

## SECTION III

## Crafting a Strategic Approach

### IN THIS SECTION

A. Seeing and Creating Opportunities . . . . .	62
B. Recognizing Dual and Shifting Roles. . . . .	68
C. Getting Clear on the Goals. . . . .	69
D. Considering the Circumstances . . . . .	72
E. Communities and Institutions: First-Meeting Challenges . . . . .	77
F. The Very Bare Necessities of Negotiation . . . . .	78

Along with the strategies you will need to build and sustain a coalition (internal strategies) there are also a number of important external strategies to employ when dealing with institutions, the press, legislators, regulators, and even allies. This section discusses some key elements of strategic thinking and approach.

## A. Seeing and Creating Opportunities

Opportunities to bring community benefits issues to the public eye can come in many different forms. Examples are listed below; see the Resource Materials Section of this manual for a chart that provides more information for community benefits campaigns on each of the examples used in this section.

### An External Event: Health Institution Restructuring

Today's ever changing healthcare marketplace is the scene of countless restructurings. Healthcare institutions are engaging in mergers, consolidations, joint ventures, and conversions from nonprofit to for-profit status. These changes often require some type of regulatory oversight that gives community leaders a public forum to raise important issues and exercise influence. In addition, community members may be motivated to mobilize and organize coalitions to represent their interests and negotiate with the institutions involved in the restructuring. In many cases, these coalitions have won valuable community benefits from the healthcare institution involved in the transaction.

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Community members mobilized when St. Vincent Healthcare System, a nonprofit hospital in Massachusetts, went up for sale. They formed the **Central Massachusetts Community Health Coalition (CMHC)** and voiced their concerns through letters to local newspapers and regulators. As a result of their vocal positions and the depth and numbers in their coalition, CMHC was able to play a successful role in the sale negotiation process. When OrNda Healthcorp (who was later purchased by Tenet Healthcare (Tenet)) emerged as the likely buyer, CMHC participated in the negotiations process. As a result of the work of the coalition, Tenet was required to create a task force that identifies and works to resolve community health needs. The task force will focus on community benefits and other essentials such as interpreter services and accessibility for the disabled. CMHC members play a significant role on the task force.

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The **Pajaro Valley Coalition to Save Community Health Care** formed as a result of the proposed sale of Watsonville Community Hospital to Community Health Systems (CHS). Watsonville is the only hospital located within its service area in California. The closest hospital is located 14 miles away in Santa Cruz. Watsonville serves a community of 100,000 that is predominantly farm labor. Thirty-six percent of the population lives at or below the federal poverty line. Watsonville is over a hundred years old and had always been a nonprofit hospital. In the fall of 1997, CHS, a for-profit hospital chain based in Tennessee, offered \$71.6 million to purchase Watsonville. By the end of January, 1998, when Watsonville and CHS signed a Letter of Intent, CHS had reduced its purchase price to \$58.6 million.

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The Coalition represented more than 16 organizations, whose members included seniors, healthcare workers, farm workers, children’s advocates, and policymakers. The Coalition formulated a set of Principles, including that the medically indigent receive free and/or low-cost medical care at the hospital, no matter who owns it. The Coalition believed all of these Principles should govern any proposed deal, and they were the standard by which they would measure any final agreement. In June, 1998, Watsonville and CSH sought the Attorney General’s required approval of the sale. In August, the Attorney General held the first public hearing on the sale. Key criticisms at the hearing focused on the over \$11 million drop in the sales price, CHS’s vague indigent care and emergency room commitments, and Watsonville’s proposed use of the sales proceeds.

The Attorney General approved the transaction in September, 1998. As a result of the Coalition’s efforts, CHS agreed to “target” the current annual charity-care expenditure, although it did not agree to a specified amount. CHS also agreed to annually increase that expenditure by a percentage equal to the regional Consumer Price Index, if necessary. CHS also agreed to extend an indigent care contract with the County of Santa Cruz, although CHS’s performance under this agreement was not a condition of the Attorney General’s approval.

## A Community-Created Event:

### a) Community Examines Hospital Books, Issues Report

Often there will not be an external event, but community leaders can still successfully raise public attention around financial issues. For example, communities can commission researchers to analyze the finances of area hospitals. Reports that detail both that local hospitals have significant surpluses and that significant health needs exist in a given community can galvanize a public reaction and uncover community health crises.

