Journal of Community Practice, 21:9–27, 2013

ISSN: 1070-5422 print/1543-3706 online
DOI: 10.1080/10705422.2013.788328

Routledge
Taylor & Francis Group

ARTICLES

Community Organizing for Health Care: An Analysis of the Process

KARABI C. BEZBORUAH
School of Urban and Public Affairs, University of Texas at Arlington, Arlington, Texas

This article examines the community organizing process for better health services for disenfranchised populations that cannot afford medical care in an affluent community. In response, concerned citizens and voluntary organizations have attempted to organize to transform policies and to implement new healthcare services. The author adopts a researcher participant role and examines the organizing process by studying six nonprofit agencies, one public health office, and shadowing the community organizer. The paper concludes that community organizing can be an especially challenging process when strategies are misaligned, stakeholders are dissentaneous, the public is apathetic to needs of low-income people, and solutions are diverse.

KEYWORDS Community organizing, nonprofit health services, grounded theory

An increased focus on health practices and health care provisions stems from the development of strategies to foster healthy work environments, efforts to facilitate citizen participation in health programs (Minkler, 1990; Wallerstein, 1992), and health care promotion models focusing on communitywide collaborations. In the United States, local governments, in collaboration with private health care agencies, provide public health services. Although the

I thank the three anonymous reviewers whose suggestions and recommendations strengthened and improved my article.

Address correspondence to Karabi C. Bezboruah, The University of Texas at Arlington, School of Urban and Public Affairs, 552 University Hall, Box 19588, Arlington, TX 76019. E-mail: bezborua@uta.edu

American healthcare sector involves a complex funding system of health care provisions dominated by Medicare, Medicaid, and private insurance systems, a marginalized population remains uninsured or underinsured. This indigent population that cannot afford health insurance often resorts to the emergency rooms (ERs) of hospitals or the community-based nonprofit clinics for their primary and preventive care. Scholars recognize the importance of nonprofits in service delivery and advocacy (Chin, 2009; Marwell, 2004) and tout the significance of community organizing for promoting health and health care (Curtis, Waters, & Brindis, 2011; Ellen, Mijanovich, & Dillman, 2001; Miller, 1976; Rothman & Tropman, 1987).

This study examines the community organizing model applied by a large and diverse community for the promotion of accessible and affordable health care to indigent populations. The units of analysis in this study are the nonprofit agencies that provide health care, advocate for favorable health care policies for the indigent, and are involved in the organizing process. The aim of this article is to examine the community organizing approach in this particular case and discuss its strengths and challenges. The objective is to explore whether a coalition of nonprofit agencies can foster improved health care services by organizing community participation. Conclusions and implications from the analysis are then highlighted.

First, the article reviews the existing literature on the role of nonprofit organizations in community development, in influencing public policy, and, in the provision of health care. The literature review consists of articles from a broad array of journals and books, ranging from those specializing in medicine and health, to scholarly work in the fields of sociology, social psychology, community development, and urban policy. The article discusses community development models and outlines their strengths and characteristics. Then, the article describes the research method adopted for generating the qualitative data from the cases for this study. This data helps in constructing the conceptual model of community development and policy advocacy. The article then compares the extant community-organizing model with other prominent models. The article concludes with a discussion of the strengths and limitations of the model, and highlights the implications for researchers and practitioners.

LITERATURE REVIEW

The terms *community organizing* and *community development* are often interchangeable, and are used as such in this article. Bracht (1999) defined community organizing as "a planned process to activate a community to use its own social structures and any available resources to accomplish community goals that are decided on primarily by community representatives and generally consistent with local values" (p. 86). Local groups, especially

voluntary organizations, to bring about intended social and health changes, organize strategically planned interventions by mobilizing community members and by promoting community health. The following sections discuss these roles of voluntary nonprofit organizations.

Community Organizing and Nonprofit Organizations

Community organizing is a comprehensive process for managing change within a community by involving citizens in dialogues on shared vision and salient issues of strategy design and implementation. Based on several definitions, Morton and Glasgow (2011) summarized a framework consisting of four characterizations for understanding the concept of community development. These characterizations explain community development as (a) a process for implementing change, (b) a program of specified activities, (c) an outcome, and (d) an ideology of action. Hence, community development is a means to bring forth positive change. By implementing positive changes, such as needs-specific programs and through their grassroots involvement, nonprofits act as catalysts in community development. The focus on privatization of public services resulted in further use of nonprofit agencies as deliverers of public services. Nonprofits' reach, flexibility, and efficiency in services make them ideal policy implementers (Saidel, 1989). Morton and Glasgow also echoed this when they stated that the community-development process can be achieved through the incorporation of communal techniques for addressing health issues and by investing in infrastructure such as support groups and medical services. Nonprofits practice communal intervention techniques by providing services through support groups that assist in information dissemination, solutions identification pertaining to health issues, and advocacy to educate the public and inform policymakers on pertinent health concerns.

