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This study considers the characteristics of a diabetes coalition that are necessary for coalition maintenance beyond the formation and building stages. A case study was done of the Tarrant County Diabetes Collaboration (TCDC). Data were collected through recorded interviews and a review of documents. The concepts of collaboration identified were: composition, ownership, value, governance, operational map, fiscal structure, and domain. These concepts are presented in a conceptual model. Conclusions made were that the two main strengths of the TCDC were composition and member's perception of value. Opportunities for growth included defining member roles, developing strong leadership, operating by an operational map and fiscal plan, and becoming recognized as a force for diabetes in the community.

THE TARRANT COUNTY DIABETES COLLABORATION:

A CASE STUDY OF A COMMUNITY

DIABETES COALITION

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CHAPTER I

INTRODUCTION

As social and chronic health problems increase and as the rate of uninsured and underinsured U.S. citizens remains high, many communities have come together to form partnerships (coalitions, collaborations) to provide the impetus to pool human and fiscal resources for program development and implementation, and to impact social policy. Whereas many coalition studies have focused on health issues such as alcohol, tobacco, and other drug abuse prevention (McMillan, Florin, Stevenson, & Kerman, 1995) and (Butterfoss, Goodman, & Wandersman, 1996), smoking cessation (Kegler, Steckler, Malek, & McLeroy, 1998), cardiovascular health (Mayer, Soweid, Dabney, Brownson, Goodman, & Brownson, 1998), and health promotion for the elderly (Armbruster, Gale, Brady, & Thompson, 1999) there is a paucity of literature on diabetes coalitions.

This study is a case study of the Tarrant County Diabetes Collaboration (TCDC) formed in 1995 as a partnership of three organizations in Tarrant County, Fort Worth, Texas who collaborated together for the purpose of increasing diabetes education and awareness in their community. The research question asked is, "How and why do TCDC members collaborate to form, build, and maintain a community coalition that has a viable impact on diabetes awareness, prevention, and education in Tarrant County?"

This paper reports the findings of a review of documents, conversations with former TCDC members, and interviews with twelve of the current members. The paper

also considers the TCDC formation, building, and maintenance process in relation to key factors of coalition success as identified by several authors (e.g., Butterfoss et al., 1996; Couto, 1998; Goodman, Wandersman, Chinman, & Imm, 1996; Hageman, Harmata, Zuckerman, & Weiner, 1999; Kegler et al., 1998; Kellett & Goldstein, 1999; Mayer et al., 1998).

The findings reveal seven identifying concepts that are the TCDC. These concepts of membership: composition, ownership, and value and the concepts of coalition identity: governance, operational map, fiscal structure, and domain are defined in a conceptual model for the forming, building, and maintaining of a community diabetes coalition.

CHAPTER II

BACKGROUND

In 1995, the Texas Agricultural Extension Service (TAEXS) of Tarrant County approached the Tarrant County Public Health Department (TCPHD) in Fort Worth, Texas about partnering to develop and implement a community-based approach to address Type 2 diabetes in Tarrant County. Key health department participants were representatives of the Health Planning and Development department, the North Texas Regional Laboratory, an epidemiologist, a registered dietitian, a health educator, and a registered nurse. The focus was directed towards increasing awareness for those at risk and education for those already diagnosed with Type 2 diabetes. A third organization, Partners at Lunch (PAL), joined the TAEXS and TCPHD in 1997. PAL was a diabetes awareness program of the Texas Association of Black City Council Members (TABCCM). The TABCCM was formed for educational purposes within Section 501c3 of the Internal Revenue Code and PAL had recently been granted a Diabetes Awareness and Education in the Community (DAEC) grant. The partnership with PAL brought expertise to the collaboration specifically in the area of conducting outreach and education and establishing support groups for African Americans (Tarrant County Diabetes Collaboration [TCDC], 1998b).

Memos and meeting documents from 1995-1997 suggest the partners met irregularly and under several different names, including "Partners for Prevention of

Diabetes" and "Diabetes Awareness Partners." By the summer of 1997, most documentation reflected the current name, Tarrant County Diabetes Collaboration (TCDC), and the current red apple icon and slogan, "Taking the Bite Out of Diabetes." In October 1997, the TCDC was formally recognized as a community partnership and a reception to celebrate its formation was held at the Milan Art Gallery, Fort Worth, Texas.

Today, 16 people representing 15 organizations or representing themselves are members of the TCDC. Membership is open to Tarrant County private, public, and civic organizations, agencies, businesses, and concerned citizens who support the mission of the collaboration. Each attending member is asked to contribute annual dues in the amount of $15. Membership is notified of meetings via email. The chairperson or a designee prepares meeting agendas. Meeting minutes are prepared and distributed on a volunteer basis as directed by the chairperson. The TCDC is headquartered at the Tarrant County Public Health Department.

CHAPTER III

SURVEY OF RELEVANT LITERATURE

Diabetes Relevance

Diabetes mellitus is a chronic disease that poses a substantial public health problem. It affects approximately 16 million Americans and is a major source of morbidity and mortality (U.S. Department of Health & Human Services, 1997). According to the 1998 National Center for Health Statistics of the Centers for Disease Control and Prevention (CDC), diabetes was the seventh leading cause of death in the U. S. (Centers for Disease Control & Prevention, 1998).

In June 1998, the Fort Worth Public Health Department (Texas) conducted a community needs assessment. Thirty-two hundred persons, out of a population of 480, 690 (estimated 1996), residing within Fort Worth's city limits, were interviewed face-to-face in their homes. Results of the survey identified diabetes as the sixth most commonly self-reported disease with a reported rate of 8.6% (Sandu & Rives, 1998).

The findings of the above survey indicated that diabetes was not equally distributed in Tarrant County. Senior citizens and minority populations suffered disproportionately high rates of diabetes. Results of the survey identified that the prevalence of diabetes was higher among minorities: white (10.0%), African American

(18.8%), Hispanic (16.3%), Asian (15.1%), and other (11.4%). Because some populations lacked adequate resources for health care, they also developed a disproportionate share of complications caused by diabetes. In Fort Worth-Tarrant County, diabetes remains the sixth leading cause of death (Sandu & Rives, 1998).

Coalition Relevance

A literature search of seven databases: Medline, ERIC, CINAHL, PsychINFO, PAR, ABI/Inform, and Social Science Index was done using the key words: community, coalition, collaboration, consortium, consensus building. The search was restricted as to English language and dates of 1988 to the present. A literature search specific to the key words, diabetes and coalitions, did not produce findings significant to this study.

Community-based coalitions as described by Feighery and Rogers (1989) are groups of individuals who represent diverse organizations, factions, or constituencies within the community, and who agree to work together to achieve a common goal. Likewise, Butterfoss et al. (1996) has described coalitions as composed of individuals who are representing their organizations and community sectors.

Even though coalition building is a popular tool to facilitate the joining of community members to achieve common goals, it is not without difficulty. Coalition evaluations suggest that successful coalitions, with success defined as achieving desired outcomes, include common organizational and membership characteristics. Smith (1997) found that coalitions, at their very best, could increase community awareness of health problems and could create new methodologies for implementing health programs. Kellett

and Goldstein (1999) describe the benefits and barriers to collaborative efforts and present a model for the process of collaboration.

Several studies evaluated health related coalitions. Butterfoss et al., 1996 identified key health coalition characteristics such as leadership roles, staff-committee relationships, organizational climate, decision-making influence, and coalition-community linkages. Armbruster et al. (1999) examined the coalition member's perception of ownership. The factors of leadership, staff skills and time, and communication skills that facilitated or impeded coalition effectiveness were studied by Kegler et al. (1998). Sutherland, Cowart, and Harris (1997) studied the coalition elements of membership, patterns of formation, functions, and organizational structure. McMillan et al. (1995) studied community coalitions and psychological empowerment.

