

SECTION II

Organizing for Community Benefits

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This section provides insight into the basics of organizing, including: why organizing is important, how to build a campaign or coalition, who to contact, and strategies for building and sustaining interest. In addition to exercises designed to help answer these questions, this section also contains a number of sample organizing tools to assist in organizing community benefits campaigns.

A. Building Community Leverage: Identifying and Engaging Participants

1. Making the Connection—Identifying Participants

Often the people making decisions about what healthcare institutions should do to address unmet community needs are people with a certain perspective on who the community is and what it actually needs. Consider the following: Who on the following list currently controls health resources and decisionmaking?

- institutional executives, such as a hospital or HMO chief executive officer
- legislators
- public health officials, such as the commissioner of the department of health
- community health outreach workers or advocates
- a working family with insurance
- Medicaid beneficiaries
- an uninsured person

Of course, it is members of the first category who usually determine how healthcare resources are used. Usually, though there are exceptions, these executives and administrators are disconnected from the needs of vulnerable populations. Institutional leaders do take “community” into account in their decisionmaking. But if they are unfamiliar or isolated from vulnerable populations, then their idea of “community” is not complete. Because of this reality, a truly effective community benefits process must involve the people most affected by the deficiencies of our health system. They should be involved as partners who are recognized for the important insights they bring to community needs and crafting solutions that will work. In fact, community benefit work, in large part, is about changing this dynamic and “making the connection” between the institutional leaders and the traditionally disenfranchised.

Take a second look at the list above. There are basically four categories to consider.

- the “people,” including community-based organizations and their leaders
- health and social service agency workers and leaders
- legislators and regulators
- institutional leaders

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In the context of community benefits all four groups are potential participants. Community benefits efforts can originate from any of these sectors. For example, some institutions are currently participating in the W. K. Kellogg Foundation funded Community Care Network, a proactive institutional effort to improve community benefits. Other campaigns have been community-driven efforts. The range of participants makes community benefits processes dynamic. Each group has different needs and interests, as well as varying levels of power. Complex interrelationships exist among them. One commonality is that they all have valuable resources and information to bring to the table. One important difference, however, is that the community will probably have the least infrastructure and resources to draw from and to support participation in the community benefits process.

This section addresses two important tasks: engaging people and developing leadership in order to “make the connection” between “people” (particularly the underserved) and institutional leaders, in order to build community infrastructure to support and ensure strong and long-term community participation. Again, your community may be well organized and this section may not be as critical for your group. However, if you or your group want to reach out to new segments of your community, or to those new to community organizing, you may find this section helpful.

2. Engaging People

No two communities are the same, and each community has different degrees of organization and involvement. Therefore, the methods your group chooses to engage people and develop leadership among organizations and individuals will vary. The common theme in all of these methods is that of active listening and building of relationships. Willingness to seek out people and organizations and to learn from their experiences will foster their participation. Developing understanding and trust among individual participants and coalition partners, and between leaders and constituents, will build and strengthen relationships. In general, the approaches suggested here should be undertaken using principles of popular education that aim to empower people by building on knowledge they already possess and treating their experience as an asset. In order to “make the connection,” community leaders will need to move beyond gaining “input” from community members, to involving them in identifying, designing, and implementing solutions to the problems. The following exercise represents an approach to systematically identify members of your community who most probably will have a direct stake in expanding community benefits.

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To read more about Community Organizing, refer to any of the following sources:

- “Citizen Monitoring” (Center for Community Change, October, 1996).
- Sally Covington and Larry Parachini, “Community Organizing: Democratic Revitalization Through Bottom Up Reform,” in *Foundations in the New Era* (Washington, D.C.: National Committee for Responsive Philanthropy, September, 1995), 44.
- Pablo Eisenberg, “Monitoring Government: Issues/Challenges/Approaches” (*Foundation News*, March/April 1979), 43–47.
- Gilda Haas, with Kent Wong, “Popular Education: Building a Bridge Between Social Action and Public Policy” (prepared for the Rockefeller Foundation, July 8, 1996).
- Denise Nadeau, *Counting our Victories: Popular Education and Organizing* (New Westminster, BC, Canada: Repeal the Deal Productions, 1996).
- Kim Bobo, Jackie Kendall, and Steve Max, *Organizing for Social Change* (Santa Anna, CA: Seven Locks Press).
- Lee Staples, *Roots to Power* (New York: Praeger, 1984); and several sources in *Action and Knowledge: Breaking the Monopoly with Participatory Action-Research* (New York: The Apex Press, 1991).

✓ **GROUP EXERCISE: Who in Your Community Has Unmet Healthcare Needs or Is Most Likely NOT to Have Access to Health Services?**

Identifying the Constituency

Across the country, diversity and depth have been the hallmarks of successful community benefits efforts. Therefore, a good place to begin organizing efforts is to think explicitly about the groups and constituencies that you might not already work with but who should be involved in this effort. This simple exercise is a framework for identifying those people and will result in a sort of “to do” list for expanding participation. If done in a group setting, this exercise provides a structured way to identify segments of your community who should be part of your group’s core constituency. Consider the following questions:

- Who in your community are uninsured?
- Who in your community are underinsured?
- What industries employ uninsured workers?
- What populations should the community benefits program serve?
- Should the community benefits serve particular neighborhoods, groups, or types of people such as children or the elderly?
- What populations do you care most about and want to see benefit?
- Who has unmet healthcare needs or bears a disproportionate burden of illness?