Nonprofit Organizations and Policy Advocacy

Nonprofit organizations include an array of organizations from those that provide direct services to those that are special interest groups. These organizations together play an important role in influencing public policies through their advocacy activities. According to Clemens (2006), nonprofits are "vehicles for the expression of articulated interests and values" p. (216). With devolution and privatization of services, the role of nonprofits as service providers has increased along with their influence in the social policymaking process. Federal cutbacks of various welfare programs (Weil, 1996), and the rise of the new federalism movement that delegates states and communities more authority over the provision of welfare programs through community development block grants also increased the importance of nonprofits. Brudney (1987) stated, "Nonprofits actually deliver a larger share of the

health and human services financed by government than do public agencies themselves" (p. 6). Additionally, public distrust of large governments, a call for decentralization, and greater reliance on local resources (Poole, 1997) has resulted in an increase in the use of community-based nonprofits. Empirical studies on nonprofit advocacy demonstrate that they engage in a wide range of public policy influencing activities on behalf of their clients, including testifying before legislative bodies, lobbying for or against proposed legislation, and networking with policy makers regarding their organizations' and populations' need (Berry & Arons, 2003; Ezell, 1991; Pawlak & Flynn, 1990). Nonprofits also represent minority groups, and encourage their participation by acting as intermediaries (LeRoux, 2007). Nonprofits in the social services, particularly those in the health and human services subsector, are most likely to participate and encourage political participation because they serve the low-income, poor, and underrepresented communities.

Access to Health Care and Nonprofit Organizations

Communities differ in their provision of public health care facilities. Access to primary health care by the indigent American population is a salient issue because the government entitlement programs do not adequately provide coverage for basic health services for the indigent and working poor. Although local governments provide some public health programs, a major portion of primary health care services for low-income people and indigent are provided through private clinics. Through grants and contracts, local governments enlist the support of private health care agencies to deliver primary and preventive health care. Because nonprofit organizations are mission oriented and more often an integral part of the community, as opposed to the bottom-line oriented for-profit clinics, they are a preferred choice as public service deliverers.

Nonprofit organizations are also more trustworthy in service delivery, and they treat indigent and vulnerable patients with more dignity (Schlesinger, Quon, Wynia, Cummins, & Gray, 2005) and encourage philanthropy in the funding and provision of services. They are also more likely to stay in the communities that need them and provide nondiscriminatory treatment to their patients (Schlesinger & Gray, 2009). These organizations make health care accessible and affordable to low-income people and have a profound impact on improving the health of communities. Although underexplored, studies have primarily focused on the impact of communities on health outcomes (Ellen et al., 2001; Ellen & Turner, 1997). Some communities have more health care facilities and health-promoting opportunities, including parks, walking and biking trails, nonsmoking environment, as well as more health care practitioners, compared to others. Most studies (Geronimus, 1992; McKnight, 1995; Minkler, 1997; Wallace & Wallace, 1990) focused on the relationship between low-income and disadvantaged neighborhoods

where the lack of physical, social, and economic resources and institutions has an adverse impact on the health of residents. However, the effects of accessible health care on a community's development are unexplored and need more thorough study.

The previous review suggests that nonprofits are important in developing community, in influencing policy-making, and for solving community problems. Based on the aforementioned roles, the extant study examines the community organizing/development model applied by a coalition of nonprofits to address health care issues. The next section discusses the characteristics of the various models of community organizing/development for promoting health.

Models of Community Development

Early policy-implementation literature often discussed two basic models of community development—the top-down approach and the bottom-up approach. Those in authoritative and statutory positions usually initiate the top-down approach to accomplish an objective that will benefit the health of the entire community. This model supports clear goals with limited number of actors where the implementation of programs is the responsibility of an agency (Pressman & Wildavsky, 1973; Sabatier, 1986; Van Meter & Van Horn, 1975). On the other hand, the bottom-up approach is characterized by the involvement of citizens and voluntary organizations, and community participation is encouraged to accomplish a common goal, i.e., community health. Bottom-up theorists (Berman, 1978; Hjern, 1982; Hjern & Porter, 1981) believe that perspectives of the target population and service providers are critical to the success of implementation. These theorists, therefore, espouse models that endorse program planning at the macro level and execution at the local level with adequate implementation flexibility. Fawcett, Paine, Francisco, and Vliet's (1993) analysis of community participation for promoting health issues conclude that for community initiatives to be successful, active involvement of key stakeholders is necessary. Community participation is very important for all initiatives toward community health goals—identification of health problems, planning of intervention, implementation of program, and recognizing challenges to program success. Participation of community in the various stages ensures sustained program success.