Butterfoss et al. (1996) studied the coalition elements of competent leadership, shared decision-making, linkages with other organizations, and a supportive environment. He found these to be factors in decreasing perceived costs, contributed toward increased perceived benefits of participation, and produced members who were more satisfied and who participated more in the work of the committees and the coalition. He found that the selection of competent leaders and the development of their skills and abilities should be a prime consideration of community coalition programs. He also found that a positive organizational climate should be developed and maintained. Member influence in decision-making seems to foster member commitment and satisfaction and this should be facilitated. He found networking outside of the coalition to be important. He also suggested that benefits for coalition members should be maximized. He concluded that

there are two steps in better understanding of coalitions. One is the value of participation. Coalitions generate participation by including diverse community groups and members. The second step of understanding coalitions is that member empowerment should stem from participation and lead to better health outcomes for the community.

Kegler et al. (1998) found that coalitions with high levels of implementation had frequent and productive communication among staff and members. She stressed the importance of establishing mechanisms for regular communication among members and between staff and members. She also found clarifying staff roles, membership criteria, leader selection, and decision-making methods all to be important to coalition effectiveness. Sutherland et al. (1997) found that when coalition members had previously worked together, when representatives were viewed as leaders, when a community model was used and a needs assessment performed, and targeted participants were involved, coalition building was an effective way that public health professionals could assist communities to produce or bring about local change in overall health status.

CHAPTER IV

PROBLEM STATEMENT

Tarrant County Diabetes Collaboration (TCDC) members, as individuals or as representatives of varied and diverse organizations, all have a stated or implied interest in diabetes mellitus as a major public health concern. This bringing together of people who all have a common interest, but who may not all have common goals or objectives, could influence the degree or density of collaboration between the coalition members. The purpose of this study is to answer the research question, "How any why do TCDC members collaborate to form, build, and maintain a community coalition that has a viable impact on diabetes awareness, prevention, and education in Tarrant County?" The dimensions of collaboration that are examined are: membership composition, member's perception of ownership, and member's perceived value to the TCDC and value received from being a member of the TCDC. Also examined are the member's perceptions of governance, structure, and the TCDC's identity in the community.

CHAPTER V

METHODS

Research Design

This study is a descriptive, longitudinal, single-case study using qualitative research methods. The case study design was chosen because it met the criteria for case studies by asking "how and why" questions, by insuring that the investigator did not have direct control over actual behavioral events, and by focusing on a contemporary phenomenon rather than on historical events (Yin, 1994). Yin also describes a case study as an "empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident" (p. 13). The TCDC certainly met this definition as being appropriate for a case study.

The approach to qualitative research that I took in this study is referred to as grounded theory. Grounded theory refers to the orderly and comparative methods of qualitative analysis that generate theory from data. The data gathered are not forced to fit existing theories, but instead are used to develop analytic frameworks. Grounded theories are discovered through observation, interviews, and document data. Unlike research performed to verify theory in which data collection and analysis are separate, linear steps, in grounded theory, data collection and analysis are concurrent (Wilson & Hutchinson, 1999). As a participant-observer, I did not begin this case study with a

preconceived theory in mind. Through interviews, documents, and interaction among Tarrant County Diabetes Collaboration (TCDC) members, I was able to gather details about phenomena such as emotions, feelings, and thought processes of the members, which would have been difficult to gather through quantitative research (Strauss & Corbin, 1998). I gathered and analyzed the data with the purpose of discovering concepts and relationships (Strauss & Corbin, 1998) and was particularly oriented toward exploring the degree and density of collaboration of members of the TCDC. These methods directed me toward inductive logic and emergent theory (Strauss & Corbin, 1998).

Population Selection

The University of North Texas Health Science Center (UNTHSC) Institutional Review Board (IRB) guided in the methodology for subject recruitment. Recruitment consisted of making an announcement at a regularly scheduled meeting of the TCDC and directing attendee's attention to a flyer announcing the study. Unfortunately, only three members, in addition to myself, attended the meeting when the study announcement was made. Since TCDC meetings are held monthly and attendance can be variable, I petitioned the IRB to include another method of subject recruitment to enhance timeliness of recruitment. The IRB approved that a UNTHSC faculty member who had completed the IRB competency and was also a TCDC member could notify TCDC members of the study and ask for study volunteers.

No formal listing of TCDC members and their demographics was available. The UNTHSC faculty member used the current TCDC chairman's email list to contact

members. I attempted to cross-reference the TCDC letterhead listing of sponsoring organization's representatives with the email addresses. Out of the 15 email addresses, seven were returned as undeliverable.

By the next month's meeting, I had conducted four interviews. I again made the study announcement and directed attention to the flyer. Two members that were present scheduled an interview. Other members began hearing by word of mouth and the faculty member sent out one more announcement. Within a time frame of approximately three months, I recruited 12 members to participate in the study.

These 12 members, plus myself as a member and participant-observer, were representative of the spectrum of sponsoring organizations and individuals (Tables 1 & 2). The members represented the local county health department, a local health science university, a pharmaceutical company, four hospitals, a private practice endocrinology group, and a national service organization. Three represented themselves. One was a pediatric physician, one was a dietetic consultant, and one represented themself as a person with diabetes. The ethnic breakdown included 62% white, 23% Hispanic, and 15% African American (Table 1). The majority of members had been TCDC members for approximately three years (Table 2). Members who did not participate in the study represented two hospitals, a private practice primary care clinic, and a managed care organization.

Table 1

Member Credentials and Years of Professional Diabetes Healthcare Experience

Credentials	Years of Experience
MD	20
RD, MS, CDE	20
RD, MS, CDE	20
RN, BSN, CDE	20
RN, BSN, CDE	9
RN, CDE	7
RN, MS, CDE	4
RN, DrPH.	3
BS	0
BS	0
MS	0
PhD	0
PhD	0

Table 2

Tarrant County Diabetes Collaboration Demographics (2001)

Representation	Years of Membership	Ethnicity
County Health Department	5	W
Self	4	B
Hospital	4	W
Hospital	4	W
Hospital	4	W
Hospital	3	W
Academic	3	W
Academic	3	H
Private Practice Group	3	W
Self	2	H
Self	2	H
National Service Organization	2	B
Pharmaceutical Company	<1	W

Procedure

Data were collected through participant-observation of the TCDC meetings and events, TCDC written communications, memoranda, meeting minutes, documents, forms, and electronically recorded face-to-face and telephone semi-structured interviews. During the summer of 2000, as a participant-observer, I began keeping a journal of my conversations and thoughts regarding the TCDC. Many of the diabetes educators who are members of the TCDC are also members of a national, professional organization for diabetes educators. These meetings and other business opportunities offered a forum for the educators to meet in casual settings; therefore, most of the educators knew each other outside of their affiliation with the collaboration. As members became aware that the TCDC would be the subject of my thesis, they approached me in conversation to discuss issues of interest or concern regarding the collaboration. Therefore, as I began the formal interviews, I had a perspective of the TCDC from the educator's point of view, but I did not know the viewpoint of the other members in the coalition and was eager to get their perspectives.

I collected and compiled all the written TCDC communications I could find from pre-inception to present (1995-2001). One of the members had saved most of the meeting agendas, minutes, memos, letters, receipts, flyers, brochures, and other memorabilia from 1995 to the present. Another former member had compiled a list of dates and activities of the TCDC since 1995 that I used, along with other data, to develop a time line (See appendix A). I had a record of email communications for the past two

years and as co-fund raiser for the Diabetes Expo 2000, I had notes, lists, letters, and memos related to the Expo.

For the face-to-face electronically recorded interviews, I used a cassette recorder. I also took notes when appropriate. I encouraged people to choose the time and location of the interview to enhance comfort and reduce potential stress. Three interviews were telephone interviews, including note taking, that were scheduled to accommodate the time schedules, and in one case, the physical limitations of the members. The interviews took place over a three-month period from late January to late April 2001.