Communities in Maine, Massachusetts, and Oregon have taken the initiative in studying the benefits hospitals derive from tax-exempt status in comparison to benefits the same hospitals have provided to their communities in return. With the assistance of hospital finance experts, members of these communities have studied publicly available documents and records such as audited financial statements, property assessments, and IRS filings over a period of years. From these documents, they were able to analyze the hospital’s operating, financing, and investing activities. They were also able to value the hospitals’ charity-care provision and tax exemptions. Study findings have been the beginning point for community benefits negotiations with these same institutions. The analyses often reveal spending priorities that do not coincide with documented community health need (e.g., high levels of capital spending in well-served communities and relatively low provision of free care or capital spending in underserved areas). Some reports document the estimated value of the institution’s tax exemption in relationship to costs of free care. These reports have garnered public and media attention stimulating stronger community efforts to establish a dialogue that can influence the design of community benefits.

After publishing a report which analyzed the finances of the acute care hospitals in Portland, Bangor, and Lewiston, Maine, the **Maine People's Alliance** organized separate meetings with executives from the four hospitals in Portland and Lewiston. In Portland, 10–12 community members met with the hospital executives, and in Lewiston, 15–20 community members attended the meetings. Maine People's Alliance identifies two successes arising from these meetings. First, Mercy Hospital in Portland agreed to open a free dental clinic and credited the community meetings with inspiring the idea. Second, when the state's largest psychiatric hospital went bankrupt and up for sale, community members organized a successful campaign to have a nonprofit, as opposed to for-profit, corporation purchase the hospital and to have community members sit on the new Board of Directors. They attribute this victory, in part, to the relationships built and developed in their initial meetings with the hospital executives and to their greater understanding of how hospitals function in the community.

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### b) Linking Neighborhoods and Constituencies for Power

Statewide organizations can accomplish several goals by engaging in efforts to link neighborhoods and constituencies to promote systemwide or institutional policy changes. Not only will they build larger and broader membership, they will also foster stronger consumer involvement in health issues and link local groups together. The local groups also benefit by becoming involved in efforts to influence health resource allocation and policy at the local and the state level.

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The **Illinois Campaign for Better Health Care** conducted a series of participatory training sessions about health issues, community needs and solutions. Participants included representatives from neighborhood-based organizations, many of whom were not directly involved in healthcare issues, but were directly engaged with community residents on a day-to-day basis. The sessions gave organizations the opportunity to learn about local health needs. It also helped to develop relationships among participants. The group then initiated discussions with a local religious hospital to improve and expand specific community benefits.

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## An Issue Focus: Challenging Institutional Behavior

Community efforts can originate from pressing community needs that require a response. Questionable institutional practices or even health status statistics regarding preventable health problems such as rising infant mortality, asthma, or violent teen deaths can be used to illustrate health system deficiencies. Raising issues of community benefit this way is particularly poignant if this information is categorized by neighborhood or ethnic group, or a disproportionate percentage of poor health status falls in one area or on one group, potentially revealing discriminatory practices.

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The **Idaho Community Action Network (ICAN)**, a grassroots membership organization, created a free-care campaign for St. Luke's Hospital in Boise based on the hospital's collection policies. ICAN first engaged in a door-to-door outreach effort to identify new members interested in health access. At a training session to discuss community benefits, many insured members who had used one of the local hospitals were satisfied with the quality of care they received and, given their satisfaction, were not clear about the relevance of community benefits. A new member at the training then spoke movingly about her experience with illness and the added stress of having a lien placed on her house because she could not pay her bill. Motivated by her story, the group decided to pursue the issue of free care and hospital collection practices.

ICAN continued its door-to-door outreach efforts and was able to find individuals with debt collection problems. The group used records from the county assessor's office to identify more individuals against whom the hospital had placed liens. These people were then contacted and personal visits set up. Many joined the effort to negotiate stronger hospital free-care policies and debt relief for those now subject to liens. ICAN also looked into St. Luke's federal 990 tax form, which provided financial information and details on free care. Additional research also showed that the collection agency used by the hospital is actually a subsidiary of the hospital.

ICAN continues to press forward with demands for improved free-care policies, a set percentage of hospital revenues dedicated to free care, debt forgiveness for low-income residents, expanded primary care access, and community involvement in a needs assessment that will help shape more community benefits.

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## An Institution-Initiated Effort: Ensuring the Community's Leadership

Healthcare institutions themselves may initiate collaboration with the community to design and set priorities for community benefits. The impetus for this might arise from external factors, such as state regulations or voluntary industry guidelines, or internal factors, such as hospital leadership renewing its commitment to community service.

