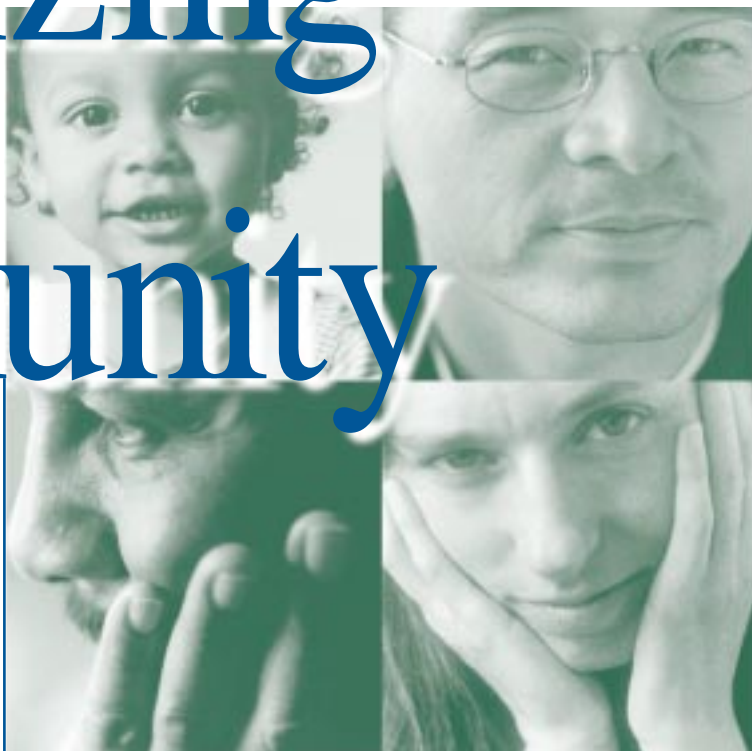




P.O. Box 17550, Denver, CO 80217-0550
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Organizing your Community

1999



Organizing Your
Community to
Improve Health:
Serving the
Medically Underserved

COLO R A D O
Coalition for the Medically Underserved
M

Colorado Coalition for the Medically Underserved Vision Statement:

The members of the Colorado Coalition for the Medically Underserved are united by a shared commitment to the following vision:

There are close to 600,000 Coloradans who do not have health insurance coverage. A similar number of our citizens are estimated to be underinsured, exposing them to economic calamity if they experience a catastrophic illness or injury. Most of the uninsured and underinsured are employed. Most did not choose their uninsured status. Yet they face the very real prospect of not being able to obtain medical care when they need it. The result is that the uninsured get inadequate or insufficient health care and their health suffers as a result. The lack of health insurance, independent of income or social class, has become a predictor of ill health.

The Coalition for the Medically Underserved views this state of affairs as unacceptable. Colorado's resources and its community values make it possible to institute a better approach to meeting the health care needs of our citizens. The Coalition believes that all Coloradans can and should have access to quality health care and prevention programs. The Coalition believes that it is critical that Colorado achieves health insurance coverage for all of its citizens. We seek to make this vision become a reality.

To Our Readers:

The Colorado Coalition for the Medically Underserved is proud to present *Organizing Your Community to Improve Health: Serving the Medically Underserved*. Published in conjunction with the *Guidebook of Colorado Community Programs for the Medically Underserved*, *Organizing Your Community* was designed to help communities develop programs that meet the needs of the medically underserved. We hope that both books will encourage the development of new community programs for the medically underserved and, at the same time, be an asset in sustaining and expanding current programs.

The Coalition for the Medically Underserved is a group of more than 50 representatives from Colorado professional and health provider organizations, state agencies, the state legislature, foundations, insurers, and consumer and business groups. This diverse group of individuals, many of whom have years of experience addressing the concerns of the medically underserved, came together over the past year to share information and identify pragmatic and politically feasible actions in Colorado to address the problems of the medically underserved.

Written to supplement the Coalition's *Guidebook of Colorado Community Programs for the Medically Underserved*, *Organizing Your Community to Improve Health: Serving the Medically Underserved* offers information and practical advice on creating community programs for the medically underserved. It is divided into four sections: *Getting Started*, *Getting Funding*, *Getting Help*, and *Competencies for Serving the Medically Underserved*. *Getting Started* includes advice on creating informal groups and formal organizations. *Getting Funding* features information on and resources for locating private and public funding sources in Colorado and the nation, as well as advice on grantwriting. *Getting Help* provides a useful guide for volunteer recruitment, retention, and management. The final section, *Competencies for Serving the Medically Underserved*, details specific issues and methods for serving clients who may be socially, culturally, and financially different from providers.

While *Organizing Your Community to Improve Health* focuses on issues important to creating and designing community programs for the medically underserved, the *Guidebook* features information on 43 community programs that currently serve the medically underserved. We think that both books will be useful and informative tools in helping your organization, or future organization, fulfill its mission of ensuring the health and welfare of all Coloradans.

Copies of *Organizing Your Community to Improve Health: Serving the Medically Underserved* and the *Guidebook of Colorado Community Programs for the Medically Underserved* are available from the Coalition for the Medically Underserved. If you have comments on either book or would like additional copies, please contact:

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Chairman, Coalition for the Medically Underserved

Organizing Your Community to Improve Health: Serving the Medically Underserved



1999

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Organizing Your Community to Improve Health: Serving the Medically Underserved

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Getting Started: Creating Informal and Formal Structures

*T*aking the first step is often the most difficult task in creating community programs. This chapter offers advice on how to develop formal and informal structures. The following pages include information on conducting a community health care needs assessment, organizing an informal structure for informal groups, and creating a formal structure for formal organizations.

Getting Started

“75 percent of success is just showing up.”
-Woody Allen

Individuals, working alone, typically can solve individual problems. Social problems, on the other hand, require the coordinated efforts of many people and that still has never been enough. The health and well-being of the medically underserved has always been a community responsibility. Prior to the mid-20th century, their care came first from immediate family and then from religious and charitable organizations. Following World War II, the responsibility shifted more and more to local and state governments, especially in the form of public health and public hospitals. Both the United Nations and many U.S. studies use health indicators, especially for the poor or disadvantaged, as a general measure of a community's quality of life.

We assume that the tradition of community concern for the health and well-being of all within that community remains strong. We also assume that even though there exists a sense of personal responsibility for the

medically underserved, few people will provide direct care. In his essay, *Needs of Strangers* (1984), Michael Ignatieff describes that sense of personal responsibility expressed through others:

“My responsibilities towards them are mediated through a vast division of labour. In my name a social worker climbs the stairs to their rooms and makes sure they are as warm and clean as they can be persuaded to be. When they get too old to go out, a volunteer will bring them a hot meal, make up their beds, and if the volunteer is a compassionate person, listen to their whispering streams of memory. When they can't go on, an ambulance will take them to the hospital, and when they die, a nurse will be there to listen to the ebbing of their breath. It is this solidarity among strangers, this transformation through the division of labour of needs into rights and rights into care that give us whatever fragile basis we have for saying that we live in a moral community.”

Defining the Problem and Assessing the Need

How big is the problem? According to the Colorado Coalition for the Medically Underserved and others who collect health data, few, if any, individuals actually die from lack of medical care in Colorado. The presence of a “safety net” of providers, hospitals, and others exists to “catch” most of those under-served by the typical health care system.

That safety net combines the resources of federal, state and local governments with not-for-profit hospitals, clinics, and providers. According to many health policy experts, the safety net has become frayed in recent years. The sale of not-for-profit community and religious hospitals to for-profit hospital chains, declining governmental subsidies, and rising costs of services have all affected the quantity and quality of the safety net.

At the same time, increasing numbers of workers, typically covered by employer health insurance benefits, are choosing to self-insure or under-insure themselves and their families, thereby placing themselves at risk to be medically underserved.

Unfortunately, national and state figures on the medically underserved, regardless of how the experts interpret them, do not really help a community define the scope of the problem. Therefore, we propose that the best place to begin is with a **community health care needs assessment**.