In the latter part of the eighties, in addition to the top-down and bottom-up approaches, scholars espoused a mixed or hybrid form of community interventions. Rothman and Tropman (1987) classified three approaches to community organizing for addressing community issues separately or in mixed modalities. These are social planning, social action, and locality development. Social planning is more a top-down approach characterized by the involvement of experts in setting goals and designing action plans. The

social action model involves forging of alliances with community organizers and activists to extend community control to marginalized populations. The locality development is a bottom-up model that empowers communities to identify local problems, setting goals, with indigenous leadership to resolve issues. Rothman and Tropman's (1987) models (often referred to as the *Rothman Models*) have retained their significance and relevance even though considerable developments were made in later years. The new approaches embraced the changing context of society to include community development based on assets (Kretzmann & McKnight, 1993), gender (Bradshaw, Soifer, & Gutierrez, 1994; Weil, 1996) and culture (Bradshaw et. al., 1994; Delgado, 2000; Laing, 2009). In sum, the community-organizing models espouse transformation through top-down, bottom-up, or mixed approaches. Scholars have tried to bridge the top-down and bottom-up approaches by focusing on ambiguity and conflict of policies in the implementation process (Matland, 1995), and on the involvement of participants in the decision-making process (Hanks, 2006). These approaches propose a variety of ways from statutory initiatives to voluntary enterprises for bringing about community transformation. The next sections describe the methods applied to gather and analyze data.

METHODOLOGY

To examine the community development process, the grounded theory (Strauss & Corbin, 1990) framework is applied. Being an exploratory study, the grounded approach is most suitable during the data collection and analysis phases. As Glaser and Strauss (1967) stated, with grounded approach, researchers can be "open to what the research site has to tell" (p. 118) and not set specific hypothesis and be bound by them. This approach assisted in the data collection process involving semistructured interviews with executives of several nonprofit organizations and community organizers, and by participating in events and meetings convened for the purposes of organizing community. Data collected from the interviews are analyzed in a systematic manner that assisted in theory building (Strauss & Corbin, 1990). The study then examines the process adopted in the community studied by comparing it with other community-organizing models. As recommended by grounded theorists (Glaser & Strauss, 1967), data gathered from the interviews, observations, and secondary published sources have been systematically categorized per their relevance to community organizing. The theoretical contextual phenomena that emerged from the analysis are explained based on the categories and the findings from the literature review.

This article applies the case study methodology to understand the community-organizing process for the promotion of health care in an urban county. Case study methodology is criticized for having no scientific value,

because such studies do not provide basis for statistical generalization. Yin (1993), however, stated that the aim of case studies is to expand and generalize theory. Case studies advance "analytic generalization," unlike "statistical generalization" of surveys and quantitative techniques (Yin, 1993, p. 36). The aim of this study is to highlight the lessons on community organizing for health care in a large and diverse county. The findings from specific case examples will contribute to the literature on community development and advance understanding on the process and challenges of community organizing for health promotion. In addition, case study methodology can generate hypothesis and assist in theory building (Eisenhardt, 1989). The application of the grounded theory in the qualitative case examples assists in explaining context specific phenomena to develop theory. By analyzing the cases, this article designs a contextual framework of community organizing that outlines the stakeholders and the direct and indirect influences for accomplishing the outcomes of healthcare services.

The focus of this study is the process of community organizing for health care promotion in a county in Texas. I adopted a researcher participant role (Gans, 1982) to get an in-depth view of the organizing process. Apart from studying six community-based nonprofit clinics, the author accompanied the lead community organizer and coordinator to events and meetings that assisted in the exploration of the organizing process. Using a semistructured format, discussions with nonprofit administrators covered topics ranging from the basics of health care programs, the role of the elected officials in the design of the existing health care policies, the role of nonprofit clinics, and the challenges of spreading awareness of indigent health care issues in a wealthy community. In addition, the administrators discussed at length the origins and missions of their programs, and the challenges to primary health care provision. The interviews and site visits were conducted between July 2010 and July 2011 with the five nonprofit administrators (with one administrator leading two nonprofits), which lasted over 15 hr. The interviews were recorded and transcribed verbatim by the researcher, from which patterns were observed and themes identified. Because the key informants requested anonymity, this article does not name the sources or the organizations interviewed. Complementing the interviews were content analysis of official documents, newspaper articles, and any published material on community organizing and health care programs. These materials were gathered from the participant organizations, minutes from the meetings facilitated by the lead community organizer, and local newspaper publications about the meetings and their outcomes. It is worth noting that these materials do not specify community organizing; therefore, utmost caution was maintained while gathering information from them. For example, information pertaining to the nonprofits' objective for community health, their willingness to work along with other organizations in a collaborative fashion, and the involvement of citizens in community-oriented dialogues were included for content analysis.

Skilled observations at the research sites also provided valuable inputs in case examination. Moreover, the researcher also participated in public meetings, and observed and documented the discourses and discussions between nonprofit executives, elected officials, professional organizations, academics, researchers, practitioners, media, and citizens interested in health care issues as they deliberated on the state of health care programs and services in this community.

Study Sites

This article studies the community-organizing process for health care promotion in a county in Texas with a population of about 800,000 people in more than 30 cities and towns within its boundaries. Although a relatively wealthy community with a median household income of $77, 905 (2009), the percentage of people living below the poverty level was 7.1 percent (US Census Bureau, 2009). The overall education and employment levels in this county are higher than the national average, yet there were an estimated 126,995 people living without health insurance in this county in 2009, which is expected to increase because of recent economic problems. Access to affordable health care is a significant problem, and certain cities and towns within this county are considered medically underserved areas. The community health clinics selected for this research are based on the roster of nonprofits maintained by the county health department. This roster contains the information of the nonprofits that received grants and worked collaboratively with the public health department. Out of the seven listed, five nonprofits agreed to participate in the research. During the data collection period, one of the participating nonprofits decided to relinquish government grants. In spite of this development, the data collected from this organization is used to understand if there were other ways to work in cross-sector partnership arrangements besides grants. In addition, the nonprofits that finally participated are similar in terms of their missions and objectives, and offered direct or indirect health services in distinct neighborhoods of the county.