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In 1996, in response to concerns raised by Service Employees International Union 1199 and **Washington Citizen Action** about the increasingly competitive and price-sensitive health system, the Seattle-King County Department of Public Health began to investigate whether there was a decrease in the level of community benefits provided by area hospitals, health plans, and other providers of health services. The Department of Public Health convened over 30 representatives from area hospitals, health plans, community-based providers, consumer advocacy organizations, labor, and business. After a year of discussion and analysis about community health needs, the group recommended specific actions that collaborating community partners could take to address specific health issues in the community. Relying on hard data and the insights of steering committee members, the report, issued in 1997, called for a community benefits focus on healthcare problems for particular vulnerable populations. The specific priorities for a coordinated community benefits program in 1998–1999 include childhood asthma, diabetes among African Americans, and breast and cervical cancer screenings among Vietnamese women.

The Steering Committee developed action plans that rely on a commitment to collaboration and coordinated financial support, as well as use of data to evaluate effectiveness. In one example of the approach used, a successful Asthma Outreach Program at a children’s clinic is to have its capacity expanded through additional medical provider staff, outreach workers and medical assistant clerical support. This element of the community benefits program will be evaluated based on the provision of services to additional patients. Start-up funding will also be provided for replication of this successful model in a region of the county that is experiencing a high rate of avoidable asthma hospitalizations. Assistance will also be provided to develop data systems to enhance evaluation of this program and to improve retention. In future years, the collaborating organizations in the King County Health Action Plan expect to increase participation and broaden efforts.

The experience of the community groups that participated in development of the Action Plan was a mixed one that has left participants cautiously optimistic. The process facilitated participation from community-based providers and advocates, rather than from community residents. The proposed programs are culturally appropriate, community-based and address genuine community need. However, the consensus-driven decisionmaking process left issues about the broader community benefits obligations of health institutions unaddressed. Sustained community attention will be required to ensure that the Action Plan efforts continue and develop the capacity to deepen community participation and broaden community benefits beyond specific programs to a stronger community voice in overall resource allocation.

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In the neighboring towns of Cambridge and Somerville in Massachusetts, teenage pregnancy, domestic violence, substance abuse, and HIV are common problems. Since the early 1990s, the **Cambridge Health Alliance**, a public authority that represents Cambridge City Hospital, the Cambridge Department of Public Health, and Somerville Hospital, has worked energetically with its community to address many of these problems. When the Health Alliance decided to open a new neighborhood health center at 119 Winsdor Street, it actively sought the input of neighborhood residents and held nearly 30 community meetings to identify community health needs and concerns. As a result of these meetings, the Health Alliance and the neighborhood developed a community advisory committee that represents varied interests of the community. The community advisory committee continues to work with the health center manager and medical director to identify priority healthcare needs.

Among the programs offered at the new Windsor Street Community and Health Center are a seven-chair dental clinic; a Latino Mental Health program staffed by bilingual and bicultural psychiatrists, psychologists, social workers, and community workers; a WIC program; and a play area for young children. Co-located at the Windsor Street Community and Health Center are six community-based programs, which include Cambridge Head Start Day Care, the Community Arts Center, Inc., Community Learning Center, Computer Center, Recreational Activities Program (RAP), and Work Force Unemployment Prevention Program. The Health Alliance also made a commitment to increase the number of neighborhood residents on staff at all levels of the health center and agreed to develop training programs to increase employment opportunities.

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### A New Law or Regulation: Community Benefits Laws

Currently, 14 states have laws, regulations, or guidelines specifically governing community benefits. In other states, a community benefits requirement might be a component of another law such as conversion or certificate-of-need laws. Many of these laws contain public process provisions which include input from community members and public hearings. As a result, community members have used these laws as tools to organize coalitions and successfully negotiate with local healthcare institutions.

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The 1996 Massachusetts community benefits guidelines were sparked by a community campaign led by Boston's Commissioner of Health and Hospitals, Judith Kurland, and the **Boston Health Access Project (BHAP)** of Health Care For All. Kurland commissioned a study documenting the rich cash reserves of Boston's numerous teaching hospitals, which contrasted sharply with the unmet needs of Boston's residents. BHAP recruited a diverse group of grassroots activists and leaders who publicly challenged the hospital's right to tax-exempt status, given their record. BHAP sought support from the Attorney General, who subsequently issued the guidelines, mandating all Massachusetts hospitals to allocate resources to community benefits and to engage the community in determining needs and designing responses.