Write your answers in the spaces below, being as specific as possible.

This list gives us a sense of who is most “at risk” if community benefits are not improved or, worse, are decreased. As you continue your outreach efforts, this list is likely to grow as new people join your group and bring new information and relationships.⁴⁴

⁴⁴ Additional information about at-risk populations and health status is available from your local health department or from interviewing clinic providers or social service agencies.

B. Outreach and Organizing Techniques

Now that you have an initial “to do” list, it may be helpful to think of the various methods or approaches that other community groups have effectively used to engage people. Each of these outreach tools also offers your group an opportunity and method to gather valuable information about health access issues and barriers. Groups have adapted the following seven traditional organizing techniques to the unique nature of healthcare issues:

1. Building on Existing Community Networks
2. Connecting One-on-One
3. Completing Questionnaires and Surveys
4. Responding to Calls for Assistance
5. Convening Community Forums
6. Conducting Community Needs Assessments
7. Utilizing Community-based Research

1. Building on Existing Community Networks

There are probably a number of formal networks of people in your community. For example, churches, unions, senior groups, disability groups, children’s groups, ethnic organizations, and neighborhood organizations are just a few. There are also informal social networks such as your coworkers, friends, classmates, and neighbors. Whether informal or formal, building on these networks is an outreach technique that is efficient and particularly useful to groups in the early stages of organizing, groups working in a new area, and well-established groups doing outreach to expand participation. There are two ways to build upon this community infrastructure: banding groups together and reaching out through an existing network.

a) **BANDING NETWORKS/ORGANIZATIONS TOGETHER**

Usually it is fairly easy to identify leaders for a particular network like a neighborhood group. Meeting with these leaders can be an important step in understanding the health needs of the people the organization represents, but also to engage its leadership for the long term. Banding groups together in the name of community benefits can be effective as well as efficient.

In Columbus, Ohio, the **Universal Health Care Action Network of Ohio (UHCAN-Ohio)** recruited leaders of local organizations that work in safety-net communities. Together this group of eleven leaders from neighborhood health centers, churches, and legal services wrote letters to the CEOs of local hospitals and were successful in arranging meetings with them. As a result of these meetings, there has been increased communication between the community and the hospitals, and unmet health needs have been identified and addressed. For example, in the case of one hospital, the free-care policy has become more user friendly, and more individuals are aware of it. The hospital has also agreed to continue meeting with community representatives on a regular basis.

b) REACHING OUT THROUGH AN EXISTING NETWORK

The networks/organizations in your community will have established ways to communicate to people in the organization and its allies. Providing and gathering information and cultivating interest can be done efficiently through existing newsletters (e.g., a brief article or questionnaire), monthly or periodic meetings (e.g., a shortened community training or question-and-answer session), or via mailing lists (e.g., an introductory letter from an organization with a questionnaire). If there is a strong interest within the network, you may be able to arrange a briefing session dedicated to the issue of community benefits.

In Brockton, Massachusetts, a diverse low-income city of one hundred thousand, members of the **Brockton Interfaith Community (BIC)** initiated a community benefits campaign with two local hospitals. A multi-issue group dedicated to building power in low-income communities, BIC had previously won benefits from banks and the city. Through its social and organizing networks, it periodically conducts household meetings throughout the eighteen congregations in its coalition to identify community issues. In these household meetings, members identified lack of health insurance, lack of prescription drug benefits, and youth violence as major concerns. BIC conducted a year-long campaign, culminating in a public meeting of six hundred people, at which hospital officials committed specific resources for health programs, youth outreach, and free medications. The outline used by BIC members at its household meetings can be found on the following page.

Sample: Outline House Meeting⁴⁵

VALUE OF HOUSE MEETING

1. Identify new talent/potential leaders both within your congregation and in its extended community.
2. Identify and cultivate networks of people (groups, associations, families, youth, neighbors, etc.) within the congregation and around it.
3. Spot “issues” that people are willing to research and act on.
4. Test leaders’/potential leaders’ ability to convene a meeting, make the contacts, build relationships within the group, and spot other leaders and networks.

HINTS FOR HOSTING

Because the culture of these meetings is RELATIONAL (not geared to a TASK or JOB) there are things the host/hostess should encourage and things to avoid:

You Want

Trust, relationship
Stories, feelings
To be a listener
To understand (why?)
To probe

Not

Information
Opinions
Dominate
React or defend
Pry

SUGGESTED OUTLINE

1. Introduce yourself. It’s important to share something about yourself, what your concerns are, what your values are. And it’s very important to make clear to your group that the focus of the gathering is to discover how they see and feel about themselves and the church community. The focus is them.
2. Do the rounds. Have everyone introduce themselves with a story, or the response to a question on which you’ve chosen to focus the gathering.
3. Focused discussion. Having heard the stories, initiate a discussion of specific concerns about family, church, community—flowing out of the rounds.
4. Summary/next steps. Be sure to lift up common concerns, a potential issue to come back to, research (who?), follow-up meeting.