Clinic A (serving the northern part of the county). This clinic provides basic health care to the medically uninsured and underserved people in the northern part of the county. This clinic has two full-time administrative staff and a couple of nurse practitioners with volunteer medical and nonmedical people serving as the staff of the organization. Since 2004, this clinic conducted 20,000 patient visits and has a 3-month waiting list for new patients. Area hospitals, physicians, corporations, and community members support the services through donations. The local government also provided grants but, because of the stringent requirements pertaining to eligibility, this clinic opted out of the grant program after receiving grants for 4 years. It depends predominantly of individual and institutional donations. The administrator attends the community organizing events and supports

the overall goal of health care accessibility and reducing disparities through community participation.

Clinic B and Clinic C (serving the eastern and western region of the county). Clinic B and C are led by the same administrator. Clinic B serves the medically underserved eastern region of the county marked by few medical care facilities. The clinic started in the early 2000s with support from local charitable foundations. Clinic C provides health care to the indigent in an affluent area that has an overwhelming proportion of hospitals and clinics. It is located in a facility within a hospital complex. The hospital administration, experiencing an increase in the number of medically indigent, decided to donate space for the establishment of a nonprofit clinic. Both operate twice a week in the evenings, supported by donations and grants. Although services are free of costs, clients are asked to donate money for capital and program improvements. The administrator commends the services provided by volunteer physicians and nurses but believes that a communitywide network of physicians' and nonprofits could streamline the health care access by the indigent. Both support the community organizing for health care access by actively participating at events held by the community organizers. However, the administrator's views of improving health care access to the poor and medically indigent is different from that of the community organizers.

Agency D (serving the western part of the county). This nonprofit agency provides social services to individuals and families, including prescription services. It serves the western part of the county that has been serving families since 1995. Emergency assistance includes food distribution and covering costs of rent/mortgage, utility bills, prescription, and gasoline. Through local government grants and donations from individuals and institutions, this organization has been serving the very poor and medically indigent. This organization is not directly involved in community organizing for health care, but believes that such actions will reduce health care services disparities in this county. The administrator, therefore, attends events and meetings facilitated by the community organizers and provide support to the movement.

Agency E (serving the northeastern part of the county). Agency E is a human service organization that provides assistance to poor families through their food pantry and resale shop, and by covering costs of a family's medical and other bills. The agency receives grants from the local government, as well as from federated fundraisers. The administrator believes in being entrepreneurial and raising money through fund-raising events and through commercial enterprises such as the resale shop. This organization was involved in the community organizing events and supported organizing for health care access and services. However, the focus area of this agency being different, it gradually began to decrease its involvement with the community organizers.

Agency F (the facilitator organization). This nonprofit agency comprises volunteer members who provide support services to other nonprofit clinics in the county. Services include grant writing, professional skills development, research, and focus groups on behavioral and mental health and indigent health. The membership consists of community members and citizens, professionals, academics, and nonprofit administrators who pool their skills and resources to assist other nonprofits that provide health care services. This agency organizes events that encourage community involvement and participation, and thereby, provides a venue for discussing the pertinent health care issues faced by the community. Further, this agency also serves as an advocate for favorable health care policies for the indigent and vulnerable populations. The lead community organizer is part of this organization, and believes that a federally qualified community health center would help in providing access to quality health care to the medically indigent people in this county.

The empirical studies, participant observations, and the content analysis showed variations in opinions toward health care in this community. Being a wealthy community, many are unaware of the problem of health care access by the indigent. Those that are involved with health care are cognizant of the need to improve the accessibility and affordability of such services. In this county, the local government provides health care to its residents through a three-pronged system. The county sponsors health care services for the indigent from its trust fund, managed by the County Commissioners who placed stringent requirements on the eligibility criteria of the recipients to ensure services only to residents and the very poor. The strict guidelines were also an attempt to ensure accountability and compliance from the nonprofits that received government grants. In addition, lack of a public hospital resulted in hospital ERs providing primary care, transferring the burden of uncompensated care on to the taxpayers. In spite of receiving support from the government, civic groups, corporations, and individuals, the nonprofits' services do not sufficiently match the growing demand for health care. The government grants require reports and patient information, including personal information of undocumented patients, for reimbursing the costs of treatment. As a result, some clinics have declined these grants. Other clinics have responded by separating the accounts for government reimbursement.

