The winner will be notified February 2011. Good luck!

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APPENDIX F

------- Membership & Involvement -------

Table 1: Benefits and barriers on why members do not become more involved

Qualities & Benefits	Barriers
▪ Networking (11) ▪ Information (5) ▪ Resources (4) ▪ Dedicated Board/Leadership (4) ▪ Education (3) ▪ Advocacy/policy efforts (3) ▪ Collaboration/information sharing (2) ▪ Community Service/Volunteering (2) ▪ Promise of organization growth ▪ Speakers ▪ Mission/Vision ▪ Referrals ▪ Professional development ▪ Reducing health disparities ▪ Meetings ▪ Membership dues ▪ Cannot say/new member (3)	▪ Time constraints (10) ▪ Work (7) ▪ Other obligations/commitments (3) ▪ Schedule conflicts (3) ▪ Nothing (2) ▪ Unsupportive of organization/program (2) ▪ Uninformed on how to become more involved and/or more supportive ▪ Unclear on mission/vision ▪ Few Hispanic participants ▪ Unfriendly nature of the coalition ▪ Unsure/new member

Table 2: What the HHCGa means to the members
▪ The organization positioned to be the leader in Hispanic health in the State. ▪ The only non profits that works for the Health of the Latino community ▪ It's a voice for the Hispanic community in Georgia regarding health policy. ▪ good forum ▪ Group of individuals and organizations that come together to educate each other, network and advocate for Latino communities to have health equity ▪ It is an organization that helps me stay connected to other resources available for the Hispanic community. ▪ Helping others ▪ It means an opportunity to work with other qualified Latino professionals to better serve our community ▪ Key organization for the advancement of health policies that benefit the Latino community ▪ resource for my customers ▪ Resources for the people I serve. ▪ Unity, Diversity, Education, Purposeful ▪ Networking ▪ "The Mission of The Coalition is to promote health policies in Georgia that improve access to health services for all Hispanic/Latino children and adults." ▪ Learning about my community health related problems and networking with people that serve the Latino community ▪

Table 3: Ways the HHCGa can contribute to the work of the membership

▪ Advocate for my agencies health issues. ▪ With health education ▪ I work at a free clinic. Our goal is to provide culturally competent care to anyone without health insurance. We do that reasonably well. I'm not sure we need any assistance. ▪ Help us share our information with other members and the community. ▪ Supporting what one does within our own organization to better serve latinos ▪ Allowing our services to be known to others and providing a great opportunity for collaboration. ▪ It contributes by providing me with valuable information about the health issues our (Latino) community faces ▪ Collaboration, networking with other organizations serving the Latino community ▪ Be available ▪ Training, cultural competency, capacity building. ▪ Continued networking, collaboration on grant writing opportunities ▪ by referring other organizations when they need our services	Themes: ▪ Collaboration/Information Sharing (6) ▪ Networking (4) ▪ Availability Support (3) ▪ Advocacy (1) ▪ Education/Training (2) ▪ Cultural Competency (1) ▪ Capacity Building (1) ▪ Grant Writing/Funding Opportunities (1) ▪ No contributions needed (1)

Table 4: Additional benefits members would like to receive

- More advocating, more education.
- Health is not independent of social factors of life. Often I need resources for Spanish speaking persons, and it would be neat to have a web site that shows links to all resources for Hispanics in the community. Health, social, legal, etc.
- Guidance
- I would like to know what opportunities are available to members to get involved, volunteer opportunities, professional development opportunities, mentoring, and professional networking
- a strong job placement forum - for employers and individuals looking for health jobs; especially bilingual candidates
- More visibility in the community
- Training, education
- Grant seeking opportunities.
- The referral part is very important it keep us connected and we get the trust of the community

Themes:

- Education/Training (2)
- Advocacy
- Bilingual electronic resources (e.g., health, social, legal, etc.)
- Opportunities:
    - How to become more involved
    - Volunteering
    - Professional Development
    - Mentoring
    - Networking
    - Jobs
    - Grant/funding
    - Client referrals
    - Marketing services/visibility

------- Leadership & Staffing -------

Table 5: Additional comments from members on HHCGa leadership, staff and/or elected officials.