Analysis

Ensuring reliability and validity enhances the quality and accuracy of any design. A methodology to increase reliability as suggested by Yin (1994) was to utilize a case study protocol. For this study, a case study protocol (See appendix B) was developed and used as a means of ensuring that the research findings and conclusions would be the same if another investigator, using the case study protocol, performed the research.

This study utilized data triangulation to address the potential problems of construct validity or "establishing correct operational measures for the concepts being studied" (Yin, 1994, p. 33). Duffy (1987) described triangulation as "the use of multiple methods, theories, data, and/or investigators in the study of a common phenomenon" (p. 130). As defined by Duffy, I utilized three types of triangulation in this study: (a) data triangulation by using a variety of data sources such as interviewing TCDC members who represented diverse credentials, years of diabetes experience, years of membership, ethnicity, and representation (Tables 1 & 2), (b) theory triangulation by using multiple

perspectives to interpret a single set of data, and (c) methodological triangulation by utilizing participant observation, face-to-face interviews, and document and archival data.

The study interview questions consisted of twelve questions relating to member/membership factors and thirteen questions relating to the member's perception of the TCDC identity (See appendix C). Before the questions were asked, the participants were given the opportunity to describe their personal demographics and their diabetes experience. At the conclusion of the 25 questions, the participants were given the opportunity to add any additional comments. Tape recordings, interview notes, and personal memoranda were transcribed and summarized.

The first step in qualitative analysis is microanalysis. Strauss and Corbin (1998) define microanalysis as "the detailed line-by-line analysis necessary at the beginning of a study to generate initial categories (with their properties and dimensions) and to suggest relationships among categories; a combination of open and axial coding" (p. 57). Strauss and Corbin further define open coding as "the analytic process through which concepts are identified and their properties and dimensions are discovered" (p. 10) and axial coding as "the process of relating categories to their subcategories" (p. 123). This microanalysis is an important step in theory development. From the 25 interview questions, documents, and memos, I identified the following 13 categories and their properties or characteristics:

- Composition—the member credentials, years of professional diabetes experience, years of membership, ethnicity and cultural interest, and representation.
- Role—the role of the member in relationship to the collaboration.

- Ownership—the sense of participation and involvement.
- Satisfaction—the level of satisfaction the member derives from membership.
- Empowerment—the sense of power in the collaboration and in the community the member derives from membership.
- Vision/Mission—the perceived purpose of the collaboration.
- Operational map—the collaboration's strategic plan, goals, and objectives as perceived by the members.
- Advocacy—the knowledge and power to create social change.
- Health education—the knowledge and resources to offer diabetes self-management training.
- Governance—the organizational structure that defines leadership and leadership attributes.
- Fiscal structure—the financial framework guiding resource development and the operating budget.
- Diversity—the collaboration inclusion and exclusion ideologies that could include cultural, ethnic, professional, educational, and organizational characteristics.
- Identity—the empowerment of the collaboration in the community.

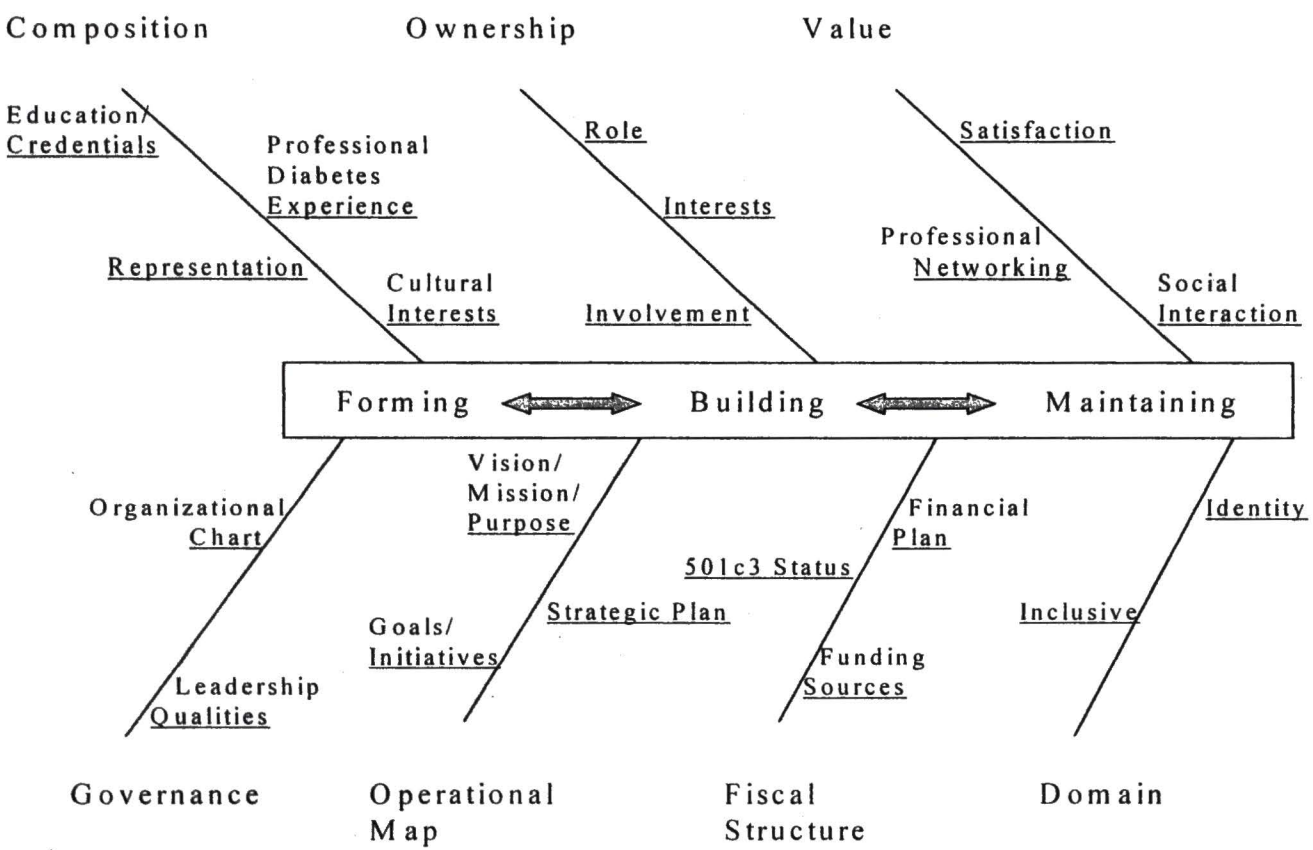
Through further open and axial coding, I identified seven concepts, along with their corresponding properties and dimensions (Figure 1) that helped to clarify and specify the degree and density of the collaboration. A picture began to emerge that helped to answer the question, "How and why do TCDC members collaborate to form, build, and maintain a diabetes coalition?"

- Composition refers to the education/credentials, years of professional diabetes experience, representation, and cultural interests of the members.
- Ownership refers to member involvement, interests, and their role as collaboration members.
- Value refers to satisfaction with being a collaboration member, social interaction avenues, and professional networking.
- Governance refers to leadership in organizational structure and leadership characteristics and qualities.
- Operational Map refers to the collaboration mission/vision and/or purpose, the strategic plan, and goals and initiatives.
- Fiscal Structure refers to an operational financial plan, not-for-profit status, and funding sources such as dues, levels of sponsorship, and grants.
- Domain refers to the collaboration's identity in the community and the membership's perceptions of the collaboration's behavior relating to inclusiveness.

Figure 1

Conceptual Model

Tarrant County Diabetes Collaboration: A Coalition



CHAPTER VI

INTERPRETATION

Formation and Building

In Chapter II, I discussed the background of the Tarrant County Diabetes Collaboration (TCDC) from its inception in 1995 to 1998. The following discussion, derived from various documents and conversations with former TCDC members, begins in the summer of 1998 when the TCDC began the formation and building process that shaped it as it is today.