The Boston Health Access Project then hired a Latina organizer to mobilize residents of one neighborhood in Boston to implement the guidelines with three Boston hospitals that served that area. The Jamaica Plain Community Benefits Group was formed, composed of grassroots community members, many of whom were Latino residents who had had little voice in the City's political establishment. The group organized a speak-out, prioritized a set of issues to bring to the hospitals, formulated programs to address the issues, and negotiated with the hospitals. Along with another active community group, Tree of Life, the community won community benefits resources for a neighbor-to-neighbor outreach and community building initiative and for a program in the schools to address the high rate of chronic asthma among children.

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### B. Recognizing Dual and Shifting Roles

Advocates and community leaders often find themselves in a particular type of role in any given effort or campaign to create change. It is often an outsider's role, the vocal critic knocking at the door of the "back room" where all the decisions are made. Your community benefits campaign may begin in this manner. But at various points in your work there may come a time when the role of your group will change. There is a tremendous difference between remaining a vocal critic on the outside and being part of a process while seated at the decisionmaking table. In the context of community benefits, a highly critical outsider's approach may not be the only option. At various stages of your work and your group's evolving relationship with the institution, a different tone and tact may be necessary, depending on your goals and the situation. For many groups and coalitions engaged in community benefit work, intermittent shifting from outsider to collaborator/decisionmaker has been necessary. In fact, you may find different segments of your group are playing different roles at the same time. In these instances, groups have had to fluctuate from engaging in more reactive analysis and critique to being in a position to set and achieve an agenda.

Increased responsibility and accountability come with “sitting at the table.” The community leader in this new position is representing and exercising power on behalf of the community. That leader has a responsibility to proactively reach out to as much of the community as possible, to remain connected, and to actively listen. The community leader engaged in an institutional community benefits process must set the example of broad and diverse community engagement, setting the standard for the institution to follow.

### C. Getting Clear on the Goals

In playing these dual roles, and in order to plan strategies, a critical first step in any campaign is to set clear goals in at least five areas. Your goals may change over time, but it is important to discern them at this early stage.

#### 1. Policy Goals

Setting some specific “external” or policy goals is necessary before choosing the style and tone of your communication with people and institutions outside your coalition. In order to set policy goals you will need to have a grounded understanding of health needs and barriers in your community. You will also need to have a sense of the types of institutions operating in your community and which of these your group believes should be responsible for community benefits.

The exercises and sections in this workbook that will help you clarify your policy goals are: “What Does It Take to Be Healthy?” (page 4), “Evaluating Community Benefits Activity” (page 5), and “The Argument for Institutional Responsibility” (page 13). Additionally, the information you have gathered and processed in your outreach efforts will be invaluable. If your policy goals are legislative, look at the Key Elements section (page 23) to identify issues you will want to consider.

#### 2. Organization and Coalition Building Goals

Not only will you want to consider policy goals such as increasing access to health care, you may want to consider “internal” goals for building your organization or coalition. For example, is it a priority to engage in outreach to new constituencies, increase participation and leadership by less active coalition members, or expand your work to a new geographic area?

In order to define goals for building an organization and to understand the importance of organizing and the integration of people into your group, see Section II.

#### 3. Short-Term and Long-Term Goals

It is important to differentiate between short-term goals (e.g., funding for the local clinic that is about to close) and long-term goals (e.g., building a strong and continuing working relationship with an institution or group of institutions). As your group chooses tactics, it will need to think about how these choices affect your organization’s credibility, reputation, and short-term and long-term goals.

## 4. Policy Arenas

Your group will also need to choose the policy arenas you seek to affect, at least on an interim basis. In the context of community benefits, there are three policymaking arenas or levels to consider: **institutional, communitywide, and statewide**. Is it the free-care policy of the local hospital your group wants to change? Or is that the first step in a larger statewide strategy to pass a law? Part of this decisionmaking will require an examination of the mission (and structure) of your group, and of the separate organizations that may be part of your group. Is your group neighborhood-focused and less likely to take on a statewide agenda? Or is it constituency-focused and more willing? Is your group willing to seek out resources to engage in a broader campaign? Of course, if you begin with a narrower focus, you may later decide to expand.