The assessment can be done through formal, structured questionnaires, gathering qualitative data through interviews, or

other techniques. No matter what technique you use, each begins with a set of important questions, such as:

In our community:

1. Who typically has less access to the health care services than they need? Describe the attributes most common among those individuals.
2. Who typically provides care to individuals who cannot pay all or most of the cost of their care? Describe each different practice, clinic, hospital, or other setting.
3. What types of health issues tend to receive the lowest coverage or rate of care for the groups described in Question One?
4. In considering the three questions above, what needs to improve in the way health care services are provided to the medically underserved?
5. What types of successes have we had in solving other community problems? What kind of failures? What did we learn, as a community, from both types of experiences?
6. Who do we know, in another community, who has addressed similar issues successfully?
7. Who, both people and organizations, consistently seem to be able to work together successfully on community needs?
8. What resources are available and what resources will we need?

These questions may seem simplistic, but the answers are typically much more complex. Rarely will the responses to these questions lead to compelling, black-and-white directions for how to proceed. We believe, however, that if there is an apparent need, some individual or small group of individuals will seek to respond, sooner or later, to that need, and when they do, others will join in the response. That suggests that the most effective community response to a community problem will involve some type of group or organization.

Community Organizations

The research for the Colorado Coalition for the Medically Underserved's *Guidebook of Colorado Community Programs for the Medically Underserved* revealed two main types of organizations that focus on the medically underserved: those that provide direct services to the medically underserved and those that seek to link persons and groups concerned with the medically underserved. Obviously, there is a great deal of overlap between the two types.

A quick review of the primary purposes of current programs that focus on the medically underserved finds that most of the community organizations provide direct health care services. A smaller number provide referrals or seek to link together community resources. The smallest number of organizations focus on information, public policy, research and data collection, and advocacy for the medically underserved. Most of the organizations featured in the *Guidebook*, however, often do some amount of all three, regardless of the primary purpose.

Interestingly, regardless of the primary purpose, almost all of the organizations have some type of **formal structure**, and almost all of them spend some time in their organizational history as a group with **informal structure**.

Informal Structure

Almost all organizations spend many months, or even years, as an informal group before moving to a formal structure. In fact, many groups fulfill their purpose and disband without ever becoming a formal organization. The distinctions, though important, are hard to make: it is not always clear when a group of people become a group, much less an organization.

For the purposes of this discussion, our working definition describes a **community group as having a common purpose, a regular system of communication, and a few, informal ways to identify members**. A group of civic leaders in a major East Coast city have been meeting for dinner once a month to discuss civic issues *since before the Revolutionary War*. They have no by-laws, no building, no officers, no dues, and no tax number.

Informal groups, though, typically have shorter life-spans, on purpose. Community organizers often say that informal community groups should either have an eternal purpose or an immediate purpose, but nothing in between. Informal groups often cannot survive a strategic planning process or changes in the environment around them. They are, for the most part, **highly value-driven, focused on one thing, and guided by need**. Participants in informal groups often report that there were

lots of unstated assumptions, beliefs, and perceptions among the group. “It was clear from the beginning ...” is often how they describe their understanding of the purpose of the group. Let that purpose be met, or have other less clear purposes intrude, and the group will begin to die.

Informal structure is not a weaker or an ineffective form of an organization. Many groups rush to create a formal structure before they really understand their purpose, the needs of their group, and the limitations of formal structure. When asked, those rushing to create formal structure often indicate they are doing so simply to accelerate the maturation rate of their organization. Little children look odd in adult clothing and with adult behavior; so do young organizations who hastily adopt formal structure. Regretfully, most informal groups come and go without leaving a lasting footprint or record of accomplishment. But for some community development experts, a community is better off with a larger number of informal groups than formal organizations.

How to Get an Informal Group Started

1. Anyone—regardless of experience, position or resources—can call the first meeting.
2. Focus on need and purpose.
3. State the questions that need to be discussed.
4. Identify someone to handle the logistics.
5. Go slow. Momentum builds naturally. Don’t be disappointed if one of the first meetings goes “flat”

and people leave confused or frustrated.

Basic Building Blocks of Informal Groups

1. Communicate, communicate, communicate.
2. Clarify expectations and simple guidelines in a letter or informal document.¹
3. Focus on need and common values.
4. Share responsibilities equally: no heroes, no martyrs, and no charismatic leaders.

Formal Structure

If informal groups are the “free spirits” of communities, then formal community organizations are the “Fortune 500.” Boys Clubs, Girls Clubs, Rotary Clubs, and Neighborhood Development Corporations can be found in all 50 states, and they all look and operate in a similar manner. One reason that the Coalition's *Guidebook of Community Programs for the Medically Underserved* features so much information about existing organizations involved with the medically underserved is the belief that **organizational structure can be replicated more easily than it can be created.**

The definition for formal organizational structure typically involves legal and financial definitions recognized by the state Attorney General or Secretary of State, the Internal Revenue Service, and others.

¹ A sample of such a document used by the Coalition for the Medically Underserved appears in Appendix I.

Almost all of the programs currently serving the medically underserved fall under Section 501(c) of the Internal Revenue code. That section covers the types of organizations and activities that can seek to operate “in the public good” as not-for-profit organizations and do not pay state or federal taxes on their income. The obvious benefit of this formal structure is the ability to keep all income. The less obvious benefits come from the widely recognized 501(c) status that makes the organization eligible for many forms of philanthropy or gifts not available to for-profit organizations.

We could not begin to provide all the conditions and steps for filing for 501(c) status in this publication, but any good attorney or the Colorado Association of Non-Profit Organizations in Denver can provide some legal guidelines. It is worth the time and expense if the organization envisions a long life.

Formal structure must satisfy internal expectations as well. One reason to create a formal structure for a community organization is to protect something of value. In early Christianity, whole monasteries and nunneries grew up to protect a single religious artifact. Houses protect their occupants, and organizational structures protect their members. Because many foundations will not award grants to organizations without 501(c) status, another important reason to create a formal structure is to become eligible for foundation grants. An informal group, when it wants to apply for a grant or buys some clinic equipment to share, suddenly has the urge to create formal structure.

Once created, formal structure often helps an organization respond to a changing environment; build for a future purpose currently not that important; and survive bad leadership, a loss in grant support, and other catastrophes typically unimagined by the informal group. Those same benefits can become liabilities if formal organizations try to respond quickly to unexpected events or find themselves spending too much time on organizational needs, like the next board meeting, instead of focusing on the organization's purpose and mission.

How to Get a Formal Group Started

1. Focus on what type of structure will help you accomplish your goals or protect something of value. Invite a lawyer with experience in not-for-profit organizations to talk with the group informally.
2. Be realistic. Consensus sounds like the best way to make decisions but cannot always be achieved. In your formal structure include both the optimum style of decision making (such as consensus) and a back-up process to use when consensus cannot be achieved or is too time consuming for the type of decision to be made.
3. Make your structure reflect your purpose and mission. Having a “finance committee” but no committee that reflects the organization’s purpose will result, inappropriately, in the structure guiding the mission.

Basic Building Blocks of Formal Organizations

1. Communicate, communicate, communicate.
2. Build in feedback loops that continually ask, “how are we doing?”
3. Become a “learning organization” in which taking risks, making mistakes, and admitting what you don’t know are norms.
4. Keep a balance between immediate goals and long-range plans.
5. Use a small board or part of a large board to oversee the operations of the organization.
6. Hire staff when appropriate.
- 7 .Encourage members (staff, board members, and other members) to stay focused on purpose, not organizational policies, procedures, and politics.

Resources for Getting Started

Books and Articles

Carver, John. *Boards That Make a Difference*. San Francisco: Jossey-Bass, 1990.

Houle, C.O. *Governing Boards: Their Nature and Nurture*. San Francisco: Jossey-Bass, 1989.

Kirk, W.A. *Nonprofit Organization Governance: A Challenge in Turbulent Times*. New York: Carlton Press, 1986.

Taylor, Barbara E., and others. “The New Work of the Nonprofit Board.” *Harvard Business Review*, Sept.-Oct., 1996, pp. 36-46.