A NOTE ON “STEWARDSHIP OF TIME”

Best to keep these meetings to one hour. In any case, agree on a time period and stick to it! Better to leave people eager to reconvene, knowing you respect their busyness, than tired and not wanting to come back.

⁴⁵ Developed by the Organization, Leadership, and Training Center, Dorchester, Massachusetts, and the Industrial Areas Foundation.

2. Connecting One-on-One

a) RELATIONSHIP-BUILDING DISCUSSIONS

Some groups organize systematic one-on-one discussions between community members in order to build relationships, expand participation, and gain a deeper understanding of community opinions.

Sample: One-to-One Outline⁴⁶

WHAT'S A 1 TO 1?

A 1 to 1 is a 30-minute face-to-face conversation with someone in their home. It's 30 minutes because you are just starting a relationship and don't want to overstay your welcome. (And if you run into someone who's very talkative, it gives you an excuse to leave!)

HOW DO I GET SOMEONE TO SIT DOWN WITH ME FOR 30 MINUTES?

Call them on the phone.

“Hi, could I please speak with Jane Doe?”

“Hi, Jane, this is _____ from (name of your congregation). (Rev./Fr./Rabbi _____) suggested I call you. Do you have a couple of minutes right now?” (If not, find out when you can call her back.)

“A team of us in (name of your congregation) is working to find out what people at (name of your congregation) are most concerned about and interested in. I'd like to find a time that's convenient for you when we could get together for a half an hour to talk. Is that possible?”

The purpose of the phone call is to set up the 1 to 1. (Do not do the 1 to 1 over the phone).

The three basic parts of a 1 to 1 are:

1. Breaking the ice and establishing your “credentials.”

- Begin by breaking the ice: “Hi, how are you? Hasn't the weather been awful? Is that a picture of your children?” And by re-establishing your credentials: “I think I mentioned on the phone that (Rev./Fr./Rabbi _____) suggested I meet with you. I'm part of the team of people in the congregation meeting with members to find out what their interests and concerns are.”

46. Based on an exercise developed by the Organization, Leadership, and Training Center, Dorchester, Massachusetts and the Industrial Areas Foundation.

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2. Finding out people's self-interest: how they see the community, what they're concerned about and why.

- To find out their self-interest, ask them “what and why” questions. Begin with questions like: “You’ve been in this neighborhood a long time—how have you seen it change?” “Tell me a little about your involvement at (the congregation).” “What are your concerns as a parent trying to raise your children in this city?” These are all basically “what” questions. The answers people give will tell you what issues they care about, what pressures they are facing.
- If you then ask them “why” questions (“Why are you concerned about that? Why is that important to you? How does that issue affect you and your family?”) the answers will tell you about their values and self-interest. They will also tell you what networks they are part of.

3. Closing by thanking them for their time and offering them an invitation.

- In closing, always thank people for their time. Then make clear what the next step is. In this case you might say something like: “We’ll be doing this kind of 1 to 1 outreach for the next several weeks. After that we plan to have a big public meeting to address some of the main concerns that people have (such as . . . something they mentioned earlier in the 1 to 1). If we do that, would you be interested in coming?” It’s important to offer people a choice, something they can say “yes” to if they choose. Whether they say “yes” or “no,” thank them again, and you’re on your way. (**Note:** your goal is not to get them to come to your next meeting. Your goal is to get to know them and find out their self-interest.)

Back in your car, or as soon as you get home, jot some quick notes about the meeting and what you learned about that person, the issues they care about, their self-interest, their networks, and their values. Bring notes to your next team meeting.

b) DOOR-TO-DOOR OUTREACH

Through door-to-door outreach or canvassing in targeted neighborhoods, organizers can connect with individuals who are not yet involved with their coalition or its organizations. While gathering information about access issues and problems, organizers can do public education as well and begin the process of developing a relationship with potential new members of their effort.

The **Idaho Community Action Network** and **Maine People’s Alliance** have both used door-to-door canvassing successfully. A sample script to use in such an effort can be found below.

Sample Script for Canvassing: Idaho Community Action Network Membership Recruitment Doorknocking

Why doorknock?

1. To find good issues
2. To find angry and concerned people
3. To sign up new members
4. To let folks know about the basic philosophy of the organization

The Rap

The rap has five parts that logically follow each other:

Get in the door: Introduce yourself and tell the person at the door whom you are with. People are generally suspicious of people coming to their door, so let the person know you are here to talk about neighborhood issues. It is important that you get in the door. That is the first indicator that you have both interested them and they have some trust of you.