Whatever type of goal you are focused on, it is important to engage in a group process to clearly lay out coalitional or campaign goals. With broad and diverse participation and information, your group is more likely to craft an effective strategy that takes into account all the subtle elements that exist in your community. In addition, exploring the goals you want to achieve as a group is necessary in order to ensure that the tactics and tone the group ultimately use are supported by its members. For example, if your group was working with a willing institution, a more cooperative tone might be in order. Members of your group may believe that this type of approach is a “sell-out” or soft. Clear group-determined goals, particularly long-term goals, may help to persuade them that tactic will ultimately yield the best results. A documented group process will also serve as a reminder that goals and tactics were democratically chosen.

✓ **GROUP EXERCISE: What Will Your Goals Be?**<sup>49</sup>

Groups will need to revisit a strategic planning process periodically, since coalitional or group goals will change or be modified over time as new developments occur and relationships change.

The following simple worksheet will help your group ensure that it has identified its goals in each of the eight areas:

Goals	Short-Term	Long-Term
<b>Policy</b> (External)		
<b>Community-Building</b> (Internal)		
<b>Arena</b> (Community institution or statewide?)		
<b>Approach</b> (External event? Community-created event? Other?)		
<b>Strengths</b> (including allies)		
<b>Weaknesses</b> (including opponents)		
<b>Opportunities</b>		
<b>Threats</b>		

49. Based on an exercise in "A Community Health Agenda for Somerville: Update 1997: Part II."

## D. Considering the Circumstances

Circumstances play an important role in determining goals and strategy.

**Consider the following three scenarios.** What might be the long-term and short-term goals for the coalition in each scenario? How might tone differ in each case? How might tactics such as media strategy, letter writing, demonstrations, and organizing differ?

**Scenario 1:** A small urban hospital is well known for its commitment to and strong relationship with an established, diverse, and broad-based multi-issue community coalition. The hospital initiates a new community benefits effort. It invites the community coalition to be part of a community benefits committee.

**Scenario 2:** Four neighborhood groups band together for the first time and write to the CEO of the local nonprofit hospital. They ask for a meeting to discuss community health needs and their concerns about the lack of communication between the hospital and the community and the paucity of information available about the hospital's free-care and community benefits policies. The hospital agrees to meet with them.

**Scenario 3:** A local nonprofit hospital is being sold to a large for-profit hospital chain with a notoriously bad record on free care and community benefits. The local hospital has a lukewarm reputation on free care and community benefits. Neither buyer nor seller will agree to meet with an ad hoc coalition made up of two small advocacy organizations. However, the attorney general, with authority to approve or disapprove the deal, pushes the seller to meet with the coalition and hammer out some agreement.

Short- and long-term goals probably will differ for the community coalitions in each scenario for various reasons. For example, each coalition is at a different stage of development, ranging from well established to fledgling. The fledgling coalition may have to devote more significant resources to organizing and outreach, with more modest (yet very important!) policy objectives. Moreover, new or ad hoc coalitions likely will not have the same perceived power as well-established groups, perhaps causing them to temper their policy goals.

The manner in which community benefits issues come to the fore also affects strategy and goals. For example, the level of cooperation and openness will be greater from the institutional initiator in scenario 2 than in scenario 3, where there may be outright hostility. Also timing and timelines will differ. The coalition in scenario 1 probably can take a slower and more deliberate approach than the ad hoc group facing regulatory deadlines in scenario 3. Despite these differences, some guidelines for strategy emerge from these examples:

## 1. Know the History

**Understand whether there is a history of good or bad communication between the institution and the community.** How does the institution itself describe its relationship with the community? Would institutional executives be shocked or pleased by the way that they are viewed by the community? If your perception of the level and quality of communication is very different from that of the institution, answering these questions will give you some clues about how forthright to be and how best to present the issue of concern to your group.

**Understand history and relations from other perspectives.** How is the institution viewed by “essential community providers” (e.g., safety-net providers such as health clinics)? By constituency groups representing the uninsured? By the media? By other competing institutions? By unions and healthcare workers? What is the general public perception of this institution? Answering these questions will help you identify perceptual barriers you may need to overcome in order to be effective. For example, people often view nonprofit children’s hospitals as charitable because they serve children. But assume the local children’s hospital does not have good free-care policies, or does not provide sufficient interpreter services. Understanding the perception barriers will help you craft an effective public message.