Structure

After not being awarded a diabetes grant, the TCPHD hosted a Strategic Planning Retreat in September 1998 for TCDC partners to focus on the organizational structure and the strategic direction of the collaboration. During the retreat, the partners re-evaluated the collaboration mission, target population, and key result areas, and drafted bylaws. Following this meeting, Judge Tom Vandergriff was invited to become the Honorary Chairperson of the TCDC. He, in turn, invited key stakeholders in Tarrant County to an organizational meeting. Fifteen of the invitees responded. The attendees at this organizational meeting refined the proposals from the Strategic Planning Retreat, including the vision and mission statements, the target population and key result areas, and the bylaws (TCDC, Meeting minutes, Oct. 30, 1998).

The vision was described as, "A community where residents with, or at risk for, diabetes have the necessary knowledge, skills, capacity, to maximize health potential and

minimize complications." The mission was, "To assist in improving the quality of life for populations at risk for diabetes by educating, coordinating, and advocating at the grassroots level through a collaborative partnership of stakeholders" (TCDC, Meeting minutes, Oct. 30, 1998). The vision and mission were voted and accepted by the meeting attendees and continue to be the vision and mission statements of the TCDC today.

The TCDC target population described at this meeting included, "under-served populations consisting of people who have been screened for diabetes and determined to be at high risk, people who are supposed to show up for diabetes education and don't, people who don't know they have diabetes, newly-diagnosed people with diabetes, and people with diabetes who have had the disease for a long time, but are under-educated" (TCDC, Meeting minutes, Sept. 11, 1998). The six key result areas were defined as education, coordination, advocacy, screening, awareness, and organization (TCDC, Meeting minutes, Sept. 11, 1998).

In addition, an ad hoc governance committee submitted recommendations for an organizational structure, which were incorporated into the bylaws. The TCDC was structured to have four officers: a chair, chair-elect, secretary, and treasurer. These officers, elected by secret ballot, along with the chairs of standing committees and the Tarrant County Public Health Planner, made up the executive committee. The executive committee was to oversee all activities of the TCDC with staff help from the TCPHD. At this meeting the TCDC also created a schedule of regular, monthly meetings with defined time and location. By the year 2000, meetings continued to be scheduled for the last

Friday of each month. Meeting notification was inconsistent and meeting attendance ranged from three to 15 members.

Initiatives

The original TCDC core partners began educational initiatives within the first year of organization. One of the initiatives was a Diabetes Club program that consisted of five "Live and Learn" diabetes education lessons. The lessons covered nutrition, exercise, and long-term diabetes complications. The Diabetes Club program was an approach at the community level to address the disproportionate rate of diabetes in African Americans, Hispanics, and senior citizens of Tarrant County. The pilot Diabetes Club was conducted at the primarily Hispanic Northside Community Center.

The TCDC resolved to offer six Diabetes Club programs per year and soon the Diabetes Club curriculum was expanded from five to six lessons. The sixth lesson promoted follow-up through ongoing self-facilitated support groups using TCDC resources as needed. Another initiative was to conduct food education demonstrations at Kroger food stores throughout the county. These programs were usually presented during the holiday season. One of the annual demonstrations was entitled "Diabetic Desserts for Healthy Holidays" (See appendix A).

In February 1998, the TCDC experienced a serious, educational initiative setback when no one showed up for a Diabetes Club held at the Fort Worth Renaissance Cultural Center and was targeted toward the Hispanic community. This initiated a review of the Diabetes Club marketing strategy and curriculum. The TCDC invited four guests (representatives of Latino Information of Diabetes for Early Risk Reduction [LIDER],

Near Northside Partnership [a Hispanic community organization], John Peter Smith Network [county hospital], and the University of North Texas Health Science Center [UNTHSC] at Fort Worth) to attend a roundtable discussion about diabetes outreach in Hispanic communities. The goal was to identify marketing strategies and to update the Diabetes Club materials and presentations based on the conscious effort to continue to address the lack of culturally and linguistically appropriate diabetes information for reaching populations at greater risk, such as the Hispanic community (TCDC, 1998a).

As a result of the meeting, area diabetes clinicians were formally invited to join the TCDC. They included registered dietitians, registered nurses, and a physician, all of whom practiced in the area of diabetes education and management. The clinicians were recruited to add expertise to the Diabetes Club curriculum development and to teach Diabetes Club lessons specifically related to diabetes treatment.

With its new clinical focus, the TCDC decided to create a Diabetes Club Manual. The idea grew out of an emerging consensus among members that the educational lesson plans and related resource materials could be consolidated (TCDC, 1998a). In addition to the Programmatic Plan, the Diabetes Club Manual included a Community Organizer's Tool Kit. The purpose of the Kit was to enhance program capacity building by helping to identify locations and populations that would allow successful programs and support groups (TCDC, 1998a).

Another educational initiative proposed by the executive committee was a Diabetes Expo to be sponsored by the TCDC in November 1999 during National

Diabetes Month. Most of the monthly meetings of 1999 were focused toward the Diabetes Expo, which was to be held at the Tarrant County Convention Center.

This initiative proved to be a large undertaking that required many human and financial resources. Approximately 400 people attended the Diabetes Expo. There were approximately 25 display booths available for view. Members and member organizations of the TCDC were given the opportunity to host a booth at no charge. For-profit businesses sponsored booths for $150-200. Diabetes awareness and education activities included cooking, exercise, blood glucose meter, and insulin pen injection system demonstrations, screenings for blood glucose, blood pressure, body mass index, and indicators of insulin resistance and Type 2 diabetes in children, vision and foot exams, seminars on nutrition and sexual dysfunction treatments. Free flu shots were available (TCDC, Meeting agendas & minutes, Aug.-Nov., 1999).

The first TCDC meeting following the Diabetes Expo was a debriefing session. No formal evaluation of the Expo took place, but consensus of the attending members was that the Diabetes Expo was a cost effective activity that met the purpose of the TCDC to provide diabetes awareness training and education to the population of Tarrant County. The decision was made by a consensus of the attending members to again sponsor a Diabetes Expo the next fall.

Most 2000 TCDC meeting discussions were directed toward the Fall 2000 Diabetes Expo. In early summer, at the request of one or two members, a subcommittee for fundraising was formed. The committee met independently to identify sponsors, create a database of sponsors, and to develop levels of sponsorship.

The second annual Diabetes Expo was held in the Fort Worth Amon Carter Exhibitions Hall, October 28, 2000. Fifty booths were available for the approximately 600-800 attendees. Screenings, exams, and demonstrations offered were similar to those of the previous year, but the booths offered a greater variety of products and services.

At the debriefing meeting following the Diabetes Expo 2000, members again expressed satisfaction with the Expo attendance and with the credit balance. A formal evaluation of industry sponsors showed a satisfaction ranking of 4.3 on a scale of 1-5. A date was set for the 3rd annual Diabetes Expo 2001 (Meeting minutes, Nov. 17, 2000).

Funding Sources

From its inception, the TCDC operated without a formal financial plan or budget. The treasurer kept a general ledger of debits and credits and reported at meetings as needed. Meeting minutes recorded ongoing discussions of obtaining 501c3 tax-exempt status issued by the Internal Revenue Service for nonprofit organizations. The TCDC treasurer reported that the collaboration had the necessary qualifications for tax-exempt status. However, because the TCDC did not have a bank account and no funds were available to apply for the tax-exempt status, no application was made.

Not having tax-exempt status became a problem as planning for the first Diabetes Expo began and as industry representatives were approached for sponsorships. TCDC members realized sponsors demanded assurance that contributions would be to a tax-exempt organization. To solve this problem in the short term, the TCDC approached The Tarrant County Community Health Foundation, a 501c3 organization. They agreed to administer the TCDC's funds for an administrative fee of 10% of the monies handled.

At the beginning of 2000, discussions at meetings related to membership dues. In the spring, a vote was taken to ask members to contribute $15 as membership dues. These dues would demonstrate continued interest and participation in the TCDC, would allow the sponsoring organizations the right to have a booth at the next Diabetes Expo, and would contribute toward 501c3 status fees. It was also voted to amend the bylaws to include membership dues.