“Hi, how are you today? My name is _____. I’m with _____. People in the neighborhood are getting together to discuss issues like _____, _____, and _____. Are you concerned about the neighborhood? Do you have a minute to sit down and talk?”

Find the Issue: First get to know whom you are talking to. Ask questions like “How long have you been in the neighborhood?” and “Has the neighborhood changed a lot since you first moved here?” etc. Second, find out what their biggest neighborhood concern is. People get involved initially because of self-interest, so you need to find out why they invited you in and what the issue is in which they are most interested. Third, explore the issue. For example, if they mention crime, find out what kind of crime—break-ins, street crime, assaults, rapes, drug deals on the corner, crack houses, etc. Essentially, what you are doing here is “cutting” the issue more specifically. This will help make it visible and winnable with a clear target.

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Polarize: Anger is a key motivator. In order to feel really angry about an issue, people must feel justified in their concerns:

- “So where are the cops at when these corner deals are going down?”
- “It seems like there are plenty downtown where all the tourists are.”
- “If this were Magnolia (a rich neighborhood) do you think the cops would allow this kind of blatant drug activity?”
- “Why do you think they allow it here?”
- “We pay our taxes, right? Don’t you think we deserve the same services as other neighborhoods?”

Build the Vision: In this part of the rap, you want them to understand some of the basic principles of the organization, such as strength in numbers, direct action, use of the media, and so on.

- “So what do you think it’s going to take to get more patrols in our neighborhood?”

c) KEY-INFORMANT INTERVIEWS

Conducting one-on-one interviews with community leaders who might be interested in a community benefits effort can be both a planning tool and an opportunity to foster interest among potential members or allies. Such “key informants” may be leaders of particular constituencies who have not necessarily focused on health issues but who work with people (such as organized tenants or public housing residents) who may have health access problems. They may be local health or social service providers who have insights into the way the local health system operates as well as into the experiences of their clients.

The **Oregon Health Action Campaign (OHAC)** completed a two-county survey by interviewing approximately fifteen people ranging from local church outreach workers to a hospital chief financial officer. Interviews lasted for 45 minutes to an hour. Interview scripts used by OHAC are on the following pages.

Sample: Oregon Health Action Campaign's Key Informant Questions

QUESTIONS FOR COMMUNITY LEADERS/COMMUNITY-BASED ORGANIZATIONS

(Material following each question is intended to serve as prompts for the interviewer.)

1. Tell me about your organization's mission, current work, and constituency.
2. What health issues do you see among your community?
 - Health may be defined broadly—violence prevention, AIDS education, etc.
 - What are different issues for different segments of the population?
 - Are there transportation, language translation, cultural, etc., issues?
3. Where do people go for care? For primary care? Pediatricians? Dentists? Emergency care? Mental health? For prescriptions? For specialists?
 - Does coverage, like Medicaid or uninsured, influence where people go?
4. What is the experience of uninsured people in terms of access and paying for care at local hospital/clinic/other (get specific answers for each site)?
 - Do low-income uninsured people receive free care in a respectful and open manner?
 - Do people know free care is available?
 - Are low-income uninsured people who obtain care subject to billing and collection actions? From hospital? For physician services received at hospital?
5. What is the experience of Spanish-speaking people in terms of language translation and cultural competency of the health delivery system?
 - Is translation available at the hospital? At clinics?
 - Are translators adequately trained? Are translators professionally trained?
 - Is translation available for scheduling and phone questions? At appointments? After hours? How much notice is necessary? Are written materials available in Spanish?
 - How do people find out what they have to do to get translation? Does facility/site ask?
6. Could you share any data or reports that describe your constituency and the issues we have been discussing? (We don't want to reinvent the wheel.)
7. Are there constituency members or other community groups who you think we should talk to about this effort?
8. Have we covered everything you think is important?

QUESTIONS FOR INSTITUTIONAL HEALTH PROVIDERS

1. Tell me about your institution and its services—your mission, size, services, who you serve.
2. What are the major health issues you see in the community? How has your institution responded to these? What community benefits programs do you have?
3. What challenges do you face in meeting community health needs?
4. Where do uninsured/Medicaid/Medicare people go for care in community? For primary care? Pediatricians? Dentists? Emergency care? Mental Health? For prescriptions? For specialists?
 - Does coverage, like Medicaid, influence where people go?
 - If given a choice, would people continue going where they do?
 - What is the quality of care like? Do people seek the same physician in clinic? Are hours and location accessible?
 - What is the waiting time for clinic? For free-care referrals? Triage system?
5. Do you have a charity care policy and/or sliding fee scale for low-income people?
6. How do you manage the need for language translation services?
 - Staff translators? ATT service?
 - How do people find out what to do to get translation?
7. Could you share any data or reports that describe your organization and the issues we have been discussing?
8. Are there other people in your institution or in the community you think we should talk to about this effort?
9. Have we covered everything that you think is important?