Organizations

Colorado Association of Non-Profit Organization (CANPO), 225 E. 16th Avenue, Suite 1060, Denver, CO 80203.

Community Resource Center, 1245 E. Colfax Avenue, Suite 205, Denver, CO 80218.

Council of Foundations, 1828 L Street, NW, Suite 300, Washington, DC 20036.

The Foundation Center, 79 Fifth Avenue, New York, NY 10003.

National Association of Community Leadership Groups, 200 S. Meridian Street, Suite 250, Indianapolis, IN 46225.

National Center for Nonprofit Boards, 2000 L Street, NW, Suite 510, Washington, DC 20036.

National Civic League, 1445 Market Street, Suite 300, Denver, CO 80202.

Appendix I

Sample: Informal Document Clarifying Expectations & Guidelines for Informal Groups

Vision, Values and Operating Principles Coalition for the Medically Underserved

Vision

By 2007, through the efforts of the Coalition for the Medically Underserved, working closely and collaboratively with many other groups and individuals over many years, Colorado has removed any substantial differences in access to quality health care and prevention programs among all people in the state. By 2007, the state has a system for health care financing and delivery which moderates the differences of socio-economic status, language and culture, geography, distribution of facilities and providers, and others.

Assumptions, Values and Beliefs²

The Coalition begins its work with some fundamental assumptions, beliefs and values related to the medically underserved. A successful process to achieve the vision above will:

1. Recognize that medically indigent, Medicaid and self-pay are one population.
2. Create collaboration and links organizations.
3. Link needs of medically underserved with existing resources and solutions.
4. Improve the safety net without removing the safety net.
5. Include principles of universal health care coverage for all Coloradans.
6. Maximize current opportunities for small change and improvement while remembering the long-term vision.
7. Expand the participation of all providers in meeting the needs of the underserved through appropriate opportunities and incentives.
8. Provide affordable coverage for kids at 185% of poverty by 2000; and all adults at 185% of poverty by 2005.
9. Seek the most readily available data and information that clearly identify the gaps.
10. Develop remedial and incremental goals and a way to monitor progress in reaching this vision.
11. Ensure the viability of safety net providers.
12. Creatively and persistently leverage new federal funds.
13. Start implementation with specific target groups or communities to check for unanticipated issues prior to full implementation.
14. Slow down and stops the erosion of employer-based coverage.
15. Include presumptive eligibility.

Operating Principles of the Coalition³

² These assumptions, values and beliefs shape the way the Coalition will pursue the vision and its efforts.

³ These principles are intended to clarify the way the Coalition will work and to establish positive ground rules in order to reduce conflict and disruption in the future.

1. The Coalition began as an organizational committee of the Colorado Medical Society, and it continues to be supported by CMS. However, to be successful, it must include the views of others who are not members of CMS.
2. The Coalition will pursue two different sets of goals simultaneously: (1) to take action on immediate issues and problems and (2) to take a more strategic view of what would have to happen in Colorado to ensure the vision stated above.
3. For the purposes of the work of this Coalition, the Coalition defines “medical services” as services that attempt to improve the medical, dental and mental health of an individual. Therefore an “underserved” individual would be any person who can not access those services in sufficient quality or quantity to improve the medical, dental or mental health of the individual because of socio-economic, language, culture, geographic or other barriers.
4. Throughout the life of the Coalition it will seek input from others. To accomplish its goals, the Coalition may create sub-committees to focus on specific action items or components of the long-range plan. Those sub-committees may involve people who are not members of the Coalition.
5. The Coalition seeks to balance the principle of involving others with the principle of efficient and effective size of the group. The Coalition believes that a membership of around 35 members would be best. All individuals invited to the September 9, 1997 meeting are considered members. Other members may be added at any time by a simple majority vote of members present at an announced meeting. A person remains a member as long as the person attends meetings.
6. Coalition members are expected to attend regularly. If a member can not attend they are expected to notify the chair or the key staff of the committee as early as possible and to designate a representative who could attend but not vote should the subject matter call for such participation.
7. The Coalition’s work may include four types: (a) staff and Coalition member work to develop “fact papers” and “position papers”; (b) mini-forums for Coalition members and others to hear from a panel of presenters on a topic or issue; (c) action groups or sub-groups of Coalition working on specific topics or issues; and (d) discussion and decision sessions of all the members.
8. The Coalition envisions a range of reasons for the Coalition to meet and work together: (a) make specific recommendations as a Coalition; (b) explore a topic and expect individual members to take it back to their constituents; (c) agree to bring resources from members and the organizations to which they belong to address an action step or goal of the Coalition; (d) develop models, scenarios and services that, in the future, will improve the system in Colorado for serving the medically underserved; (e) prepare for the legislative session by discussing, in advance, the issues which might arise; and (f) develop and implement processes and policies that meet the goals of the Coalition. Each topic might include a couple of these reasons, but before much time is spent by the Coalition for an issue, it should decide what outcomes it wants.
9. The Coalition will use a range of decision-making processes. In the event it seeks to make decisions by consensus and can not reach consensus in two meetings, the Coalition will make the decision by a three-quarters majority of members present at that meeting. Any decision of the majority will be communicated as a decision of the Coalition. From time to time the Coalition will use a “consent” process in which items will be acted upon unless a member voices an exception to the proposed action.
10. All meetings will have agendas and all agendas and supporting material will be mailed out in advance.
11. The chair of the Coalition will be Gary VanderArk, M.D.
12. The key staff of the Coalition will be Ellen Stein, Colorado Medical Society. Others from CMS, consultants, or resources of Coalition members will assist her as appropriate.
13. The Colorado Trust has agreed to support basic operational costs for one year unencumbered by a requirement for a specific outcome and with only these guidelines: that the Coalition be open to individuals other than CMS members; that the Coalition members participate in the activities of the Coalition; and that the Coalition attempt to provide both a general forum and specific actions or goals for improving the delivery of health services to the underserved now and in the future.

Getting Funding: Private and Public Funding Sources

Community programs that focus on the medically underserved may benefit from a variety of local, state, federal, and private funding sources. This chapter reviews the various resources available to community programs. The following pages include advice on how and where to find information on public and private funding sources in Colorado and across the nation and a list of potential funding sources for health related programs. Also included is a section on public programs that focus on the medically underserved. The chapter concludes with a brief section on successful grantwriting.

Resources for Information on Funding Sources

1999-2000 Colorado Grants Guide

The most thorough and comprehensive resource for locating potential funding sources for programs in Colorado is the *Colorado Grants Guide* published by the Community Resource Center.

The Grants Guide includes listings of over 200 foundations, corporations, national funders, state government agencies, and religious organizations. The Guide also includes information on their areas of interest, boards and trustees, and funding requirements. Listings are cross referenced by 50 different "areas of interest" and 12 "types of grants."

Each Grants Guide listing includes the funding organization's name, address, contact information, proposal deadlines, purpose and mission, areas of interest, grant types, restrictions, application process, recent grants awarded, geographical area, trustees, assets, and the highest, lowest, and average grant award.

The Guide includes a comprehensive index that not only lists funding organizations

alphabetically but lists them by: areas of interest, geographic location served, types of grants, and foundation trustees.

In addition, the Guide offers a special tools section with a common grant application, articles on successful grantwriting, a sample grant proposal, and a bibliography of other fundraising resources.

The *1999-2000 Colorado Grants Guide* is available in book form and on CD-ROM. For more information contact: Community Resource Center, 1245 East Colfax Avenue, Suite 205, Denver, CO 80218. Telephone: (303) 860-7711.

E-mail: crcamerica@mho.net or visit their website at www.crcamerica.org

1998-1999 Colorado Foundation Directory

This comprehensive reference guide to over 175 Colorado private and community foundations that provide grants to nonprofit organizations and scholarships to individuals is a joint publication of the Community Resource Center and the Junior League of Denver. The Directory also includes a copy of the Colorado Common Grant Application form, and a listing of other grantwriting resources and references.¹ For more

information on the 1998-1999 Colorado Foundation Directory contact: the Junior League of Denver (303) 782-9244.