With a credit balance of $1000 after the Diabetes Expo 2000, the members voted by consensus to begin application for 501c3 status. Members also voted to develop a membership subcommittee to define TCDC membership. The impetus for defining membership came from the fact that the TCDC letterhead listed several supporters who had not paid dues or had not attended one meeting in the last year.

The TCDC has unsuccessfully applied for three state and federal diabetes grants. In 1998 the TCDC responded to a Request for Proposal (RFP) from the Texas Health Department and the Texas Diabetes Council for a Diabetes Awareness and Education in the Community (DAEC) grant. One of the requirements of the DAEC grant was that there be a coalition of community partners whose purpose was awareness and education for people with diabetes. The TCDC submitted that they fulfilled the requirement for a diabetes coalition in Tarrant County. However, the TCDC was not awarded the grant and the City of Fort Worth Public Health Department, who, in a competitive effort had also responded to the same RFP, was awarded the DAEC grant.

The executive committee responded to two further opportunities for funding. During the summer of 1999 the executive committee became aware of a Department of

Health and Human Services grant for funding blood glucose screening for undiagnosed youth. They submitted an application; the grant was reviewed, but not awarded.

The third grant opportunity arose when a CDC RFP for a Racial and Ethnic Approaches to Community Health (REACH) 2010 grant became available. Executive committee members of the TCDC, representatives from UNTHSC, PAL, and Concillio de La Raza of Dallas met to draft a letter of intent. A consensus was not reached and the group did not apply for the grant. Following the meeting, representatives of UNTHSC and the TCDC regrouped and applied for the grant. Additionally, other representatives of UNTHSC and La Raza representatives grouped and applied for the grant with La Raza as the lead agency. The La Raza group was awarded a planning grant in the fall, 2000.

Maintaining

To answer the question, "How and why do the TCDC members collaborate?" I analyzed the theoretical concepts of membership composition, member perceptions of collaboration ownership and value of membership, perceptions of governance, operational and fiscal structure, and identity. Following is a discussion of these study findings including the key concepts of composition, ownership, value, governance, operational map, fiscal structure, and domain. These key concepts are also organized into a conceptual model (Figure 1).

Composition

The composition of the TCDC membership emerged as an important characteristic in analyzing the degree and density of the collaborative efforts of the

coalition. The 12 members who were interviewed, and myself as a participant observer, made up the 13 people represented in Tables 1 and 2.

Most of the members were health care professionals with post-graduate degrees. Six of the registered nurses (RN) and registered dietitians (RD) were also Certified Diabetes Educators (CDE) and worked directly with people with diabetes as diabetes educators. Two others, an MD and an RN, DrPH, were involved in research studies of Type 2 diabetes in children. The five non-health care professionals were involved with diabetes through their profession or through their personal experience.

The members who were CDEs had an average of 13 years of professional diabetes experience each and worked in situations where they were providing daily direct diabetes awareness and education. Even so, their expressions of interest in helping to relieve the burden of diabetes were similar to the non-CDE members. Though the interest or concern did not differ, the ideas of how to address the issues of diabetes awareness and education did differ.

There was overwhelming agreement that the Diabetes Expo was a cost-effective and time-efficient program to bring diabetes awareness and education to large groups of people. The diabetes educators, though, voiced their concern that people with diabetes additionally needed comprehensive education and training to self-manage their disease and promoting self-management programs was not part of the TCDC agenda.

Most of the members stated they were TCDC members as representatives of their employers. However, except for the County Health Department, the employing organizations did not influence the TCDC as a coalition as much as did the individual

member's interest. The employing organization's greatest contribution to the coalition was in allowing the employee time to attend coalition meetings and events. Several members said they did not think the organization they represented had a clear idea of what the TCDC was or what their role was as a supporting organization.

Eight of the 13 members described their ethnicity as white, three as Hispanic, and two as black. Four of the five non-white members spoke passionately about their concern for reaching out specifically to the people of their race who had diabetes and stated the significance of the increased prevalence of diabetes in Hispanic and Black groups. The white members did not speak in terms of ethnicity, but used terms such as "the medically indigent" or the "underserved" to describe the diabetes populations of their interest.

In summary, the educational qualifications and the years of professional healthcare diabetes experience of members was impressive. The TCDC appeared to be composed of the important diabetes stakeholders in Tarrant County and showed an ethnically diverse face. A noticeable omission, however, was a lack of community representation from Hispanic and Black organizations. Another important finding was that even though the member's organization was listed on the letterhead, most of the members were personally responsible for their dues and other expenses related to the coalition. The tone of the interviews seemed to be that the TCDC was a group of individuals working together, rather than a partnering or a coalition of organizations.

Ownership

Ownership consisted of the concepts of role, interests, and involvement. When asked about their role, the members who had been with the coalition the longest and who had been involved in the original structuring, were clear about why they were members and could clearly define their role in the coalition. They said they provided leadership and were active in "moving the coalition forward." However, when most of the other members were asked about their role, they made statements such as "not well defined," "cloudy," "no role," and "don't know where I fit in." One member said, "I was not involved. I got so frustrated. I would go to meetings, but I never understood my role." A few others stated they knew what they would like their role to be, but did not feel their contribution was sought or recognized by the group.

The personal and professional diabetes interests of the members contributed to ownership. Other than one member who joined the TCDC specifically because of professional interests in community coalitions and how coalitions work, the other members were focused on diabetes as a disease and its impact on family and community. Members repeatedly and strongly voiced expressions of wanting to "make a concerted effort to get the message out." They expressed concern that people with diabetes were not getting the information, treatment, and supplies they needed to manage the disease. Their personal interests in being a member were in making a significant impact on diabetes in the community and they felt they could better accomplish this working together with others of like interests than they could individually.

Involvement or participation was a component of ownership. The Diabetes Expo was mentioned repeatedly throughout the interviews and all but one member stated they had been involved with the planning and running of the Expo. It seemed to be the one unifying factor. However, many members also voiced that they would feel more involved in the coalition if there were initiatives beyond the Expo. Several stated they had areas of expertise they would like to share with the coalition that would enhance their feeling of involvement.

As described by the conceptual model (Figure 1), ownership was described by the three concepts of role, interests, and involvement. Whereas many expressed they did not know what their role was, they stayed in the coalition with the hope that "things would improve." They also stayed because of their sincere interest in the diabetes cause and they hoped they would find their role within the TCDC. In the meantime, they were glad to be involved with the Diabetes Expo and desired to become involved in possible future initiatives.

Value

Another key concept of the TCDC was value. Value was described as satisfaction, empowerment, professional networking, and social interaction. When asked to describe their level of satisfaction with being a TCDC member, only two members stated they were satisfied. One of them said they felt frustrated because of time constraints in accomplishing goals but said, "What we have done, we have done well." Several members scaled their level of satisfaction from one to ten (with one being the

lowest level). Members ranked their levels of satisfaction as a "7", a "3", and two "1s". Others described their satisfaction level as low or moderate.

Many of the responses were long and included reasons for their dissatisfaction. Following are some portions of the responses: "I always feel as though there is something missing. And I think, even after two or three years (of membership), I am still fuzzy as to the focus of the organization." "Sometimes I walk away from meetings not knowing quite what we have accomplished. Frankly, I don't like that feeling." "I think there are some communication issues that limit our effectiveness as a group." "I have no sense of satisfaction. I do not get a warm, fuzzy feeling. A volunteer should get that kind of feeling—like I have improved someone's life." "I want to do more than a fair. A group of health care professionals should be able to do more in a year than plan a health fair." "We don't network enough as a group. The letterhead names an impressive number of organizations, but I don't know what resources each organization can contribute to the group." "The meetings are a waste of time. There is no clarity of purpose and no substance. No vote is taken."