**Understand the history of the mission of the hospital or institution.** If it is a nonprofit, does it engage in fundraising? Do their annual reports and fundraising efforts espouse “charity” as a core element of the institution’s mission? Has its mission changed at any time in the past? Who are its major donors? If it is a for-profit or large chain, how does the institution behave in other communities? Getting this type of information may allow you to use the institution’s own words and claims as tools.<sup>50</sup> For example, if a large hospital chain has provided certain benefits and resources to another community where it owns an institution, it is easy to argue to a regulator and the media that your community deserves the same. Additionally, comparing lofty mission statements to actual practices can also be effective.

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**Roger Williams Hospital in Rhode Island** originally was incorporated in 1904 “for the purpose of establishing and maintaining a hospital and of rendering medical and surgical aid to those in need thereof, and especially for the purpose of assisting such poor and unfortunate persons as are in need of medical and surgical treatment and are unable to apply therefore . . .”

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50. Information about the healthcare institution’s mission can be found in its articles of incorporation which can be requested from the secretary of state’s office or department of corporations. The mission statement may also be available on the institution’s Web site.

**Understand the structure and finances of the institution.** Gaining a sense of the financial condition of the institution and how its money flows may reveal new issues and opportunities. Does the hospital make all of its resources available to the community to address unmet needs, or are these resources hidden and untapped? What is its corporate structure? For example, does this structure include a foundation with a strong charitable mission, which, however, is used for fundraising? Are there substantial assets in one or more subsidiary corporations? If the institution is nonprofit, are some or all of its subsidiaries for-profit? Is it engaged in a partnership with an HMO or other hospital with a better community benefits record? Such information will allow you to see additional leverage points and issues that will interest the media, regulators, and legislators. For example, a nonprofit institution that claims it is doing all that it can for community benefit, may have tremendous assets that are untapped for such uses. A local nonprofit institution may be allied with a for-profit that is draining charitable resources from the community.

**Understand the institution's current community benefits activity.** Was the community involved in shaping this activity? Will the institution provide your group information about its activities? Look at the key elements on page 23: Do the institution's community benefits activities include any of the elements outlined in that section that your group deems critical? Are they addressing unmet needs of the underserved? Look back at the true community benefits examples on page 5. Do the institution's activities meet the criteria your group identified in those exercises? Answering these questions will help you begin to craft an overall approach to the institution and a media strategy as well. If your state has a community benefits law, check to see whether an annual report is required. Also check with the attorney general's office; most have a charitable trust department that will be helpful to you. You should also consult the institution's 990 Forms.<sup>51</sup>

## 2. Gain an Institutional Perspective

In scenario 2, no relationship exists between the institution and community; although the institution is willing to meet with the community, a delicate and balanced approach is necessary. A balanced approach should include being a critical outside voice as well as engaging in efforts to build trust and relationship, and efforts to gain an understanding of the institution's perspective.

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51. Financial and corporate structure information can be found in the institution's Form 990 filings with the Internal Revenue Service. Under new IRS regulations, tax-exempt organizations must provide requesters with copies of their exemption applications and their three most recent 990s. Organizations may make these documents available on their Web sites. Organizations that do not comply with these new requirements are subject to penalties of \$20 per day of violation to a maximum of \$10,000. See 64 Fed. Reg. 17,279 (1999). Many of the financial documents are very complicated to read and it is advisable to consult with financial experts such as university professors.

Understanding history will help you gain perspective, but there are other important questions to answer: Is the local healthcare industry changing around the institution? Is the institution facing fierce competition or is it the fierce competition that is confronting other institutions? As for community benefits, how does this institution rank against other local entities? What reasons might the institution have for working with your group? Does your group see common interests that the institution may not? Answering these questions will help you to make an informed guess as to how committed the institution might be to any given community benefits process. The answers also will help reveal potential allies and other targets. For example, if the institution you're focusing on is a "Goliath" in your community, smaller and/or public institutions feeling squeezed by its presence may be very happy to work with your group to ensure that "Goliath's" resources address unmet community needs.

Also determine who are the institution's leaders, including the board of directors. Consider meeting with them one-on-one. What kind of background and life experiences do these leaders have? Keep in mind the relative inexperience of some institutional executives in dealing with constituency and community leaders (as opposed to business and civic leaders). What do you think they might expect upon meeting you or members of your coalition? What stereotypes might be at play on both sides? How might your definition of "community" and "community leaders" be different than theirs? How do you want the coalition to be perceived? Additionally, who within the leadership do you or members of your group have a relationship with? Where (or who) are the potential points for influence?

### 3. Find Your Allies

Allies, such as the attorney general in scenario 3, can also be important to create leverage for or give greater weight to the community. Situations like scenario 3 are probably not the norm. It is more likely that you will have to seek out allies.