3. Completing Questionnaires and Surveys

Questionnaires are another tool to perform outreach and systematic information gathering. Community groups have used brief surveys to ask community members about major health problems in their area (e.g. asthma, drug use, family violence, etc.) and barriers to care (e.g., lack of insurance, no interpreters, no transportation). More complex survey projects usually require support from the hospital, a state or local health department, or other institution. Whether the questionnaire is conducted by community organizations or by an institution as part of a formal needs assessment, it should contribute to the process of engaging people in the community benefits effort.

Brief written questionnaires about access to care can be distributed through fuel assistance programs, Head Start, churches, and locations in specific communities. It can be publicized in local newspapers, in church bulletins, and at community meetings. The survey cover sheet and the people distributing it should communicate that the questionnaire is part of a project to both identify needs and address them. Finally, the results should be reported back to the community, which is an ideal opportunity to organize further discussion about needs and solutions through public meetings, the media, or other forums.

Maine Consumers for Affordable Health Care (MCAHC) distributed two thousand two-page questionnaires about health access issues. Distribution was conducted through Head Start programs, Community Action programs, Area Agencies on Aging, churches, and other low-income organizations. The distribution effort was not labor intensive—the forms were made available through each organization’s existing outreach efforts. After three months, over seven hundred questionnaires were returned (this represented twenty-one hundred individuals since one form often covered an entire family).

Through the returned questions, MCAHC learned about the broad extent of prescription-drug access problems and found that the parents of children enrolled in children’s health access programs were uninsured. At least fifteen families who filled out questionnaires have become active health advocates in a parent health advocacy network. MCAHC continues to use the questionnaire respondent list to inform people about new community health or access programs and to notify them of opportunities to support improved health access. A copy of the questionnaire can be found on the following page.

Sample Survey: Consumers for Affordable Health Care Foundation

DO YOU OR A FAMILY MEMBER NEED HEALTH CARE OR HEALTH INSURANCE?

We are a nonprofit consumer organization working to make health care affordable and available for you and your community. To do so, we need current information from consumers. This survey is **entirely confidential**. No personal information will be released without your express permission.

ABOUT YOU AND YOUR FAMILY

In the following chart, please write the age of each household member. Then, put a check under each category that is true for that person.

Person	Age	Has Medicaid	Has Private Insurance	Has No Insurance	Has a Doctor	Sees Doctor Regularly	Has a Dentist	Sees Dentist Regularly
1	_____	_____	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____	_____	_____

If anyone in your household is covered by Medicaid and has problems finding a dentist or doctor to treat them, list their ages: _____

If anyone in your household has health problems, please list their ages and conditions:

Age: _____ Conditions: _____

Age: _____ Conditions: _____

Age: _____ Conditions: _____

In the space below, please tell us about problems you or a family member had getting or paying for health care or health insurance. (Please continue on reverse side if needed.)

Have you had problems paying for or obtaining prescription drugs? ____yes ____no
If so, please describe:

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OTHER COMMENTS?

What is the approximate yearly income of this household? _____

In order to help keep us informed, it would be helpful to have your name and address. Providing your phone number would help if we need to contact you about your responses. Thank you!

Name: _____ Phone: _____

Street/Box: _____ County: _____

Town: _____ Zip: _____

This survey is entirely confidential. No personal information will be shared with others without your express permission.

Thank you for your time! We hope that with this information we can improve healthcare access for all Maine families.

Please return this survey to: **Consumers for Affordable Health Care Foundation, P.O. Box 2490, Augusta, ME 04338-2490.**

What is Consumers for Affordable Health Care Foundation?

CAHC Foundation is an independent nonprofit organization whose mission is to empower and inform consumers that their voice will be heard in shaping healthcare policy and programs. For more information contact us at (207) 622-7083.

SAMPLE

4. Responding to Calls for Assistance

Healthcare or other advocacy or community organizations often receive calls from people who are experiencing problems with the healthcare system. These calls can come from people who don't have insurance and want information about where they can get health care, or from those who have received bills they can't pay, or from people who may have received inadequate care because their local hospitals did not have an interpreter. These calls seeking help and information are an opportunity to do one-to-one outreach and to learn about individual problems and experiences. Keeping track of these calls and the problems you hear will allow you to see trends and issues that may indicate systemic problems that could be addressed through community benefits. Keeping track of callers and their issues will also allow you to contact them about changes that may benefit them such as changes in eligibility for a particular program.

By their nature, advocacy organizations try to help people with their immediate problems. But in order to engage callers, the organization should:

- Develop protocols for asking questions. The basic questionnaire on the preceding pages will be the type of survey you will want to use. Do what you can to make sure you have sufficient time to talk through the survey with the caller.
- Document and analyze the information you gather from your pool of callers. Look for trends.
- Involve callers in dealing with their problems. This will serve to educate callers about the shortcomings of the health system and decrease their isolation by supporting them in self-advocacy.
- Formally invite callers to get involved with efforts to make changes that will affect them or resolve their problems.
- Involve callers in institutional or policy follow-up, whether or not there are solutions to their immediate problems. Can an institution, for example, a hospital, be approached to change a harmful policy? Can a regulator be urged to craft a regulatory solution? Is legislation necessary or possible? Should the media be made aware of the problem? Are there other people in the community that might be facing the same problem that should be contacted?
- Keep callers informed of changes that may affect them.