The members stated two to one that being a member of the TCDC did not give them a feeling of empowerment. Most members answered "no" to the question, "Does being a member of the collaboration give you a feeling of being empowered?" and had nothing more to add. Two members who felt empowered both stated they felt it was the structure or organization of the TCDC that empowered them to accomplish tasks in the community.

In differentiation from low satisfaction and empowerment feelings, members overwhelmingly voiced positive responses when asked if being a member of the TCDC was of value to them professionally. The professional value stemmed from the networking with other professionals interested in diabetes and the opportunities the coalition afforded for looking at issues from a more global perspective. Responses tended to carry the same themes: "expand network," "in touch with others," "see how other organizations are solving problems," "finger on pulse," "different perspective," and "out of tunnel vision."

Members also stated they experienced personal value from coalition membership. Several had family members with diabetes or had diabetes themselves and were appreciative of the opportunity to interact with diabetes educators on a personal basis. One member expressed the positive benefits of peer interaction this way, "There are many peers that I do not interact with on a day-to-day basis and (because of the coalition) I find interacting with them pleasurable as well as emotionally and intellectually rewarding."

Three members did not perceive personal value from coalition membership. Two members felt "left out." They noticed that members seemed to know each other on a more personal level and felt they were not included. They both stated they did not attend meetings frequently and that was a possible reason for their perception of not gaining personal value from membership.

Most members declared their participation in the TCDC to be of positive value to the coalition. The diabetes educator's responses reflected their particular areas of

expertise. Additionally, the non-educators each clearly described their value. They defined their value to the coalition as leadership, bringing support and credibility from their institutions, providing insights into the Hispanic culture, and being a liaison to the medical community.

In summary, the TCDC members stated they were not satisfied with being members. They gave many reasons that were similar to the findings of Butterfoss et al. (1996). He said coalition members would experience increased satisfaction if they were encouraged to not only attend meetings, but to become a fully participative member by being involved in meetings, organizing activities, and working for the coalition outside of scheduled meetings. However, decreased satisfaction with being a member did not prevent the TCDC member from feeling they had gained value though social interaction with other members and through the opportunities for professional networking. They also felt as if they had contributed value to the coalition.

Governance

Two factors members considered important in the concept of governance were: how the TCDC was organizationally structured and the leadership qualities of the TCDC leadership team. When I asked the interview question, "What does the TCDC organizational chart look like?" seven of the members said either that they did not know or that there was not one. Two of the members, who were or who had been TCDC officers, described the organizational plan accurately according to the bylaws. Members who had an idea of how the TCDC was organizationally structured were not sure who the officers were. The chairman was the only officer whom all the members could name.

Most members said they did not think there was a chairman-elect or a secretary. They could not recall anyone taking meeting minutes. Members assumed the treasurer was the person who handed out balance sheets at the meetings. Most could not remember voting for officers, but assumed there must have been an election.

Several members addressed the role of the Tarrant County Public Health Department (TCPHD) in the organizational structure of the TCDC. They were not specific in their description of the role of the TCPHD, but thought it should be playing a larger role in the sharing of human resources and expertise. One member, on the other hand, thought the TCPHD played a very important role and descriptively defined it as "the mother who is holding the baby (TCDC) in its lap." To add emphasis to the Health Department's important role, the member added, "It is the container that holds the collaboration and all its parts."

As described by researchers (e.g., Butterfoss et al., 1996; Kegler et al., 1998), the members also expressed communication skills and organization of meetings as the leadership qualities they felt contributed most to a successful coalition. Members said it would be important to get regular meeting notices and regular meeting minutes. Most members also said they would appreciate a traditional meeting format with discussion of agenda items and a vote on actions to take. One member said, "There is no opportunity to vote if we want to do the Expo or if we want to do (Diabetes) Clubs. Decisions are kind of done by consensus, I guess."

The members summarized the definition of governance as a combination of who the leaders are and the leadership attributes they possess.

Operational Map

Most of the members could not verbalize the TCDC vision and mission statements. The vision was, "A community where residents with, or at risk for, diabetes have the necessary knowledge, skills, capacity, to maximize health potential and minimize complications." The mission was, "To assist in improving the quality of life for populations at risk for diabetes by educating, coordinating, and advocating at the grassroots level through a collaborative partnership of stakeholders." However, when they were asked to verbalize the purpose of the TCDC, their statements very closely matched the vision/mission statements. All members interviewed used the words, education, awareness, and management, or synonyms, to describe the purpose for a diabetes coalition in Tarrant County. Many of them used terms such as "education to the underserved," "combat the disparities," "educational effort at grassroots level," and "reduce the burden in the community." In addition to the educational purpose, many spoke of the coalition itself as the purpose in "bringing people together who can make a difference." One member named "advocacy" in addition to community service as the purpose.

Whereas the purpose of the coalition was very clearly understood and verbalized by the members, when asked about a strategic plan for the coalition, all but two members said there definitely was not a strategic plan or if there was one, they were not aware of it. One member of the two who said there was a strategic plan, stated it was a "minimal plan with a limited operation because we are a group of volunteers."

Likewise, the members were not sure how to answer the question, "What are the goals and objectives of the TCDC?" One member said, "If I could answer that, I might not be so frustrated. I guess it is the Expo and the Clubs." Another member said, "They are limited. The Diabetes Expo is about 50% of the goals and the Diabetes Clubs are about 50% of the goals." Nine members named the Diabetes Expo as a means of meeting a goal. Four members named the Diabetes Clubs as a means of meeting a goal. The eight members, who did not mention the Diabetes Clubs in answer to this question, did not mention the Clubs at any other time during the interview.

Even though the purpose of the TCDC was clear, the TCDC was not perceived to operate from a strategic plan. Organizers of the TCDC had developed a strategic plan and presented it to the membership in 1998, but by the time of the interviews for this research, most of the members did not perceive that the TCDC operated according to a strategic plan. In addition, most of the members knew of and participated in only one initiative, the Diabetes Expo.

Fiscal Structure

When asked about the financial structure of the TCDC, most members said they had no knowledge of the TCDC operating according to a financial plan or if it did, they were not aware of it. Several members equated structure or plan with funding for the Diabetes Expo. One member said, "Basically the strategic aspect was to fund the Expo. We did not want to go in the hole. We did not want to be anything less than self-sufficient."

When asked about a budget, most members said the only thing they knew was that at meetings prior to and after the Expo, they had received a balance sheet with a record of checks written and received with no explanation of the reasons for the distributions. It appeared that during the remainder of the year, the TCDC functioned largely with in kind donations.

When members were asked for their vision of what they would like the financial structure of the TCDC to look like, most agreed the collaboration needed to achieve Internal Revenue Code 501c3 status. There was a spirit of optimism that the monies cleared from the Diabetes Expo 2000 would be sufficient for 501c3 application.

Other funding sources came from the annual membership dues of $15. Most said they paid those dues from personal funds and were not reimbursed from their sponsoring organization. The members agreed that since the dues were nominal, they did not mind personally paying them because they felt it was necessary to support essential costs such as paper, copying, and postage.

There was general agreement that the TCDC required greater operating funds. On the other hand, there was not a consensus on funding sources. A few suggested there needed to be levels of sponsorship. A few others mentioned federal, state, or county government grant opportunities as a means of building financial resources, but sounded discouraged about getting funded. A few said the local health department should take a more active financial role since it was the lead organization of the collaboration.

There were mixed ideas regarding whether the TCDC should have a paid administrative staff. Some voiced it would be difficult for them to have a complete sense

of trust in the TCDC if it had paid administrators, especially if coalition members did not vote for who would be named to that position.

In summary, the members agreed that the TCDC had achieved about all it could with the present funding structure. A member said, "(The collaboration) is stretching a few dollars to the max." The general attitude was that the TCDC was an all-volunteer organization operating without a plan of funding or support and the fact that it had supported two Diabetes Expos was impressive, but not enough.