Other Resources For Information on Funding Sources²

Colorado Association of Foundations
c/o The Denver Foundation
455 Sherman Street, Suite 220
Denver, CO 80203
(303) 778-7587

The Association serves primarily as an information forum to its membership of over 60 foundation and corporate members.

Colorado Association of Nonprofit Organizations (CANPO)
225 E. Sixteenth Avenue, Suite 1060
Denver, CO 80203-1614
(303) 832-5710
(800) 333-6554

Through its informational programs, publications, and group purchasing services, CANPO helps charitable and philanthropic nonprofits to efficiently manage their organizations and their resources. The association serves over 900 members.

¹ This description is reproduced with the permission of the Community Resource Center, 1245 East Colfax Avenue, Suite 205, Denver, CO 80218. Telephone: (303) 860-7711.

² Most of the information on other resources for grantseekers is taken directly from *1997-1998 Colorado Grants Guide* and reprinted with the permission of the Community Resource Center, 1245 East Colfax Avenue, Suite 205, Denver, CO 80218. Telephone: (303) 860-7711.

Colorado Secretary of State
1560 Broadway, Suite 200
Denver, CO 80203
(303) 894-2251

Contact the Secretary of State's office to receive the proper forms for incorporating as a nonprofit organization, as well as for general reporting procedures.

Community Resource Center (CRC)
1245 E. Colfax Avenue, Suite 205
Denver, CO 80218
(303) 860-7711

CRC conducts regional and statewide workshops on fundraising, board development, and other nonprofit related issues, as well as provides one-on-one consulting and technical assistance services. The Colorado Grassroots Leadership Program is a year-long training for key staff and board members of grassroots nonprofit organizations.

Council of Foundations
1828 L Street, NW, Suite 300
Washington, D.C. 20036
(202) 466-6512

The Council Of Foundations works to promote responsible and effective philanthropy. In addition, COF provides educational programs, development workshops, publications, and technical assistance.

Denver Public Library
Central Library
General Reference Department
10 W. Fourteenth Avenue Parkway
Denver, CO 80204-2731
(303) 640-6280

The Central Library is a depository for information compiled by The Foundation Center. In addition, there are a number of grant directories, corporate annual reports, and other publications related to grant research and writing.

National Clearinghouse for Primary Care
Information (NCPCI)
8201 Greensboro Drive
McLean, VA 22102
(703) 821-8955, ext. 248

NCPCI provides information services to support the planning, development, and delivery of ambulatory health care to urban and rural areas that have shortages of medical personnel and services. Materials are available on health education, governing boards, financial management, administrative management, and clinical care. Bilingual medical phrase books, a directory of Bureau of Primary Health Care (BPHC) funded health centers and programs, and an annotated bibliography are also available. Although NCPCI will respond to requests from the general public, its primary audience is health care practitioners and administrators.

The Foundation Center
79 Fifth Avenue
New York, NY 10003-3076
(212) 620-4230

The Foundation Center (TFC) is an independent nonprofit clearinghouse. TFC publishes a number of grant directories and other resources on nonprofit-related issues.

The Grantsmanship Center
1125 W. Sixth Street, 5th Floor
P.O. Box 17220
Los Angeles, CA 90017
(213) 482-9860
(800) 421-9512

The Grantsmanship Center offers grant-related training through workshops and follow-up support. Trainers review proposals and provide technical assistance.

Potential Funding Sources for Health-Related Projects

A.V. Hunter Trust
(Denver, CO)

Anschutz Family Foundation (Denver, CO)

Arapahoe Medical Society (Englewood, CO)

Bacon Family Foundation (Grand Junction, CO)

Balke Trust (Colorado Springs, CO)

Blue Cross Blue Shield of Colorado Foundation
(Denver, CO)

Boettcher Foundation (Denver, CO)

Bonfils-Stanton Foundation (Denver, CO)

Boss Living Trust (Denver, CO)

Bureau of Primary Health Care (Washington, D.C.)

Burns Foundation (Denver, CO)

Centura-St. Thomas More Hospital (Canon City, CO)

Colorado Department of Public Health & Environment
(Denver, CO)

Colorado Osteopathic Foundation

Colorado Springs Community Trust Fund
(Colorado Springs, CO)

Coleman Company Charitable Trust, Inc. (Golden, CO)

Colorado Avalanche Community Fund (Denver, CO)

Colorado State Bank Foundation (Denver, CO)

The Colorado Trust (Denver, CO)

Colorado Women's Cancer Control Initiative
(Denver, CO)

Community Foundation of Boulder (Boulder, CO)

Community Foundation of Northern Colorado
(Fort Collins, CO)

Comprecare Foundation (Denver, CO)

ConAgra
(Omaha, NE)

Coors Foundation
(Denver, CO)

COPIC Medical Foundation (Englewood, CO)

Creative Ministries of Presbyterian Women
(Louisville, KY)

Cyprus Amax Foundation (Englewood, CO)

Delatour Foundation (Fort Collins, CO)

Deneen Charitable Trust (Denver, CO)

The Denver Foundation (Denver, CO)

The Denver Post, Season to Share (Denver, CO)

El Pomar Foundation (Colorado Springs, CO)

Exempla Lutheran Medical Center

Episcopal Church (New York, NY)

Fannie Mae Foundation (Washington, D.C.)

Friends of Man (Littleton, CO)

Giddings Foundation (Colorado Springs, CO)

Gill Foundation (Colorado Springs, CO)

Goodstein Foundation (Casper, WY)

Goodwin Foundation (Grand Junction, CO)

HealthONE Foundation (Denver, CO)

Heginbotham Trust (Holyoke, CO)

Helen K. and Arthur E. Johnson Foundation
(Denver, CO)

Hewitt Family Foundation (Denver, CO)

Hewlett Packard Company (Palo Alto, CA)

Hill Foundation (Denver, CO)

J. D. Edwards Foundation (Denver, CO)

Janus Funds Foundation
(Denver, CO)

John G. Duncan Charitable Trust (Denver, CO)

Johnson Foundation (Denver, CO)

Joslin-Needham Family Foundation (Brush, CO)

Joslyn Charitable Trust (Colorado Springs, CO)

Junior League of Denver (Denver, CO)

Kaiser Permanente (Denver, CO)

Kenneth Kendal King Foundation
(Denver, CO)

Kitzmiller-Bales Trust (Wray, CO)

The Kresge Foundation
(Troy, MI)

Levy Memorial Foundation (Denver, CO)

Lindsay Trust (Denver, CO)

Mabel Y. Hughes Charitable Trust (Denver, CO)

Madigan Foundation (Denver, CO)

Maytag-Crawford Trust Fund
(Colorado Springs, CO)

Medical Center of Aurora (Aurora, CO)

Monfort Family Foundation
(Greeley, CO)

Newborn Hope (Colorado Springs, CO)

North Colorado Medical Center Foundation
(Greeley, CO)

Poudre Valley Hospital District Board
(Fort Collins, CO)

Poudre Valley Hospital Foundation (Fort Collins, CO)

Rabb Foundation
(Englewood, CO)

Robert Wood Johnson Foundation (Princeton, NJ)

Robinson Family Foundation (Denver, CO)

Rose Community Foundation (Denver, CO)

Schramm Foundation (Denver, CO)

Schuller Fund (Denver, CO)

Sisters of Charity of Leavenworth (Leavenworth, KS)

St. John's Foundation (Boulder, CO)

Sterne-Elder Memorial Trust (Denver, CO)

Stone Trust (Colorado Springs, CO)

Summit Foundation (Breckenridge, CO)

Susan G. Komen Foundation (Dallas, TX)

Swan Foundation (Denver, CO)

Taylor Foundation (Denver, CO)

Temple Hoyne Buell Foundation (Englewood, CO)

United Way

W.K. Kellogg Foundation (Battle Creek, MI)

**Public Funding Sources:
State Programs**

Colorado Indigent Care Program³

The Colorado Indigent Care Program (CICP) is a state program that provides partial provider reimbursement for medical care to low-income residents. Coloradans who are at or below 185% of the federal poverty level and ineligible for Medicaid may qualify for the CICP. The Colorado Department of Health Care Policy and Financing (HCPF) administers the CICP.