Of course, running a system like the one described above can be complicated and may require tremendous resources. Some groups have established hotlines or helplines, and can modify existing practices in line with the suggestions above.⁴⁷ Others may not have the resources to engage in record keeping and systematic analysis. Instead they may want to focus on one-to-one outreach techniques, engaging the caller and supporting his/her participation.

47. For more information on establishing helplines, contact Health Care For All at (617) 350-7279.

5. Convening Community Forums

Community forums and “speak-outs” also help organizations identify potential participants in a campaign while learning of additional unmet needs. Working with local community groups and agencies, such as senior groups, tenants’ groups, day care centers, and neighborhood associations, local people can be recruited to attend and speak about their healthcare experiences and needs. This approach can be used by community groups or conducted collaboratively with an institution.

The **Lynn Health Task Force**, an established group with membership of nearly one hundred grassroots activists, community groups, and social service agencies, initiated a community benefits effort in Lynn, Massachusetts, a racially diverse working-class city of ninety thousand with many unmet health needs. As required under the community benefits guidelines issued by the Massachusetts Attorney General, the local hospital had filed a community benefits report. The Task Force found the report inadequate and responded by filing a rebuttal and initiating its own campaign. After gathering information, the Task Force then organized a community meeting, or “speak-out,” on community health needs, attended by seventy people. The Task Force’s work plan for this speak-out can be found on the following page.

Sample Community Meeting Work Plan: The Lynn Health Task Force Community “Speak-Out”

1. Group decides on target participants: The Lynn Health Task Force targets participation from community members, agencies, city officials, and hospital officials. It uses its own membership list and knowledge of its planning group to identify individual activists and representatives of legal services, senior groups, unions, a community kitchen, the community health center, and the Visiting Nurses Association (VNA).

2. Publicity: a) Mailing and phone calls made to members, churches, agencies, city officials, hospital leaders; b) flyers posted in public places; c) articles in the local newspapers.

3. Location, time, logistics: Meeting held on a weekday evening in a downtown location near public transportation. Childcare offered. Transportation provided through a senior service organization. Refreshments provided.

4. Organization of the meeting: An experienced facilitator from the VNA who leads an open “brainstorming” discussion about health needs of the community. The results were recorded on butcher-block paper, put on walls around the room. Activity: Participants were asked to “vote” on their top three priorities by going up and putting stickers on the butcher-block paper. Needs were prioritized by the number of “votes.”

5. Issues identified: More primary care providers, free care, transportation, information on programs, mental health, HIV, teen pregnancy, substance abuse, hospital interpreter services, and domestic violence counselors.

6. Follow-up: All meeting participants invited to become part of the Task Force. Newspaper articles published about the meeting and the needs identified. The Task Force put together a report using this information and the results of the telephone poll, and then asked for a meeting with the hospital. Members divided up responsibility for further investigation of each major issue.

7. Results: Membership/leadership expansion: New members joined the Task Force, resulting in renewal and expansion of its role as a leader in the eyes of community members and both hospital and city officials. Community education: Heightened community understanding of unmet health needs. New resources and enhanced community role: When the hospital went up for sale shortly after the speak-out, the Task Force played a role in choosing the new owner and negotiating resources for community-identified health issues, as well as institutionalizing community participation in hospital governance.

6. Conducting Community Needs Assessments

Community needs assessments involve gathering existing data and information from community and public health sources, conducting surveys, and doing focus groups and interviews. Less formal assessments can be done using many of the individual outreach techniques described in this section, including household meetings, interviews, community forums, and questionnaires targeted to underserved people. The needs assessment may be conducted by a community coalition or in collaboration with a health institution. If a needs assessment is being used to expand participation, the people being surveyed must also be invited into the process and given opportunities to develop their leadership.

7. Utilizing Community-Based Research

As described previously, the process of gaining community participation is in part an information-gathering process, largely focused on community need. However, there is often additional information that must be gathered to craft an effective campaign. This information usually concerns the local health delivery system and any regulatory oversight that might apply to a particular situation or issue. (See Section III for more on important research tasks.) In many instances having community members directly participate in gathering information about the health system can be an important part of the leadership development process.

Members of the **Brockton Interfaith Community (BIC)** conducted “research actions” as part of their campaign. Grassroots leaders met with the CEOs of two hospitals, with the health center director, and with the commissioner of the state agency that regulated free care. They also sought information and organized meetings on public programs and financing mechanisms with advocates, academics, and public officials. As BIC leaders became local experts on their healthcare system and its power relations, they were further developing their leadership skills, involving more people, expanding their allies, and preparing themselves for negotiations with hospital officials.