Domain

The two concepts of coalition identity and coalition inclusive behavior were described as the domain of the TCDC. The members unanimously perceived the community's view of the TCDC as unawareness. Most made strong statements such as, "I don't think the community knows it (TCDC) exists." One member said, "There is not a physician in Tarrant County who has a clue about what we are doing." Another member said, "As far as being sought out as a leader...in the policy and development arena, we are not even seen as a player." Other statements made were, "There is no name recognition," and "Except for the mayor's proclamation at the first Expo, no one knows about us."

Most members also felt the coalition had had an impact on the community, specifically through the Diabetes Expo, even though the general perception was that the community was unaware of the TCDC as a community coalition. One member said, "Attendees at the Expo do not know the Expo is a product of the collaboration." Additionally, a member said, "I think most people who came to the Expo did not know

who was promoting it or putting it on." Another member said, "I think the reps respond to the Expo because they are notified by the educators they call on. They know the educator's name, but not the collaboration's name."

The prevailing opinion was, "We would like to be more visible, to do more in the community, but as things stand right now, this is about it." A few members said they would like to see the TCDC have community name recognition like United Way or Mayfest (a community service activity). They wanted the TCDC to be the resource center or clearinghouse for community diabetes education and awareness in Tarrant County, but felt limited by human and financial resources.

Most members said they thought the TCDC to be an inclusive coalition. When asked specifically if the members perceived the coalition as inclusive or exclusive in nature, they answered, "Anyone interested in diabetes is welcome." One member expressed regret that there was not a hospitality committee to recruit and retain new members. A few of the members had other opinions. One member felt as if the coalition was a "first name" club where the other members seemed to know each other both professionally and socially and left other members out. Another member felt as if the members themselves should do more networking. One member felt as if the organizations involved in the collaboration perceived it as open and inclusive, but said, "Organizations that have separate goals, not the same goals as the collaboration, will choose not to participate."

All concepts described in the conceptual model (Figure 1) are important to the forming, building, and maintaining of the TCDC. The concept of domain, however,

seemed to be critical to the maintaining stage. The members feared that the community did not know about the TCDC, did not know who the representative organizations were, did not know what the TCDC did or what it could do. The members wanted to "get the message out," but wondered how they would accomplish the goal.

CHAPTER VII

CONCLUSIONS

Previous research has focused on health related community coalitions as discussed in Chapter I, but little previous research has focused specifically on coalitions for diabetes education and awareness. Nevertheless, many of the theoretical frameworks for coalition forming, building, and maintaining, as described by the researchers in Chapter III, also apply to a diabetes coalition and specifically to the Tarrant County Diabetes Collaboration (TCDC). The focus of this study was on the characteristics that make the TCDC a community diabetes coalition.

Theoretical frameworks for successful coalitions include the concepts of strong, local leadership, open communication, member satisfaction, member empowerment, organizational ownership, an operational map with goals that reflect the vision, and adequate funding to achieve goals. Coalitions that operated by these frameworks appeared to be successful in that they achieved their goals.

The TCDC has formed and it is building. The questions arise, "Will the TCDC be able to continue to build upon the vital concepts of composition, ownership, value, governance, operational map, fiscal structure, and domain?" "Will the TCDC reach the maintenance stage?" Prior to this study, I would have answered, "No—well, maybe." After months of research and immersing myself in the history, after interviewing 12

members and engaging in conversation with former members, I will answer the question with a "Yes—well, maybe." Two TCDC strengths made me change my mind and yet hedge my bet. First, there was no doubt that the members of the coalition felt a passion for reducing the burden of diabetes in their community. The overriding theme throughout the interviews was that they wanted to "get the message out." Even though they did not feel satisfied with being a member of the coalition, they continued to attend meetings, continued to look for a role they could fill, and continued to support the existence of the coalition with their resources.

Second, the Diabetes Expo, one of the two apparent goals or initiatives of the TCDC, was an initial success and promised to become an annual event serving the diabetes community with increasingly greater opportunities for awareness and education. These two strengths, the passion for "getting the message out," and the achievement of a goal (Diabetes Expo), are the collaborative characteristics that have brought the TCDC to its present status as a coalition. Even though the members want to do more than sponsor an annual Diabetes Expo, given the present organizational and financial structure, the TCDC appears to be functioning at its maximum potential. Thus, the hedge.

The study findings revealed several opportunities that could influence the maintenance of the TCDC. First was the composition of the TCDC. This diabetes coalition is unique from other health related coalitions in that the membership includes a large percentage of certified diabetes educators (CDE). A CDE is a person who has been certified to provide diabetes education that meets certain standards, particularly the national standards of the American Diabetes Association (ADA). These standards

emphasize comprehensive, individualized diabetes education programs. On the other hand, other coalition members view diabetes education from a broader perspective. They are not as focused on following ADA standards, but on providing a more generalized education program to larger numbers of people. The members would be well served to take advantage of these diverse perspectives by collaborating together to utilize the TCDC as a forum to provide diabetes awareness and education via many different modalities.

The second area of opportunity for the TCDC to begin the maintenance stage was in the concept of ownership. The concept of ownership was defined as the member's role, interests, and involvement. The literature supports the concept that members who participate and who are involved are more satisfied (Butterfoss et al., 1996). Up to the present time, the only role the members had the opportunity to function in was in relationship to the two goals in place—the Diabetes Expo and the Diabetes Clubs. If the members develop a strategic plan including goals and initiatives, opportunities will be available for members to become involved and to define their role. The members can then have a reason to continue as members and to become owners of the coalition.

The third characteristic important to coalition maintenance was the concept of governance. According to Kegler et al. (1998), and supported by the TCDC conceptual model, organization and leadership are important to the governance of a coalition. According to the TCDC members, the leadership structure was not as important as the selection of competent leaders and the qualities of leadership those persons possessed. The leadership qualities most often cited as important were communication skills and

how meetings were conducted. One suggestion would be that elected leaders be provided the opportunity to attend a leadership workshop that would include sessions on how to conduct a meeting. Another suggestion would be that leaders share with members their own philosophy of leadership and their personal styles of communication.

Fourth, my findings support the theory that successful coalitions operate according to an operational map. The operational map concept for the TCDC includes vision/mission/purpose, and a strategic plan that includes goals and initiatives. The TCDC members know the coalition's vision and mission as the purpose, but they are unclear as to how to achieve that purpose. This is because the TCDC does not operate according to a strategic plan. At the present time, only two goals are in place--the Diabetes Clubs and the Diabetes Expo. However, the status of the Clubs is unclear. I would recommend the TCDC membership as a whole take time to develop a strategic plan, including goals and initiatives, based on the vision and mission of the coalition that would take the coalition beyond the building stage and into the maintenance stage.

The fifth area of opportunity lies within the fiscal structure of the TCDC. The TCDC does not have a financial plan and I would suggest that the TCDC membership design a plan including an operating budget. Again, because the membership is small, I would suggest it to be important that all members participate in the planning. Once a plan is in place and a budget developed, the treasurer could give a report at each meeting. This would keep the members apprised of the financial status of the coalition. The financial plan could also include potential TCDC funding sources. Decisions for involvement in grant writing and collaborating with other institutions should be brought

before the membership for a vote. Requests for special projects funding should also be brought to the full coalition for a vote. These suggestions would incorporate shared decision-making and could possibly lead to increased trust.

The last concept I see as an opportunity is the concept of domain that includes coalition identity and inclusive behavior. The TCDC is inclusive and it is diverse, but it is not known outside of its walls. One way to heighten its image, is for the TCDC to look like a coalition of organizations and not like a group of individuals. Members should be encouraged to promote the TCDC within their own organization and to describe to the organization how it could play a more pivotal role in increasing the TCDC identity. Organizations could become more involved through corporate sponsorships of programs such as the Diabetes Expo and by providing in kind marketing expertise. Also, as continued efforts are made toward applying for grant monies, sponsoring organizations could be approached for letters of support and this could increase their awareness of the TCDC and its mission.