CICP providers discount charges to people that qualify for the CICP. Licensed hospitals, community clinics, or birth centers who contract with the CICP administration may become CICP providers. Individual physicians are not eligible to become CICP providers.

Hospitals that participate in the CICP must discount facility and outpatient care charges. However, physician charges for hospital care may not be discounted. Rating technicians at participating CICP hospitals will know if physician charges are discounted.

Community clinics that participate in the CICP must discount **all** charges. There is never a separate physician charge for care received in a community clinic. When community clinic physicians provide care in a hospital, their physician charges may not be discounted.

Some physician bills for hospital care are discounted under the CICP; it is up to the

³ Description of and information on CICP was provided by and reproduced with the permission of the Colorado Department of Health Care Policy and Financing, Colorado Medically Indigent Care Program, 1575 Sherman Street, 5th Floor, Denver, CO 80203-1714, (303) 866-2580.

CICP hospital and its physicians to determine whether or not to discount physician charges. Individual physicians must sign an agreement with the CICP hospital for physician charges to be eligible for CICP reimbursement. Providers must notify the CICP administration if they have physician participation. Providers that fail to notify the CICP administration of physician participation cannot bill the CICP for physician charges. CICP hospitals are responsible for paying participating physicians. CICP hospitals and its physicians negotiate the CICP physician reimbursement percentage.

You may call (303) 866-2580 to receive a list of CICP providers or call (303) 866-5506 to determine if your facility is eligible to contract with the CICP administration.

Child Health Plan Plus (CHP+)⁴

The Child Health Plan Plus is a new full-coverage health plan that covers Colorado children and youth age 18 and under living in a financially qualified family who are not eligible for Medicaid (CHP+ is a managed care plan and is not Medicaid). An estimated 83,000 Colorado children are eligible for CHP+. The program covers visits to doctors and clinics for preventative, acute, and specialty care; emergency care; inpatient and outpatient hospital services; prescription drugs; glasses; hearing aids; behavioral and mental health care; family planning and prenatal care; and outpatient substance abuse treatment.

⁴ Description of the Child Health Plan Plus (CHP+) was taken from: Colorado Coalition for the Medically Underserved, *Meeting the Needs of the Medically Underserved: A Plan for Colorado*, 1998.

Benefits are provided by HMOs in 24 Colorado counties and by a fee-for-service network in the remaining counties. Monthly payment amounts and copayments are based on annual income and family size, with federal and state funds used to subsidize premiums.

For more information on CHP+ contact Rose Cantrell, Provider Relations Coordinator at (303) 691-7622 (Denver Metro) or 1-800-359-1991 ext. 7622 (toll-free statewide).

Colorado Uninsurable Health Program (CUHIP)⁵

The Colorado Uninsurable Health Insurance Plan provides comprehensive, full-service health insurance to Coloradans who are denied insurance by private insurers because of pre-existing medical conditions. The plan serves as a health insurer of last resort for individuals and children with a chronic medical condition.

As required by state law which established the plan, premiums are higher than market based rates. Despite this, participants repeatedly cite access to health care without financial ruin as CUHIP's most important benefit.

Any person who has been a resident of Colorado for at least six months and is either a U.S. Citizen or a legally admitted alien is eligible for coverage under CUHIP if he or she can meet one of the following conditions. The person has applied to an insurance company for health insurance and:

1. The application has been rejected or refused because of the health or medical condition of the applicant;
2. The application has been accepted but with a reduction or exclusion of coverage for a period exceeding six months;
3. The person has had health insurance coverage involuntarily terminated by an insurer in Colorado for any reason other than non-payment of a premium or premiums; or
4. The person has one of the medical conditions included on the list of presumptive medical conditions established by the CUHIP Board of Directors.

Persons who are ineligible for CUHIP coverage are those who are eligible for health care benefits under Medicare, Medicaid, or private insurance. For more information on CUHIP contact the Colorado Uninsurable Health Insurance Plan at (303) 863-1960 (Denver Metro) or 1-800-672-8447 (toll-free statewide).

Colorado Women's Cancer Control Initiative⁶

The Colorado Department of Public Health and Environment, Cancer Prevention and Control Program received funds from the Centers for Disease Control and Prevention to develop the Colorado Women's Cancer Control Initiative (CWCCI). The CWCCI pays for breast and cervical cancer screening and some follow-up exams for low income uninsured women 50 years of age and older.

⁵ Description of the Colorado Uninsurable Health Insurance Program (CUHIP) was taken from: Colorado Coalition for the Medically Underserved, *Meeting the Needs of the Medically Underserved: A Plan for Colorado*, 1998.

⁶ Description of CWCCI was provided by and reproduced with the permission of the Colorado Department of Public Health and Environment's Colorado Women's Cancer Control Initiative, 4300 Cherry Creek Drive South, Denver, CO 80222-1530 (303) 692-2505.

Funding is available through the CWCCI on a contractual basis with many agencies and organizations including: private nonprofit, local health departments, hospitals, medical centers and community based organizations. Currently, the CWCCI has \$1.9 million for contracted services and 46 contracts.

Contractors must be able to provide or subcontract for the provision of the following screening services: clinical breast exam, pelvic exam, Pap smear, and screening mammogram. Funds are also available to pay for selected diagnostic services such as diagnostic mammograms, surgical consultations, ultrasounds and some biopsies for screen detected breast abnormalities and colposcopy and repeat Pap smears for screen detected cervical abnormalities. **Women must be screened through the CWCCI to in order to receive diagnostic services through the program.**

The CWCCI requires that data be submitted on program designated forms for all clinical exams including screening, diagnostic, and treatment. The CWCCI will reimburse the contractor on a monthly basis and provide a detailed report of the reimbursement.

Contractors must provide follow-up for women with screen detected abnormalities and referral for further diagnosis and treatment. The CWCCI will assist the provider with tracking and follow-up for women who have screen detected abnormalities and women who are enrolled in the CWCCI will receive an annual screening reminder letter.

Quality assurance standards must be met by all contractors and subcontractors and include the following: mammography providers be certified by the FDA and be in compliance with the Mammography Quality Assurance Standards Act of 1992; cytology

laboratories must be in compliance with the federal Clinical Laboratory Improvement Act of 1998; contractors are required to use nationally accepted guidelines for the follow-up for women with screen detected abnormalities. Copies of follow-up guidelines are distributed to all contractors by the CWCCI.

To receive contractual or additional information about the CWCCI, contact Lori Borelli, Service Administrator at (303) 692-2531.

Essential Community Provider Grants Program⁷

The Essential Community Provider (ECP) Grants Program is designed to assist ECPs in serving the medically indigent population and to identify and implement cost-effective options to expand access to services for the medically indigent population. The ECP Grants Program is funded by legislatively determined allocations of Medicaid Managed Care savings and administered by the Colorado Department of Health Care Policy and Financing. In order to be eligible for the ECP Grants Program, a health care provider must have applied for and been given ECP status. Grants are awarded on an annual basis. Grant applications are released each year as soon as the appropriation for this program is determined by the General Assembly.

Essential Community Providers (ECP) are health care providers that have historically served medically needy or medically indigent patients and demonstrate a commitment to serve low income and medically indigent

⁷ Description of the Essential Community Provider (ECP) Grants Program was taken from: Colorado Coalition for the Medically Underserved, *Meeting the Needs of the Medically Underserved: A Plan for Colorado*, 1998.

populations who make up a significant portion of its patient population or, in the case of a sole community provider, serve the medically indigent patients within its medical capability. In addition ECPs waive charges or charges for services on a sliding scale based on income and do not restrict access or services because of a client's financial limitations.

In order to qualify as an ECP, a health care provider must provide services to medically indigent and low-income patients, who are not eligible for Medicaid through at least one of the following delivery systems: disproportionate share hospital, local county and district health departments, county nursing services, regional health departments, federally qualified health centers, school-based health centers, Family Medicine Residency Training Programs, rural health clinics, state certified Title X family planning agencies, sole community providers, new health care providers, and health care providers.