As illustrated here, community groups may also draw on expertise from community-based healthcare organizations and from academics who track the many changes taking place in the healthcare system. These sources are helpful to understanding both the big picture of what’s happening as well as specific issues. Community-based providers may know the history of a given health institution and how it operates, especially when it comes to underserved populations. In addition, local health centers and social service agencies are likely to have conducted needs assessments of low-income neighborhoods as part of their ongoing planning efforts.

Putting It Together

Although your group will never really be finished doing outreach, putting the information you have gathered into some accessible form to be shared with your group and its new members is a critical step. A formal report, or at a minimum a less formal tabulation of the information your group has gathered, will be necessary. It will be important for new members to see that the time and energy they took to answer a questionnaire or participate in a community speak-out actually will be used to further the work. Your group should do the best it can to analyze and prioritize the health needs and issues that can be identified in the “raw data.” In the Lynn Speak-Out (page 52) there is a description of a simple group exercise to use to “group prioritize.” Once prioritized, this information can be the basis for the next steps. For example, it will help your group shape its agenda, issue a report on health needs, or form the basis of a letter to a hospital or institution to begin a community benefits dialogue. Even though your health assessment won’t be formal or scientific, the broader and more diverse your group, the more weight the assessment will carry.

C. Creating an Outreach Work Plan

As you can see, you will likely need to use several methods in your outreach efforts. Your choice of approach will depend on your organization and the relationships you already have. Your group has identified constituencies it wants to reach out to and thought about the various methods of outreach. At this point a work plan might be helpful.

✓ GROUP EXERCISE: Outreach Work Plan

In the spaces below, write down the names of the constituencies you listed on page 37 and fill in the chart for each. Doing this planning in a group setting will ensure that you make use of all the relationships and knowledge that individuals in your group may have. It will also increase the number of people to volunteer to do the work!

Constituency	Contact	Initiation	Method of Contact	Date by Which Contact Should Occur
Homeless	Campaign to End Homelessness—Jim Smith	Julie knows Jim and will call and invite to next meeting	Telephone call	Two weeks prior to meeting
Children with disabilities	[Name(s)]	Rob	Questionnaires distributed at Head Start (call to see if Family Voices has chapter here)	[Date]

EXERCISE II-2

D. Membership Development

1. From Action Comes Ownership

Once your group has sparked the interest of new people and organizations, it needs to involve them in many different types of activities and at many levels of your group's work. The goal of involving people is "leadership development" or more specifically:

- to build relationships and confidence and decrease isolation
- to share responsibility and power
- to demystify public health data, the local health system, and health policy jargon
- to familiarize new leaders with the potential participants (institutions, regulators, media, legislators, etc.) so they can see/experience power dynamics, relationships, personalities, and styles
- to have people working together comfortably and engaging in effective group problem solving
- to build commitment and ownership
- to strengthen the work with the experience and knowledge of each participant

Some opportunities to involve new members include:

- leadership and decisionmaking roles within your coalition
- representing the coalition in negotiations and meetings with institutions
- representing the coalition in dealings with the press
- representing the coalition in regulatory proceedings
- conducting and organizing new trainings and forums and continuous outreach efforts

2. Providing Support

If your group builds a proper support system, new members engaging in these activities will gain confidence and knowledge. Proper supports could include pairing new members with well-established members to do research and engaging in activities to build experience. Additionally, by providing practice sessions, such as mock negotiations, you will enable new members to become skilled at tasks such as public speaking and negotiation.

3. Building on What You Hear

The recruitment and involvement of new members make up a dynamic and long-term process. Engaging in continued outreach will ensure a growing base of support and create a solid foundation, built layer by layer, for your group. The keys to success are:

- active listening;
- keeping your outreach going by periodically revisiting some of the planning techniques and exercises found in this manual, such as “Who in Your Community Has Unmet Health Care Needs?” (page 37), “Putting It Together” (page 54), or the Outreach Work Plan (page 55), as new members join your group and bring new information and relationships;
- paying attention to integrating new members, keeping them active, and sharing information and power.

Following up on information gained from new members or from ongoing monitoring will help to sustain your group. Building on what you hear will keep your group grounded and ensure that its goals are current. Developing a reputation for your group as an active listener will increase your group’s credibility with the community at large. Great diversity and depth within your group will ensure your credibility with regulators, industry leaders, and the press, who will view your group as truly representative of the community and a pipeline of information.

E. Building Strong Community Organizations

Unless your group is long established, it will be necessary to create some structures for decisionmaking and communication. Because community benefits are ultimately about resource allocation, clear processes for choosing priorities, setting goals, and choosing tactics are essential. Clarifying the ground rules early will help your group avoid later conflict or competition for community benefit resources among constituencies that may have different needs and priorities. Establishing and utilizing these internal processes will ensure that all participants will feel respected and will support the group’s efforts.

The following are important questions for groups involved in a *community-driven effort* to improve community benefits.

1. What are the mission and principles of the group or the campaign?

“To identify populations in the state with barriers to accessing appropriate health care, to advocate for adequate and appropriate services and to empower these populations to be active participants in their own health care.”