Other suggestions include: increased use of the letterhead and logo; developing and distributing a marketing brochure; information at the next Expo about the TCDC, its mission and goals; and TCDC representation at civic and community meetings and functions.

With diabetes becoming increasingly prevalent in the U.S. and globally, and with it considered a major public health issue, ideas for further research might focus on other diabetes coalitions as they begin forming and building. The case study design served well for the study of a coalition and it would be interesting to apply the TCDC conceptual

framework to other diabetes coalitions to compare strengths and weaknesses. Another focus for further research might be an evaluation in two or three years of the TCDC and its identity, especially evaluating organizational involvement and sponsorship.

APPENDIX A

TIME LINE

Timeline

Fall 1995	Texas Agricultural Extension Service (TAEXC) approaches the Tarrant County Public Health Department (TCPHD) about partnering to develop a community-based approach targeting at-risk groups for Type 2 diabetes.
Winter 1996	A pilot Diabetes Club is conducted at the Northside Community Center
Spring 1996	The first Diabetes Club (five educational sessions) model is conducted at the Northside Community Center.
Spring 1997	Partners at Lunch (PAL) becomes the third core partner to join this collaboration initiative.
Summer 1997	Diabetes Club brochure is designed.
Fall 1997	The TCPHD hosts a downlink satellite broadcast via the Centers for Disease Control and Prevention-- "Diabetes: A Life of Balance, A Community of Support, A Call to Action." All interested agencies and individuals are invited to view the video and participate in discussions of new projects and partnerships to control diabetes in the community. The collaboration conducts in-store food demonstrations: Diabetic Desserts for Healthy Holidays at Kroger stores throughout the county. A reception to celebrate the formation of the Tarrant County Diabetes Collaboration (TCDC) is held at the Milan Art Gallery, Fort Worth, TX. The slogan is Taking A Bite Out of Diabetes. A picture of the three core partners (TCPHD, TAEXS, PAL) is printed in the Fort Worth Star-Telegram.

Spring 1998	Diabetes Club curriculum is revised to six sessions. Special guests are invited to share dialogue about diabetes outreach in Hispanic communities. They represent Dallas Concilio LIDER, Near Northside Partnership, JPS Network, and UNTHSC. Focus is directed toward updating Diabetes Club education materials and presentations to be culturally appropriate to the Hispanic community.
Summer 1998	A Diabetes Club Manual is developed for community-based programs that includes: Programmatic Plan and Community Organizer Tool Kit to enhance capacity building for the model program. Invitations to join the TCDC are extended to Tarrant County health care professionals with interests in diabetes. The core partners of the TCDC (TCPHD, TAEXS, PAL) respond to a Texas Health Department and Texas Diabetes Council Request for Proposal (RFP) for a Diabetes Awareness and Education in the Community (DAEC) grant. Agenda of TCDC meeting calls for new officers. The TCPHD sponsors an all day TCDC Strategic Planning Retreat to focus on new strategic directions and organizational structure. The group discusses vision and mission, target population, and key result areas.
Fall 1998	Fifteen people respond to a letter signed by Judge Tom Vandergriff, Honorary Chairperson/TCDC inviting key stakeholders in Tarrant County to an organizational meeting of the TCDC. They vote to accept the vision and mission statements, target population, and the key result areas.
Winter 1999	Regular, monthly meetings of the TCDC were scheduled. A letterhead including key stakeholders is designed. Diabetes Clubs continue, utilizing the Organizer's Tool Kit.
Fall 1999	First Diabetes Expo is held in Tarrant County Convention Center. Approximately 400 attendees visit approximately 25 booths sponsored by TCDC members and invited vendors.

Winter 2000	The TCDC executive committee responds to a Department of Health and Human Services RFP for a "screening for diabetes" grant. The proposal is reviewed, but not awarded.
	Leaders from UNTHSC and the TCDC meet together to discuss responding to a CDC RFP for a Racial and Ethnic Approaches to Community Health (REACH) grant. The group takes no action.
Fall 2000	The second annual Diabetes Expo is held at the Amon Carter Exhibition Hall. Attendance is estimated to be 800 attendees with approximately 40 booths manned by TCDC member organizations and invited vendors. Sponsorships bring in approximately $10,000.

APPENDIX B

CASE STUDY PROTOCOL

Case Study Protocol

"A case study protocol is more than an instrument. The protocol contains the instrument but also contains the procedures and general rules that should be followed in using the instrument" (Yin, 1994, p. 63).

I. Field Procedures
   A. Determination of Persons for Interviews
      1. Representatives from supporting organizations/agencies as identified by the TCDC letterhead
      2. TCDC meeting attendees
   B. Interview Preparation
      1. Participant names, phone numbers/e-mail/FAX, address and directions
      2. Appointment calendar
      3. Introduction guidelines including investigator credentials for research and participant responsibilities
      4. Consent forms
      5. Interview questions forms and notepad
      6. Tape recorder, extra batteries, extra tapes
      7. Carrying case for documents, notes, tape recorder and tapes
   C. Identification of Documents
      1. Memoranda/meeting minutes
      2. Documents/forms
      3. Physical artifacts i.e. banners, symbols, logos, etc
      4. Archival records

II. Case Study Questions
   A. Coalition Member/Membership
      1. Representation/composition
      2. Roles
      3. Participation/Buy-in/Ownership
      4. Satisfaction
      5. Personal demographics
      6. Personal empowerment
   B. Coalition Identity (interviewee's perception of TCDC's identity in the community)
      1. Purpose
      2. Mission/vision
      3. Goals/objectives/operational map
      4. Social change vs. social work

5. Governance
6. Fiscal structure/resources
7. Diversity/inclusion
8. Domain
9. Community empowerment
10. Health education
11. Advocacy

C. Open and axial coding from themes or patterns derived from the participant's words as described by Strauss and Corbin.

APPENDIX C

INTERVIEW QUESTIONS

Interview Questions

Please tell me about yourself and your diabetes background.

Coalition Members/Membership:

1. How did you hear about the TCDC?

2. Regarding membership: a) who is membership open to? b) what are membership requirements? c) what do you know about a memorandum of understanding?

3. As a member of the collaboration, a) are you representing an organization, group, etc.? b) are you allowed to take work time to participate in the collaboration meetings and functions? c) are you reimbursed for travel or other expenses?

4. How would you define your role as a member of the collaboration?

5. What activities of the collaboration do you have a role in?

6. How involved do you feel in the collaboration?

7. Do you feel as if your participation in the collaboration is of value to you? If yes, how is the collaboration of value to you professionally/personally?

8. Do you feel as if your participation in the collaboration is of value to the collaboration? In what ways?

9. In your own words, how would you describe your level of satisfaction with being a member of the collaboration?

10. Does being a member of the collaboration give you a feeling of being empowered?

11. Why are you interested in this coalition?

12. Would you describe your diabetes interests as being a) broad or b) more focused? Please explain your answer.

Coalition Identity:

13. What is your perception of the purpose of the TDCD?

14. What is your understanding of the mission of the collaboration?

15. Does your understanding of the purpose of the collaboration mesh with your understanding of the mission?

16. What are the goals and objectives of the collaboration?

17. In what way do these goals reflect/not reflect your personal goals for the collaboration?

18. Are there specific goals for the collaboration that you would like to see advanced?

19. Do you perceive that the collaboration operates according to a strategic plan?

20. What do you know about the finances of the collaboration?

21. In your opinion, does the present financial situation enable the collaboration to meet and/or exceed its goals and objectives?

22. If not, what would you envision the financial structure of the collaboration to look like?

23. What does the collaboration's organizational chart look like?

24. In your opinion, how does the community (defined as private, public, civic, governmental entities and peoples of Tarrant County) perceive the collaboration in terms of inclusiveness?

25. What impact do you think the collaboration has made as a community organization?

The interview is completed. Would you like to make any other comments?

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