The lead community organizer, through a network of professionals and nonprofit administrators, has established a voluntary nonprofit committee comprising community members, activists, and health care providers with a shared interest of focusing on the critical health care issues of this county. It collaborates with and maintains a network of health care professionals, providers, researchers, organizations, elected officials, and interested citizens to improve health care access and affordability and to spread awareness of the community's health issues to the policy making bodies so that they are able to make informed decisions. The committee also provides assistance to nonprofits within its network with grant-writing services, and by encouraging

dialogue to finding solutions to health care issues. Fawcett, Francisco, Paine-Andrews, and Schultz (2000) stated that a major challenge of a community health partnership is the development of a shared vision that must be broad and inspiring to be able to encompass multiple organizations and yet realistic to motivate accomplishment of objectives. In this case, the organization's mission is ensuring adequate health care for all residents of the county, and therefore, encompasses the multiple nonprofits engaged in providing different types of health care services, i.e., geriatric care, adult and child care, as well as specialty services. Further, this organization originated as a support group that acted as a bridge connecting the nonprofit clinics and the client population to the electorate.

FINDINGS

Based on interviews and participant observations, the author finds that the local government adopted several methods to provide health care to its citizens. Through grants and contracts, the county used for-profit and nonprofit clinics to provide health care to the indigent. These methods maximized benefits to the recipients while increasing efficiencies in distribution.

When nonprofits are policy implementers for the government, the role of political ideology and affiliation of the elected officials become significant. In this case, the monies for indigent health care come from a trust fund managed by the Commissioners Court, comprised of officials affiliated with the Republican Party. They opposed the increase in funding for indigent health care and imposed stricter conditions to grants in keeping with their conservative Republican ideology. Therefore, political ideologies of those in control of the resources could be an important factor in the funding of health care, setting restrictions on grants, and rejecting health care to undocumented aliens.

This discussion highlights the important role played by nonprofit clinics in health care and complements previous studies on the greater reliance on nonprofits as service providers (Brudney, 1987; Poole, 1997). Community benefit is another aspect of nonprofits' involvement in health care because collaboration with a community benefits its residents, particularly low-income people, minorities, the elderly and other underserved groups, by improving their health status and quality of life. The indigent population also benefits from the availability of affordable primary care and preventive services at accessible locations.

A CONCEPTUAL FRAMEWORK

Apart from the significant role of nonprofit clinics in health care, their involvement in community organizing is worth mentioning. Based on the

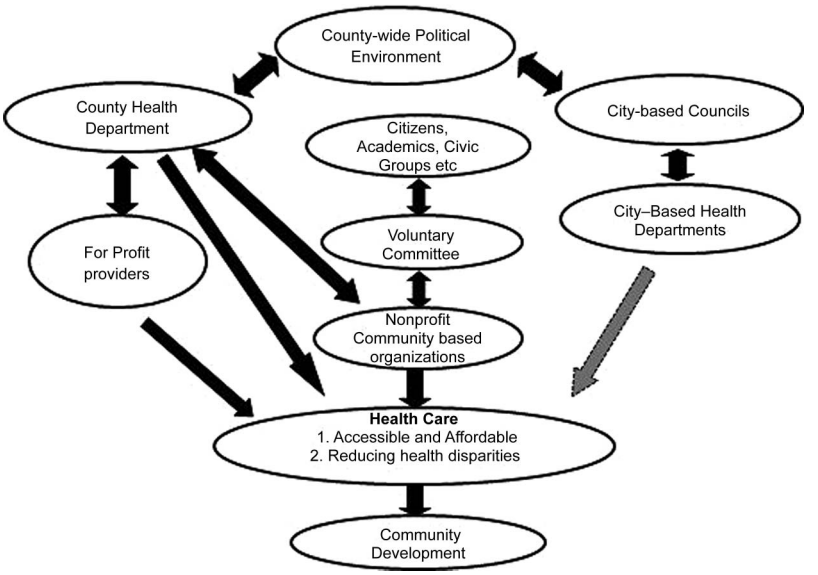

FIGURE 1 Community Organizing: A Framework of Key Influences and Outcomes.

case analysis and findings, a preliminary conceptual framework (Figure 1) is presented here that delineates the role of the stakeholders in community organizing for health care promotion, and explicitly describes the process of health care provision in the community. This framework suggests the vital role of the community organizers in forging alliances with community resources such as nonprofits, civic bodies, citizens, and other grassroots organizations for the promotion of affordable and accessible health care. The funds provided by the government are insufficient for meeting the demands for health care. To address this gap in health care services, the core group of community coordinators has organized as a nonprofit organization by mobilizing support from voluntary organizations, civic groups, and concerned citizens. This alliance also generates public opinion on the health concerns faced by the residents primarily by influencing at a personal level, through regular meetings, and bridging connections with the appointed and elected officials of the county.

The double-tipped arrows in the framework delineate the influencing role between the various actors in the network in organizing for health care promotion. The voluntary committee of citizens and professionals, illustrated in the middle of the figure, regularly communicates with grassroots organizations, nonprofit administrators, civic groups, and citizens to foster dialogue and discussions on the state of health care services, challenges, and issues to arrive at a solution. The committee establishes and maintains networks with county commissioners, directly and indirectly, through the county health department and city council members. These elected and appointed officials

often attend the public meetings and educational sessions on critical health care issues organized by the committee. Academics, researchers, and citizens frequent these meetings to voice their opinions thereby providing the policymakers with more information on pertinent issues.