In addition to meeting these requirements and providing services under at least one of these delivery systems, the health care provider must also waive charges or charge for services on a sliding scale (including copayments) to individuals and families with income at or below 185% of the federal poverty level.

For more information on the Essential Community Provider Grants Program or for information on how to obtain ECP status contact: Carol Reeder, Administrative Program Specialist at the Department of Health Care Policy and Financing (303) 866-3076.

Public Funding Sources: Federal Programs

Medicaid⁸

Medicaid is a joint federal and state program, with the federal government matching state Medicaid dollars. The Colorado Department of Health Care Policy and Financing administers the program. Medicaid is the primary payment source for acute and long-term health care services for about a quarter million of Colorado's low income citizens, including participants in the state's new welfare referral program, Colorado Works. Medicaid coverage includes a broad array of services including physician care, prescription drugs, hospital care, mental health care, long-term nursing facility care, and long-term home and community-based care.

Medicaid covers families with children and pregnant women, the elderly, and people with disabilities if state and federal guidelines are met. Applications for Medicaid are taken through county departments of social services, where eligibility is determined. People who are not U.S. citizens can only get Medicaid if they have a medical emergency. Help from Medicaid is based on the amount of money the household makes and the assets the family possesses. Expanded Medicaid benefits for children provide preventative care such as immunizations, dental care, and early treatment of potentially disabling conditions.

In fiscal year 1997, the Colorado Medicaid program enrolled close to 270,000 people, one-third of whom were elderly or disabled. Colorado Medicaid paid over \$120 million in

⁸ Description of the Medicaid program was taken from: Colorado Coalition for the Medically Underserved, *Meeting the Needs of the Medically Underserved: A Plan for Colorado*, 1998.

1997 in additional reimbursements to hospitals and health centers that provide the highest volumes of care for Medicaid clients and uninsured Coloradans, to enable these agencies to continue to provide uncompensated care.

The Medicaid program reimburses providers at a reduced rate for medically necessary services furnished to enrolled Medicaid clients. Covered services include: physician and clinic services, hospital care, prescriptions, home health care, and mental health services. For more information on Medicaid contact the Colorado Department of Health Care Policy and Financing (303) 866-3513 (Denver Metro) or 1-800-221-3943 (toll-free statewide).

Federally Qualified Health Centers

Colorado has 15 health centers that receive Bureau of Primary Health Care Federally Qualified Health Center (FQHC) grants as Community Health Centers, Migrant Health Centers, or Health Care for the Homeless sites. These 15 health centers operate 84 clinic sites in Colorado. FQHCs are characterized by five essential elements which differentiate them from other providers:

- They are located in high-need areas;
- They provide comprehensive primary health care services to their patients;
- Their services are available to all residents of their service areas, with charges based upon ability to pay;
- They are governed by community boards, thus ensuring their accountability and responsiveness to local needs; and

- They are non-profits or public agencies with a mission to provide health care to the medically underserved.⁹

Federally Qualified Health Centers serve areas that are designated as Medically Underserved Areas (MUAs) or Medically Underserved Populations (MUPs). An MUA/MUP:

- Has higher than average rates of poverty;
- Has higher than average rates of infant mortality;
- Has more elderly persons than average;
- Has significant shortages of primary care providers; and
- Is designated as an MUA/MUP by the federal government (although State governors can request designation as well).¹⁰

Federally Qualified Health Centers must provide or arrange for the provision of at least the following services:

- Primary health care by physicians (family practice, pediatrics, general internal medicine, and obstetrics) and mid-levels (physician assistants, nurse practitioners, and nurse midwives);
- Maternity care for pregnant women (prenatal, delivery, and postpartum care);
- Preventative, developmental, diagnostic, and treatment services for infants and children (including immunizations, well-child care, etc.);

⁹ Information on FQHC requirements provided by and reproduced with the permission of Colorado Community Health Network (CCHN), 800 Grant St., Suite 505, Denver, CO 80203, (303) 861-5165.

¹⁰ Information on MUAs and MUPs provided by and reproduced with the permission of Colorado Community Health Network (CCHN), 800 Grant St., Suite 505, Denver, CO 80203, (303) 861-5165.

- Adult preventative services (Pap smears, glaucoma screening, breast and colon exams, etc.);
- Diagnostic laboratory and radiology services;
- Emergency care for minor trauma;
- Pharmaceutical services;
- Patient case management (including, as appropriate, outreach, counseling, referral for specialty care, and follow-up);
- As necessary, translation services if a substantial portion of patients speak little or no English;
- After hours care on a 24-hour basis;
- Coordination of and follow-up for hospital care and admitting privileges for FQHC physicians at local hospitals; and
- Additional optional services based on patients' needs, such as home health, mental health care, or health education.¹¹

FQHC services must be available to all service area residents regardless of their ability to pay, and:

- FQHCs must accept Medicaid by law, and are reimbursed for 100% of their reasonable costs for Medicaid services. In Colorado, FQHCs may receive a combination of capitation and fee for service payments for Medicaid patients. The average Medicaid reimbursement rate for Colorado FQHCs is \$90.00 per visit.
- FQHCs must accept Medicare by law and are reimbursed on a reasonable cost basis.

¹¹ Information on FQHC required services provided by and reproduced with the permission of Colorado Community Health Network (CCHN), 800 Grant St., Suite 505, Denver, CO 80203, (303) 861-5165.

- If patients have private insurance, the insurance company will be billed for covered services.
- For uninsured patients, FQHCs must use a sliding fee scale based on income and family size. Services are not provided for free, although arrangements for payment can be made.
- Colorado state programs for the uninsured also provide revenues for FQHCs, including the Colorado Indigent Care Program, or CICIP, the Child Health Plan Plus (CHP+), and the Colorado Uninsurable Health Insurance Program (CUHIP).¹²

To ensure that FQHCs remain community-responsive health care systems, each FQHC must:

- Be a local, private nonprofit corporation or public agency; and
- Be governed by a Board of Directors, a majority of whose members must be registered, active patients of the CHC and who, as a group, are representative of the patients served.¹³

The Bureau of Primary Health Care (BPHC) is part of the Health Resources and Services Administration, one of eight agencies of the Public Health Service in the federal Department of Health and Human Services. The BPHC provides leadership in promoting access to primary health care for medically underserved populations, including those

¹² Information on FQHC client services and fees provided by and reproduced with the permission of Colorado Community Health Network (CCHN), 800 Grant St., Suite 505, Denver, CO 80203, (303) 861-5165.

¹³ Information on FQHC governance provided by and reproduced with the permission of Colorado Community Health Network (CCHN), 800 Grant St., Suite 505, Denver, CO 80203, (303) 861-5165.

with special needs, such as the homeless and people with or at risk for HIV infection. Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and the Public Housing Primary Care Program build primary care infrastructure by establishing systems of health care, coordinated with social support services. They provide comprehensive, family-oriented primary health services to medically underserved, disadvantaged populations experiencing financial, geographic, or cultural barriers to care.¹⁴

Community Health Centers, Migrant Health Centers, Health Care for the Homeless, and Public Housing that receive BPHC grants are automatically eligible for a cost-based reimbursement rate from Medicare and Medicaid, under the Federally Qualified Health Center (FQHC) program. The BPHC also reviews applications from centers seeking to qualify as FQHC "look alikes" because they meet the statutory requirements for these programs but do not receive BPHC grant funding.¹⁵

For more information on Federally Qualified Health Centers in Colorado and funding opportunities from BPHC contact the Colorado Community Health Network (CCHN). CCHN is the state association of Community Health Centers and provides a number of services for FQHCs.

Colorado Community Health Network
800 Grant Street, Suite 505
Denver, CO 80203
(303)861-5165

Annette Kowal, Executive Director
Jennifer Miles, Associate Director

¹⁴ Description of the Bureau of Primary Health Care taken directly from www.medaccess.com

¹⁵ Taken from the Bureau of Primary Health Care website at www.bphc.hrsa.dhhs.gov

National Health Service Corps¹⁶

The National Health Service Corps (NHSC) is a program of the Federal Health Resources and Services Administration's Bureau of Primary Health Care. The mission of the NHSC is to assist underserved and vulnerable populations through the development, recruitment, and retention of community responsive, culturally competent primary care clinicians dedicated to practicing in health professional shortage areas.