Allies may or may not be part of your coalition, depending on how much your interests align. In the area of community benefits and depending on the types of institutions your group focuses on, you may find unusual allies. For instance, a financially strapped public hospital may be a strong ally in scenarios 2 and 3. In other instances, hospitals in general may be strong allies if your group chooses to focus on HMOs. There is, of course, a long list of traditional allies such as labor unions, neighborhood providers, nurses, constituency groups, and ethnic neighborhood groups. The key is to think broadly.

✓ **GROUP EXERCISE: Allies List**

Potential Ally	Contact Person	Common Interest? (allies)	Conflicting Interest? (opponents)	Inside/ Outside Coalition	Person to Initiate Contact and Deadline

**EXERCISE III-2**

## E. Communities and Institutions: First-Meeting Challenges

Your group has organized, trained, and researched. You have identified or created an opportunity to raise the community benefits issue. The institution(s) agrees to meet with you. Now what? First-meeting challenges won't be part of every campaign. Look back at the three scenarios on page 72; the coalition in scenario 1 will not have to pay as much attention to the flow, content, and credibility issues involved in a first meeting. However, if your situation and circumstances more closely resemble scenario 2 or 3, you will need to put some energy and thought toward that first meeting, even if you have dealt with the institution before.

By answering many of the questions concerning history and perspective, you have the information you need to begin planning for the meeting. Think about the following items as you plan.

1. **Draft an agenda:** You want to eliminate surprise to the extent possible. You also want representatives of the institution (as well as the representatives from your group) to be prepared. Prior to the meeting, the agenda should be shared and discussed with whoever is coordinating the meeting on behalf of the institution. It should include goals for the meeting, a list of attendees, and time frames for discussion. Perhaps most importantly, it should include time to discuss next steps.
2. **Consider the attendees:** Who will represent your group? And from the representatives, who will be the point person? Looking at the agenda, what would be the appropriate roles for each attendee? And who will be present from the institution? How many people overall? We recommend you seek an institutional representative with decisionmaking authority or substantial influence to meet with.
3. **Keep a record:** Make sure that agreements, next steps, assigned tasks, and other important information are written down. The minutes to the meeting can be shared with the institution to ensure that the process continues to build upon the work that has been done and the agreements that have been reached.
4. **Prepare adequately:** Is there any documentation or paper that you want to present or that you want from the institution before the meeting. Is your group clear on the goals? Is your group clear on things NOT to say?

Your coalition/group should be clear on what it *hopes* to accomplish and what *can* be accomplished in this first meeting. Coalition goals for a first meeting might include:

- establish credibility
- show strength by revealing depth and diversity of coalition
- show expertise by revealing knowledge that you and your members bring to the table
- show cooperation
- ease fear, break down stereotypes that may exist

## SECTION III Crafting a Strategic Approach

It is unlikely that you will begin hammering out a community benefit plan in this first meeting (although not impossible!). While topics for discussion will vary, consider the following potential first meeting topics:

- introductions of organizations and individuals
- highlight common ground and shared interests and concerns
- discussion of unmet health needs of underserved
- discussion of the particular health needs your group has identified and how you did it
- sharing of specific information, e.g., what the institution's free-care policy is
- defining a process for working together
- defining goals for working together
- setting general timelines and deadlines
- agreeing on evaluation
- other?

### F. The Very Bare Necessities of Negotiation

Not every situation will require negotiation, but there may come an intimidating time when your coalition will engage in negotiation with an institution or group of institutions. This may evolve over time into a more collaborative decisionmaking process, but the following are some techniques we should think about. Despite the formality of the word “negotiation,” each one of us negotiates every day. For example, we negotiate with our family and with our coworkers, and supervisors. In reality, negotiation can be described simply as a situation where both sides have positions but are willing to compromise to reach agreement. In fact, it may be helpful to have an explicit discussion in your group about the ways in which people have gained negotiation experience in their own lives. We don't intend to summarize the many written works on the art of negotiation. Instead, we hope to provide you with the minimum: basic concepts and a worksheet to use to ensure that your coalition or group representatives have the necessary information to engage in effective negotiations.

Those who represent and negotiate on behalf of the campaign must be given decisionmaking power. One could imagine the logistical nightmare of trying to get group approval for even the slightest change in negotiated terms. The group should give the representatives a range of decisionmaking authority, with clear parameters and a bottom line.