The framework further suggests the somewhat influencing roles between the county health department and the city council, as well as between the city health department that offers minimal health service, and the nonprofit health clinics. These influences, implicit in the relationship between the various actors, suggests their importance to the success of the model. This conceptual model explains the process by which the actors move toward the outcome (depicted by the single-tipped arrows) of health care that is accessible and affordable, and that which reduces health disparities, leading to community development. An important aspect of this framework is the community development outcome. Morton and Glasgow's (2011) argument that a developed community would include changes that affect health outcomes further validates this point that all of the stakeholders are significant to developing the community.

DISCUSSION

The foregoing analysis points to the very important role of a broad array of citizens and grassroots organizations for the goal of organizing community. The models of community organizing described earlier suggests two primary approaches, the top-down and the bottom-up, and a mixture of both. Each is likely to be successful depending on the nature of the problem and the involvement of the stakeholders. Based on the analysis of the extant case of community organizing for promoting health care, the Table 1 compares the key roles played by the stakeholders and the methods used in the three approaches with that of the extant case.

As depicted in the table, the bottom-up approach to community organizing is more prevalent in the case studied. Community members identified the growing problem of unaffordable health care from the increase in ER visits by the uninsured for nonemergency conditions. To address this problem, community members established free clinics in medically underserved areas through philanthropic support from citizens and businesses. With the increase in demand for health care, community organizers and nonprofit clinics sought local government support, who responded with grants to reimburse the cost of providing health care to the indigent. The funding, however, were sporadic and insufficient, and reporting requirements stringent resulting in several nonprofit clinics opting out of the program. The loss of revenue and increasing demand for services led the nonprofits to rally community support for policies toward health care. By collaborating with the committee comprising of the community organizers, these nonprofits initiated

TABLE 1 Comparison Between the Models and the Case Studied

Community Organizing	Top-Down	Bottom-Up	Mixed	Extant Case
Role of policy makers	Significant throughout the process	Insignificant in the beginning	Important in various phases	Insignificant in the beginning
Role of voluntary organizations	Significant as policy implementers	Significant throughout the process	Significant throughout the process	Significant throughout the process
Role of community organizers	None	Significant	Very important	Significant
Role of experts (in the specific problem, e.g., health care)	Significant	Knowledgeable on the specific problem	Significant	Knowledgeable on the specific problem
Citizen involvement	Insignificant	Significant	Significant	Significant
Methods adopted	Directives from government and other statutory bodies that are implemented by local organizations	Grassroots organizing, identification of problems, and setting community-specific solutions	Grassroots organizing and forging alliances with policy makers and other authority to identify community problems and set community specific solutions	Grassroots organizing, identification of problems, forging alliances with voluntary organizations, civic groups, and citizens to discuss pressing problems
Unanimity in means to accomplish goals	Significant	Significant	Significant	Insignificant

discussions and debate at public meetings and forums attended by elected officials, public administrators, citizens, and news media. Researchers, academics, and experts are part of the core group of people who initiated the organizing of community to promote health care policies for the indigent. The role of the various stakeholders in the identification of the problems and setting community specific solutions by collaborating with voluntary organizations, civic groups, and citizens were significant.

CHALLENGES

Interorganizational collaboration is important when goals are comparable. However, in the case studied, there is a lack of consensus among the stakeholders regarding the means to accomplishing the goals. Whereas, some stakeholders believe that a community health center in a medically underserved area of the county would alleviate the problem of inaccessible and unaffordable health care, others believe that including physicians in a countywide network of health care providers providing free treatment to indigents in their offices would help offset the problem. Others believe that more grants to nonprofit clinics would help resolve the problem. Although equal participation of all stakeholders is critical, a lack of equal participation and consensus signifies this case. The core membership tries to involve citizens and voluntary organizations in the public meetings, but these have low attendance rates. Furthermore, most of the leadership in the core group have affluent backgrounds and do not resonate well with the indigent, low-income, and undocumented immigrants.

The case does not resemble the top-down and the mixed approaches to community organizing because the role of government and statutory bodies were insignificant in the process. This bottom-up approach has certain challenges. First is a lack of statutory pressure with adequate funding to implement programs. Second, stakeholders in top-down approaches are unanimous on strategies to accomplish goals. In this case, there is dissension on methods to health care promotion among the stakeholders. Third, experts' involvement in goal setting and action planning is significant in both the top-down and mixed methods. In this case, experts consulted did not participate actively in the organizing process or with the evaluation of solutions to address the gap in health care. Finally, the absence of indigent and low-income populations' representatives in the core committee involved in community organizing is significant. Most bottom-up approaches accomplish their goals because of the involvement of the beneficiary in the organizing process. In this case, the nonprofit administrators represented their clients. However, the requirements of the beneficiaries of public health care were not taken into account. A group comprising of affluent citizens made decisions on what would be best for the indigent population.