Health professional shortage areas, or HPSAs, can be found in rural and urban communities across the Nation. HPSA sites are eligible to receive NHSC recruitment and placement assistance. Since 1972, the NHSC has provided more than 21,000 health care clinicians to community-based systems of health care across the Nation. In close partnership with these communities, the NHSC combines resources to best meet the needs of the underserved.

The NHSC encourages health professionals to spend all, or part, of their careers serving the Nation's neediest people. The NHSC offers several programs for students and clinicians to encourage them to serve in HPSAs. The NHSC provides scholarships, fellowships, and mentoring programs to students who are committed to serving the underserved. In addition, the NHSC offers loan repayment assistance to clinicians who choose to serve at eligible sites.

The Federal Government designates areas of the country as having practitioner shortages if a minimum number of specified criteria are met. Primary medical, dental and mental

¹⁶ Information concerning the National Health Service Corps and health professional shortage areas is taken directly from the Bureau of Primary Health website at www.bphc.hrsa.dhhs.gov

health HPSAs are defined by the following criteria:

- The geographic area involved is rational for the delivery of health services;
- A specified population-to-clinician ratio representing shortage is exceeded within the area; and
- Resources in contiguous areas are over-utilized, excessively distant or otherwise inaccessible.

If a geographic area does not meet the shortage designation criteria but a population group within the area has access barriers, a population group designation may be appropriate. In some cases, individual

facilities may be designated as HPSAs. To be designated as an HPSA, an application must be submitted to the Division of Shortage Designation. For more information on HPSAs contact: Division of Shortage Designation, Bureau of Primary Health Care, 4350 East-West Highway, Room 9-1D1 Bethesda, MD 20814 (301) 594-0816; the Colorado Primary Care Office (303) 692-2478; or the Colorado Community Health Network (303) 861-5165, ext.35.

For more information on the National Health Service Corps and its recruitment and retention services contact the NHSC website at: <http://www.bphc.hrsa.dhhs.gov>

GRANTWRITING¹¹

For many informal groups and formal organizations, approaching foundations for funding can be a confusing and frustrating process. In addition, as government funding dwindles and operational costs inflate, competition for funding becomes more intense. Although your program may be an excellent program essential to meeting community needs, this does not mean that it will automatically obtain funding. To ensure that their funding requests get considered, programs must rigorously research potential funding sources and their organizations.

Conducting Research

The first step in seeking funding is to locate funding organizations whose missions closely match the mission of your program. It is important, however to remember that each funder is distinct. Each has its own mission, strategies, funding priorities, rules, regulations, and deadlines. For example, many funding organizations only accept applications through a Request for Proposal, or RFP, process. Therefore, it is essential to understand the funder's organization before you approach them.

To compile a list of potential funding sources, consult a grants guide or directory that provides information on funders who make grants in areas related to your work. The best source for information on funding sources in Colorado is the *1999-2000 Colorado Grants Guide*. Published by the Community Resource Center, the *Grants Guide* provides information on over 200 entities that provide funding to Colorado organizations. Contact the Community Resource Center, 1245 E. Colfax Avenue, Suite 205, Denver, CO 80218, 303-860-7711.

Another good resource on funding sources in Colorado is the *1998-1999 Colorado Foundation Directory* published jointly by

the Community Resource Center and the Junior League of Denver. The Directory includes information on over 175 private and community grant-giving foundations. Contact the Junior League of Denver at 303-782-9244.

During your research, you should begin compiling a list of funders who make grants in areas related to your work. Be sure you have information on the funder's specific requirements, including: application forms, deadlines, supporting materials needed, address, and phone and fax numbers.

Once you have a list of potential funding sources for your program and some general information about their requirements, you should make initial contact with the organization. Call or write the organization and request additional information that will help you know more about their organization and help you decide if there is a close fit between your project and their mission. Documents that can inform your decision include: annual reports, brochures, and application packets.

When you find that a funder's mission is a good match for your project, you should start thinking about approaching the funding organization. Most funding organizations

¹¹ Information in this section from Robert F. Long and Joel J. Orosz, *Approaching the Foundation*. A Kellogg Foundation Resource from www.wkkf.org.

receive many more proposals than they can fund each year. It is important to make your proposal stand out from others. One way to do this is to directly address the proposal to the most appropriate program staff person in the organization. To find out who the key staff person responsible for project development in the appropriate area is, call the organization. You should briefly describe your project to the person who answers the phone and ask them who the most appropriate staff person would be.

After you have identified the key staff person associated with your type of project, talk with this person about your project and appropriate next steps. This initial contact begins your relationship with the funder and introduces your project to the organization's staff. To find out the best approach for each funder, be sure to ask the staff person about procedures and preferences for communications. It is extremely important to follow the funding organization's rules, procedures and deadlines.

The "Pre-Proposal"

Now you are ready to send a brief "pre-proposal" to the funder. Do **not** send a full proposal to start with. In the pre-proposal, it is important to be as brief as possible. A two or three page pre-proposal will help the staff person decide if your project complements the funding organization's mission. If the staff person agrees that the project matches, then a full proposal will be requested.

The pre-proposal should contain a brief, concise statement of the problem. Do not include a long, drawn-out statement; most program staff are familiar with the problems in their area of interest. The most important component of the pre-proposal is an explanation of what your project will do

about the problem. You should include two to three paragraphs that specifically explain how your project plans to solve the problem. Be sure you explain how your project will be managed, including implementation steps and timelines.

It is important to include information on how the project will be sustained. In one or two paragraphs, you should tell the funder how your project plans to sustain itself after the organization's funding ends, including plans you have for seeking funding from other sources to continue your project.

Next, you should explain in a paragraph how you intend to evaluate the results of your project. The evaluation plan should present what your organization wants to learn and how you will use the evaluation information to improve upon and sustain the project.

The last section of the pre-proposal should be a simple budget. The budget should have five or six line items and should tell the funder exactly how you plan to spend their money. The budget line items should correlate to the activities you delineated earlier in the pre-proposal.

The brief, concise pre-proposal is not intended to tell the organization everything about your project, but it should give the program staff a clear enough picture of your project to help them decide if your project matches with their organization's mission. If the pre-proposal catches a staff person's eye, more information, a full proposal, and, possibly, a site visit will be requested. At that time, the program staff person will be informed enough about your project to offer any assistance you need in developing the full proposal.

Proposal Checklist

There are several items that funders look for in almost every proposal:

- ✓ **A New Approach:** The project should demonstrate and incorporate knowledge and awareness of the strengths and weaknesses of past and current approaches to the problem.
- ✓ **Knowledge of the Funding Organization:** The applicants should be able to persuasively demonstrate a close match between the project and the funding organization's mission.
- ✓ **Commitment and Determination:** The applicants should display a commitment to the project and should show that they are determined to carry through with the project with or without the funding organization's money.
- ✓ **Improving the Lives of People:** Funding organizations prefer to help projects that directly improve the lives of people, not the size and strength of organizations.

- ✓ **Investing Your Own Money:** The applicants should tell how they are investing their own money in the project. This not only demonstrates a commitment to the project, but also shows how the project can sustain itself.
- ✓ **A Comprehensive, Collaborative Approach:** Usually, complex problems are not solved simply. Applicants should show the funding organization that they understand the complexity of the problem and are willing to work collaboratively with anyone to solve it.
- ✓ **Project Sustainability:** Funding organizations like to help projects that are, or have the potential to become, so important to the community that they continue after the grant period has ended.

Getting Help: Volunteer Recruitment and Management

For many community programs, volunteers play a key role in the evolution and maintenance of their services for the medically underserved. Some programs initially rely on volunteer providers, administrators, and staff but gradually replace volunteers with paid staff as the program evolves. Other programs remain volunteer-based and provide most of their services through volunteers. Still others use a healthy combination of both volunteer and paid staff to deliver services. The following section highlights key themes in the literature of volunteer recruitment and management offering advice on and pointing out the various issues programs should consider when recruiting and managing volunteers.