"I think that orientation sessions for new members would be very helpful in providing information regarding the Coalitions mission and purpose in the community. This would help new members become acquainted with the history of the Coalition and its current projects/programs, as well as ways to become more involved."

Would like transparency and more communication to members of what is going on

"Would like staff/board members to offer mentoring opportunities"

We need to be stronger at political and influential levels.

They (Board Members) are not a strong cohesive group.

------- Coalition Satisfaction -------

Table 6: Professional development opportunities and/or trainings of interest to the membership.

- Topics regarding integrated health
- Continuing education credits (i.e., MD & NP credits) (2)
- Do not know/new member
- Professional leadership trainings
- Advocacy trainings
- Mental health trainings
- Locating resources for medical assistance
- Information on local youth services

Table 7: Additional Areas of Satisfaction or Dissatisfaction

- Quarterly meetings too early
- Quarterly meetings too long
- Would like a contact list of the membership, with description of the services they provide
- Would like to see a bigger presence in the community
- Increase promotion of access to quality healthcare for Latinos
- Need more political influence to make necessary changes on Latino health issues

Table 8: Membership expectations (Have expectations been met?)

Positive Comments

- Getting the word out to the community - this is being met
- Regular meetings (met)
- Communication (newsletters, e-mails-met)
- I am always able to meet people and learn about new resources
- Yes – expectations met

Neither Positive/Negative

- My expectations are to keep me updated on resources available for health care in the Hispanic community. Expectations are met somewhat.
- Besides their quarterly meeting, I don't know what else they do.
- I just joined less than a month ago...
- I believe that the Coalition can be a recognized entity for other private and public organizations.
- I expect the Coalition to become a well recognized, trusted and respected organization among Hispanics living in Georgia
- Being the "to go" organization for health issues impacting Latinos
- To provide health related info to my customers
- Education, health related activities, capacity building for the members. Not completely.

Negative Comments

- To be the leader, the 'go to' person whenever anyone wants to learn or inquire about Hispanic health. Not met yet.
- More opportunities of work for all the members when a goal is set
- To be a voice through out GA and especially in the health world of GA - not yet
- I expected it to foster collaboration. No
- Annual Membership Renewal reminder (not met)

------- Coalition Diversity & Culture -------

Table 9: Comments regarding HHCGa diversity

- "The coalition tries to be representative but the problem is that we need more professionals from the different subgroups to be as members or in leadership roles." (Regarding diversity of Latino cultures within the HHCGa.)
- Would like to see more health services
  - Mental health services (2)
  - Social services
  - Health education
  - Health promotion
  - Dental
  - OB/GYN
- Would like to see more policy makers (2)
- Would like to see more corporations
- The coalition needs to have bilingual communication, both written and/or verbal, so it can attract more individuals who are not English proficient
- Would like to see more representation from the small health clinics that serve Latinos

------- Organizational Climate -------

TABLE 10: COALITION UNITY

	Affiliation to HHCGa		
	Leadership[1]	Members[2]	
Areas of Unity and/or Cohesion	**N Mean (SD)**	**N Mean (SD)**	**P-Value**
There is a feeling of unity and cohesion in the coalition.	10 2.5 (1.35)	16 2.1 (0.96)	0.42
There is a strong emphasis on practical tasks in The Coalition.	10 2.4 (1.35)	16 2.0 (0.82)	0.41
There is not much group spirit among members of The Coalition.	10 1.4 (1.35)	16 2.1 (0.81)	0.10
There is a feeling of belonging in The Coalition.	10 2.7 (1.06)	16 2.0 (0.82)	0.07
The Coalition rarely has anything concrete to show for its efforts.	10 2.1 (1.10)	16 1.75 (0.93)	0.40
Members of this coalition feel close to each other.	10 2.5 (1.08)	16 1.8 (0.75)	0.07
Members of The Coalition work well together.	mklkjh10 2.6 (1.17)	16 2.2 (0.75)	0.34

[1] Leadership: HHCGa Board Members & Staff

[2] Membership: HHCGa individual members & members representing an organization

* Denotes statistical significance of ≤ 0.05