CONCLUSIONS

The case examples presented offer several points on community organizing that are similar to previous studies (Hjern, 1982; Rothman & Tropman, 1987): (a) grassroots identification of problem, (b) identification of community specific solutions through collaborative discussions, and (c) use of community resources to educate the public and generate opinion about the critical problems faced by the community. Certain obstacles impede the success of this model: (a) disagreement over strategy or means to accomplish goals, (b) a disproportionate and low participation of community, (c) imbalanced knowledge of successful health care service delivery methods, and (d) leadership from backgrounds very different from the backgrounds of the targeted population. These problems to community participation and organizing could be resolved through improved collaboration and coordination between the stakeholders, a better understanding and appreciation by the stakeholders of the strategies to accomplish the goals, leadership based on knowledge and learning of successful implementation of organizing models, and solutions based on collaborations.

A critical success factor apparent in the current case is the role of the facilitator organization that persistently sought its goals of building trust and generating commitment from community members through formal and informal mechanisms. The efforts of this organization to inform and share knowledge about the healthcare conditions have generated some interest as obvious from the citizens' turnout at its monthly meetings. However, success in this case would require more formal and informal collaboration and alliances between organizations to achieve the goals of healthcare. Measures such as improved communication and information sharing, mitigating organizational differences, and working toward a shared goal of enhancing community health would contribute to developing community. Therefore, an evidence-based and participatory approach could result in better implementation of the model. Furthermore, being a large and diverse community, inclusion of public officials and statutory bodies in the goal-setting and action-planning stages would have made the process more legitimate and successful. In addition, the inclusion of indigent stakeholders in the organizing phases could have helped with goal clarity and unanimity in strategies.

The challenges associated with community organizing, as evident in this case context, could resonate well in other affluent suburban communities with similar socio-economic conditions. With increased migration of low-income people to the suburbs of major urban cities, which traditionally house middle- to high-income families, suburban communities are now facing complex challenges especially in public healthcare provision. During unfavorable economic environments, coupled with the rising costs of healthcare, communities, especially those that are relatively wealthy, are unprepared to address the challenges of providing health services to the

poor and indigent who cannot access or afford primary care. In such situations, organizing the community for addressing such needs will take time as strategies for accomplishing the goals of mobilizing community, acquiring participation from voluntary associations, and gaining patronage from elected officials require some amount of initial success in terms of evidence of positive societal effects. The conceptual model formulated from the evidence gathered and analyzed in the extant research could be examined in future empirical studies in similar communities. Findings from future studies in similar contexts will provide more data to modify and strengthen this model and propose new approaches to organizing community.

Community participation and organizing provides for improved implementation of community-specific solutions. It also provides a forum for active and equal participation by the stakeholders and informed decision-making by the policy makers. However, if not exercised well, it could lead to failure in implementation and loss of trust from the community. The role of nonprofits is not limited to service delivery only; they also should provide a medium for mobilizing community participation and advocating on their behalf to policy makers.

REFERENCES

Berman, P. (1978). The study of macro and micro implementation. *Public Policy*, *6*, 157–84.

Berry, J. M., & Arons, D. F. (2003). *A voice for nonprofits*. Washington, DC: Brookings Institution.

Bracht, N. (1999). *Health promotion at the community level: New advances* (2nd ed.). Thousand Oaks, CA: Sage.

Bradshaw, C., Soifer, S., & Gutierrez, L. (1994). Toward a hybrid model for effective organizing in communities of color. *Journal of Community Practice*, *1*, 25–42.

Brudney, J. L. (1987). Coproduction and privatization: Exploring the relationship and its implications. *Journal of Voluntary Action Research*, *16*, 11–21.

Chin, J. J. (2009). The limits and potential of nonprofit organizations in participatory planning: A case study of the New York HIV planning council. *Journal of Urban Affairs*, *31*, 431–460.

Clemens, E. S. (2006). The constitution of citizens: Political theories of nonprofit organizations. In W. W. Powell & R. Steinberg (Eds.), *The nonprofit sector: A research handbook* (pp. 207–220). New Haven, CT: Yale University Press.

Curtis, A. C., Waters, C. M., & Brindis, C. (2011). Rural adolescent health: The importance of prevention services in the rural community. *Journal of Rural Health*, *27*, 60–71.

Delgado, M. (2000). *Community social work practice in an urban context: The potential of a capacity- enhancement perspective*. New York, NY: Oxford University Press.

Eisenhardt, K. M. (1989). Building theories from case study research. *Academy of Management Review*, *14*, 532–550.

Ellen, I. G., Mijanovich, T., & Dillman, K. (2001). Neighborhood effects on health: Exploring the links and assessing the evidence. *Journal of Urban Affairs*, *23*, 391–408.

Ellen I. G., & Turner, M. A. (1997). Does neighborhood matter? Assessing recent evidence. *Housing Policy Debate*, *8*, 833–866.

Ezell, M. (1991). Administrators as advocates. *Administration in Social Work*, *15*, 1–18.

Fawcett, S. B., Francisco, V. T., Paine-Andrews, A., & Schultz, J. (2000). A model memorandum of collaboration: A proposal. *Public Health Reports*, *15*, 174–190.

Fawcett, S. B., Paine, A. L., Francisco, V. T., & Vliet, M. (1993). Promoting health through community development. In D. S. Glenwick & L. A. Jason (Eds.), *Promoting health and mental health in children, youth, and families* (pp. 233–255). New York, NY: Springer.