—New Hampshire Minority Health Coalition

2. Who is the membership? Are individuals and organizations able to be members? Are hospital staff able to join? Are organizations or government agencies doing business with the health institution allowed to be members? If yes, what level of interconnection is acceptable and how will conflicts of interest be avoided?

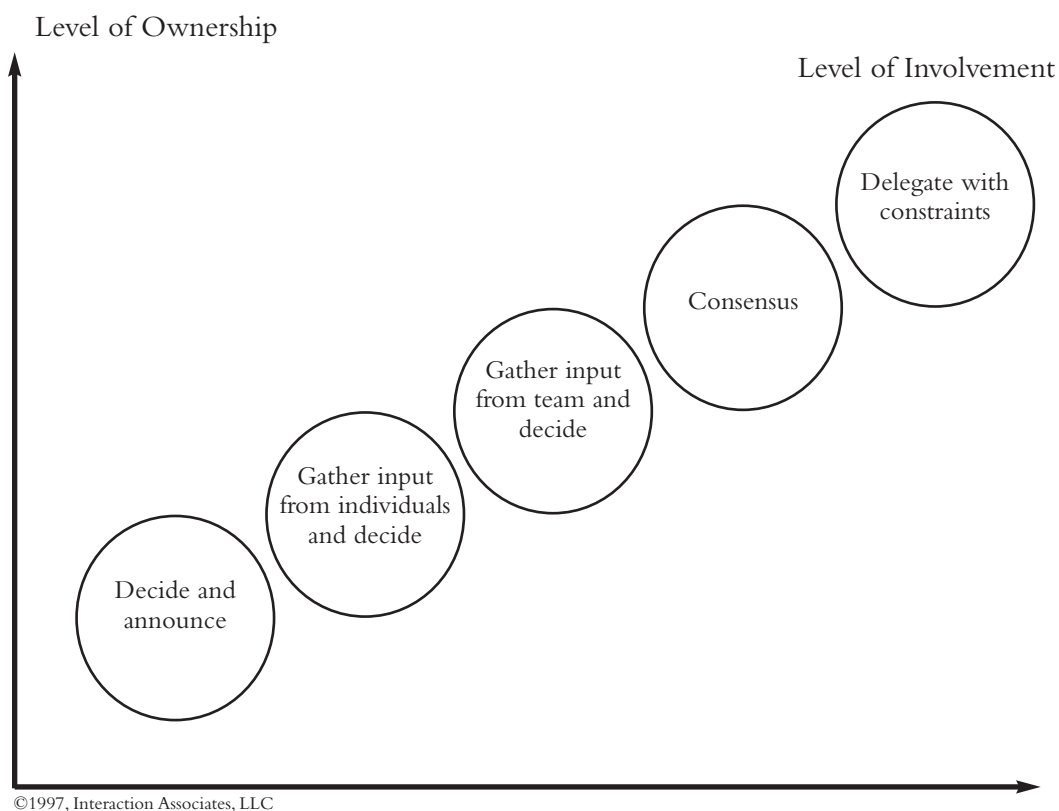
SECTION II Organizing for Community Benefits

3. Will it be a priority to develop leadership and group ownership especially among those most affected by the issues? How will new members be recruited and integrated into the group? What are the group's policies about integration? What is its position about giving people authority within the group?

In Hartford, Connecticut, healthcare advocates endeavored to reach out to parents and develop leaders within communities while working to improve health services for area children. The **Building Parent Power (BPP)** organization was formed. Community outreach took the form of eight monthly workshop sessions that would train parents to participate in healthcare decisionmaking. Participants came from a range of racial and cultural backgrounds and learned valuable advocacy skills while becoming more unified as a group. During the training, when an issue emerged involving the possible loss of Blue Cross/Blue Shield's assets from a proposed merger, parents felt confident enough about their knowledge and skills to testify at public hearings, sponsor community forums, engage in local outreach, and write articles for local media.

4. How will decisions be made? How will leadership be chosen? Will some or all decisions be delegated to designated individuals or to group decisionmaking?

Levels of Involvement in the Decisionmaking Process



SECTION II Organizing for Community Benefits

5. How will the group communicate with its own members and with the outside world, including other community groups who may not be members, but are interested in the campaign?

- group e-mails?
- broadcast faxes?
- newsletters?
- phone trees?

6. What resources are necessary to carry out the action plan? Where will these be obtained?

- in-kind contributions?
- donations from membership?
- grant support?

Community representatives participating in an institutional effort to improve community benefits will also have to address the same questions. This is particularly important if the representative does not come from a broad-based and diverse coalition. The community leader in this situation must be proactive and structure ways to ensure that he or she is being accurate and true to the interests of the underserved segments of the community. Some of the outreach tools described in this manual can help a representative accomplish this goal. Community representatives in institutional processes have another specific duty. That duty requires them to advocate for a commitment by the institution to reach beyond its familiar circle of collaborators and involve new and diverse people, particularly disenfranchised populations, in its efforts.⁴⁸

⁴⁸ A more in-depth analysis on organizational development can be found in “Handles for Organizing a Healthy Community,” published by The Access Project.