## Understanding Both Sides

Understanding the institutional perspective becomes especially important in a negotiation phase. In particular, it is important to understand how issues you raise may be received by the institution. For example, consider the following list of issues or demands a community coalition might be concerned about in the sale of a local hospital to a for-profit buyer:

1. Admit, treat, and seek Medicaid enrollment for all uninsured patients.
2. Keep the emergency room open indefinitely.
3. Have clear notice, visible to the public, stating the institution's policy for treatment of the uninsured.
4. Produce and distribute pamphlets on policies for uninsured patients.
5. Continue or increase current level of financial support for outpatient clinics.
6. Provide shuttle services that will pick up all low-income or underserved patients requesting rides to and from the hospital and between the hospital campuses and satellite facilities.
7. Provide translation services for every language represented in the institution's population.
8. Create a program to provide prescription drugs to the members of the community who are uninsured or whose insurance does not cover prescription drugs and cannot afford to pay for them.
9. Furnish statistical information regarding admission and treatment for the uninsured as well as other basic primary care services.
10. Establish a Community Advisory Board with community members who live in communities served by the institution.
11. Preserve as many jobs as possible to maintain services and quality patient care.
12. Use endowment or foundation money to be used for community services or other community benefits in line with donor intent.
13. Continue operation of HIV/AIDS programs for as long as five years.
14. Continue maternity-care services, including midwife services, and continue to provide transportation vouchers to disadvantaged pregnant mothers.

How realistic is this list? What are the odds that the for-profit buyer will agree to the outlined terms—for example, the demand to keep the emergency room open indefinitely? It may intend to do so, but it may not want to commit and tie its hands. Is there another way to present the issue that may be more viable from the institution's perspective and yet achieve important community goals? Often you will be able to reach only partial agreement on a term. If this is the case, one solution might be to create an opportunity for reconsideration at some later date. In other words, if you can't reach agreement in the short term, try to make sure that there will be a community process at the point that the issue again becomes relevant.

## For Example:

**Original demand:** Keep the emergency room open indefinitely.

**Modified demand:** Keep the emergency room open for a term of five years. At the end of the five-year term, and at any point thereafter that the institution proposes to discontinue ER service to the community, the institution shall provide at least one public hearing 90 days prior to any decision. The institution shall also accept written comment from the public for the 90-day period. Prior to the public hearing, the institution shall issue a report detailing how the critical services provided by the ER will continue to be available to the community.

**Original demand:** Provide shuttle service that will pick up all low-income or underserved patients requesting rides to and from the hospital and between the hospital campuses and satellite facilities.

**Modified demand:** Provide shuttle service between the hospital and its satellite facilities. Work with other local agencies that provide transportation on an areawide basis to do a transportation-needs assessment and plan. The plan should coordinate and expand existing services for low-income or underserved patients and set minimum standards for minimum response times. Provide funding to hire a consultant to design the plan.

In the preceding examples, it may be that the negotiation can only carry the coalition a certain distance toward its goals. If a compromise term is acceptable to the institution, this may be the point where your group needs to turn away from the institution and focus on broader change to achieve the underlying goal. In the emergency room example, perhaps a legislative remedy would be appropriate. Such a remedy might include legislative changes requiring licensed acute-care hospitals to provide emergency services. What seems like a setback in your community benefits work might become the basis of a legislative campaign.

✓ **GROUP EXERCISE: Gimme, Gimme**<sup>52</sup>

The following exercise can be used as an icebreaker to start off a training session on negotiations for your group. It makes the point that we negotiate things every day: What movie do you want to go to? This yard sale item is too high—can you sell it for less? Will you do your homework after school or after dinner?

**Step 1:** Choose one person who has something that is really nice: a leather jacket, a delicious cookie, a nice pen.

**Step 2:** Select someone else to try to get the item from that person. Give him/her about five minutes to try to get it. (Maybe do this twice with another pair of people; vary the power dynamics by having a white male try to get something from a Latina woman, or a Latina woman try to get it from a Latino male.)

**Step 3:** After they've tried—and they may or may not succeed—talk about the “tactics” the person used to try to get the item. (Did he/she beg? Reason? Threaten? Name drop? Enlist help?) Write these down on a big sheet of paper.

**Step 4:** Also talk about ways the person in step 1 tried to avoid giving the item to the other person. Did he/she just stonewall? Sidestep? Pass the buck?

All of the brainstormed items on your lists are just what can happen in negotiations.

<sup>52</sup>. Based on an exercise developed by Health Care For All, Massachusetts.