Gans, H. (1982). The participant of observation as a human being: Observation on the personal aspect of fieldwork. In R. C. Burgess (Ed.), *Field research: A sourcebook and field manual* (pp. 53–61). London, UK: George Allen and Unwin.

Geronimus, A. T. (1992). The weathering hypothesis and the health of African-American women and infants: Evidence and speculations. *Ethnicity and Disease*, *2*, 207–221.

Glaser, B. G. & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Chicago, IL: Aldine.

Hanks, C. (2006). Community empowerment: A partnership approach to public health program implementation. *Policy, Politics, & Nursing Practice*, *7*, 297–306.

Hjern, B. (1982). Implementation research: The link gone missing. *Journal of Public Policy*, *2*, 301–308.

Hjern, B., & Porter, D. (1981). Implementation structures: A new unit of administrative analysis. *Organizational Studies*, *2*, 211–27

Kretzmann, J. P., & McKnight, J. L. (1993). *Building communities from the inside out: A path toward finding and mobilizing a community's assets*. Evanston, IL: Institute for Policy Research.

Laing, B. (2009). A critique of Rothman's and other standard community organizing models: Toward developing a culturally proficient community organizing framework. *Community Development*, *40*, 20–36.

LeRoux, K. (2007). Nonprofits as civic intermediaries: The role of community-based organizations in promoting political participation. *Urban Affairs Review*, *42*, 410–422.

Marwell, N. (2004). Privatizing the welfare state: Nonprofit community-based organizations as political actors. *American Sociological Review*, *69*, 265–291.

Matland, J. (1995). Synthesizing the implementation literature: The ambiguity–conflict model of policy implementation. *Journal of Public Administration Research and Theory*, *5*, 145–174.

McKnight, J. (1995). *Careless society: Community and its counterfeits*. New York, NY: Basic Books.

Miller, C.A. (1976). Societal change and public health: A rediscovery. *American Journal of Public Health*, *66*, 54–60.

Minkler, M. (1990). Improving health through community organization. In K. Glenz, F. M. Lewis, & B. K. Rimer (Eds.), *Health behavior and health education: Theory, research, and practice* (pp. 257–287). San Francisco, CA: Jossey-Bass.

Minkler, M. (1997). *Community organizing and community building for health*. New Brunswick, NJ: Rutgers University Press.

Morton, L. W., & Glasgow, N. (2011). Health: A new community development challenge. In J. W. Robinson & G. P. Green (Eds), *Introduction to community development: Theory, practice, and service-learning* (pp. 229–244). Thousand Oaks, CA: Sage.

Pawlak, E., & Flynn, J. (1990). Executive directors' political activities. *Social Work*, *35*, 307–312.

Poole, D. (1997). Building community capacity to promote social and public health: Challenges for universities. *Health and Social Work*, *22*, 163–170.

Pressman, J., & Wildavsky, A. (1973). *Implementation*. Berkeley, CA: University of California Press.

Rothman, J., & Tropman, J. E. (1987). Models of community organizing and macro practice perspectives: Their mixing and phasing. In F. M. Cox, J. L. Erlich, J. Rothman, & J. E. Tropman (Eds.), *Strategies of community organization: Macro practice* (pp. 3–25). Itasca, IL: Peacock.

Sabatier, P. (1986). Top-down and bottom-up approaches to implementation research: A critical analysis and suggested synthesis. *Journal of Public Policy*, *6*, 21–48.

Saidel, J. R. (1989). Dimensions of interdependence: The state and voluntary-sector relationship. *Nonprofit and Voluntary Sector Quarterly*, *18*, 335–347.

Schlesinger, M., Quon, N., Wynia, M., Cummins, D., & Gray, B. (2005). Profit-seeking, corporate control and the trustworthiness of health care organizations: Assessments of health plan performance by their affiliated physicians. *Health Services Research*, *40*, 605–645.

Schlesinger, M., & Gray, B. (2009). Nonprofit organizations and health care: The paradoxes of persistent attention. In W. W. Powell & R. Steinberg (Eds.), *The nonprofit sector: A research handbook* (pp. 378–414). New Haven, CT: Yale University Press.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques*. Newbury Park, CA: Sage.

US Census Bureau. (2009). *American community survey*. Retrieved from http://factfinder.census.gov

Van Meter, D., & Van Horn, C. (1975). The policy implementation process: A conceptual framework. *Administration and Society*, *6*, 445–488.

Wallace, R., & Wallace, D. (1990). Origins of public health collapse in New York City: The dynamics of planned shrinkage, contagious urban decay, and social disintegration. *Bulletin of the New York Academy of Medicine*, *66*, 391–434.

Wallerstein, N. (1992). Powerlessness, empowerment, and health: Implications for health promotion programs. *American Journal of Health Promotion*, *6*, 197–205.

Weil, M. (1996). Model development in community practice: A historical perspective. *Journal of Community Practice*, *3*, 5–67.

Yin, R. (1993). *Applications of case study research*. Beverly Hills, CA: Sage.