Volunteer Recruitment

In order to create a successful volunteer program, organizations must begin with a careful evaluation of the program's needs, goals, mission, and vision. Knowing where your program is and where it wants to be should help define when, where, and how volunteers may be of use in your organization. Before considering recruiting volunteers, organizations should fulfill the following tasks:

- Determine objectives and strict goals
- Define the purpose of the group
- Identify who the beneficiaries are
- Identify what tasks need to be performed
- Delineate the mission of the organization
- Agree upon future goals
- Decide what constitutes success for the organization

Once the organization has a clear picture of itself, it can begin to construct a volunteer

program. It is important to lay the groundwork for your volunteer program by making certain that the following elements are in place.¹

- A clearly defined and understandable goal for the volunteer program
- Clear plans of actions and objectives
- Clear job descriptions
- A clear organizational chart of jobs
- Well defined tasks
- Trained, equipped supervisors
- Easy-to-follow reporting methods
- Assessment criteria and methods based on the tasks to be accomplished
- A plan for recognizing and rewarding good work
- A plan for redirecting inadequate work
- Trained interviewers

¹ Steve McCurley and Sue Vineyard, *101 Tips for Volunteer Recruitment*. Downers Grove, IL: Heritage Arts Publishing, 1988, 22.

- A real need for volunteers
- A positive and respectful attitude toward volunteers

These elements will form the core of your successful volunteer program. Now that the structure has been established, you can begin considering your potential volunteers.

What Volunteers Are Best for Your Organization?

A clear idea of specific tasks and job designs is necessary because the needs of your organization will help to define what type of worker will be right for your volunteer position. A general list of qualification to consider is included below, but only your organization can determine specific qualifications for individual volunteer positions.

- Education
- Skills
- Experience
- Amount of time able to donate
- Motivational needs
- Personal qualifications the volunteer must bring to the job (i.e., physical, mental, emotional strengths, specific personality types, etc.)

About Your Future Volunteers: A Few Points to Remember

Sometimes the word "volunteer" may imply negative meanings. For example, it may connote someone in a second-class position who is unable or unworthy of being employed in a paid job. Some of these misperceptions may be dispersed by a change in language. Alternate terms such as "community service," "*pro bono* work," "activism," "public service," and "donor"

may sound more attractive to the potential volunteer.²

Volunteer is a pay category, not a function.³ It is necessary to prepare job descriptions and provide a title for volunteer positions. This serves two important functions: it helps the potential volunteer determine whether or not the job is right for him or her and clearly states the organization's expectations of the worker.

Recruiting

In order to best recruit volunteers and ultimately create a satisfied body of workers, the organization must identify what motivates its volunteers and thus accommodate their special needs. There are some general motivations to appeal to in volunteer recruitment campaigns.⁴ In general, volunteers are motivated by the prospect of:

- Accomplishing satisfying work
- Being a role model
- Being needed
- Bettering the community
- Building self-confidence
- Changing the world
- Empowering others
- Experiencing different life-styles
- Fulfilling a tradition
- Gaining academic credit

² Susan J. Ellis *The Volunteer Recruitment (and Membership Development) Book*. Philadelphia: Energize Inc., 1996, 34-35.

³ Susan J. Ellis *The Volunteer Recruitment (and Membership Development) Book*. Philadelphia: Energize Inc., 1996, 16.

⁴ Steve McCurley and Sue Vineyard. *101 Ideas for Volunteer Programs*. Downers Grove, IL: Heritage Arts Publishing, 1986, 21-22.

- Gaining recognition
- Gaining work experience
- Giving back what you have gotten
- Helping
- Helping others
- Influencing others
- Learning new skills
- Learning responsibility
- Making professional contacts
- Meeting new challenges
- Meeting people
- Putting faith into action
- Sharing time with peers and community
- Showing that you care
- Staying active
- Trying out a new career
- Using natural talents or
- Utilizing untapped educational skills

Theories on Personal Motivation

By matching the job with the needs of the volunteer, the worker will be more successful and the organization will benefit. A few important psychological studies have been conducted which provide some insight into why people volunteer and how the organization may best match the volunteer to a specific job.

Abraham H. Maslow identified five different levels of human needs which motivate a person to perform any task.⁵ The levels are hierarchical, thus the lowest level

⁵ First published by Abraham Maslow in 1954 (*Motivation and Personality*: New York: Harper and Row, this idea is reprinted in most books on volunteer motivation. This adaptation was derived from Steve McCurley and Sue Vineyard, *101 Tips for Volunteer Recruitment*. Downers Grove, IL: Heritage Arts Publishing, 1988, 14-15.

must be fulfilled before a person will move on to the next stage.

1. Physiological Needs: Acquiring those things necessary for basic bodily functioning.
2. Safety Needs: Acquiring those things necessary for the safety of body and properties.
3. Social Needs or Need for Love: Ability to create and sustain relationships.
4. Esteem or Status Needs: Achieving accomplishments recognized by their peers and community.
5. Need for Self-Actualization: Finding an outlet for talents, creativity, and benevolence.

Volunteer recruiters may employ these ideas in their search for volunteers and in the types of duties they ask volunteers to perform. A correlation may be made between the motivation for an individual volunteer and the type of job he or she is employed to perform. For example volunteers trying to fulfill physiological needs will benefit from a free meal or climate controlled setting. The volunteer who seeks safety can learn skills to help them get a paid job or a higher level of education. Social needs may be met by the volunteer meeting new people, building personal and community relationships, and being recognized as a part of an organization. The volunteer who seeks esteem can receive recognition among peers and the community and feel personally rewarded. Self-actualization is fulfilled when the volunteer can use talents, be creative, and be challenged.

Another theory of personal motivation has been constructed by David MacClellan and John Atkinson.⁶ This three-fold model describes the desires for achievement, affiliation, and power in order to achieve a feeling of personal success. Below is a description of how these may be translated into task-oriented skills for a successful volunteer.

1. The "achievement" person needs specific goals, specific instructions, challenges, and outlets for problem-solving and, thus, is suited for jobs such as research and analysis, fund-raising, reports, and leadership positions.
2. The "affiliation" person needs relationship opportunities, a contented work environment, and personal interaction. This person is suited for work on committees, social work, recognition events, and the like.
3. The "power" person needs influence, position, and to have an impact on others and, therefore, is well-suited to public-speaking, fundraising, problem solving, and heading committees or projects.

Screening Applicants

It is extremely important to nominate someone in your organization to recruit and interview applicants. A successful recruiter has these qualities:⁷

- Ability to care about people
- Communication skills

⁶ Steve McCurley and Sue Vineyard. *101 Ideas for Volunteer Programs*. Downers Grove, IL: Heritage Arts Publishing, 1986, 16-17.

⁷ Steve McCurley and Sue Vineyard, *101 Tips for Volunteer Recruitment*. Downers Grove, IL: Heritage Arts Publishing, 1988, 33.

- Comprehensive knowledge of organization
- Creativity
- Flexibility
- Good interviewing skills
- Open-mindedness and fairness
- Organizational skills
- Persuasiveness
- Positive attitude
- Skills in bargaining and negotiation
- Understanding of recruitment methods

*...and the best volunteer recruiter is a satisfied volunteer.*⁸

Some Practical Pointers for the Screening Process

The interview will allow the organization to determine the usefulness of the applicant and the applicant to determine whether or not the job is right for them. A successful screening process begins before the actual one-on-one interview; a simple job application can help you decide who is qualified for the position and whom you should invite for a personal interview. The volunteer job application should include the following:⁹

- Agency name, address, and phone number
- Supervisor
- Job title
- Job description
- Anticipated results of the job

⁸ Steve McCurley and Sue Vineyard, *101 Tips for Volunteer Recruitment*. Downers Grove, IL: Heritage Arts Publishing, 1988, 34.

⁹ Steve McCurley and Sue Vineyard. *101 Ideas for Volunteer Programs*. Downers Grove, IL: Heritage Arts Publishing, 1986, 11.

- Time parameters of the job
- Qualifications
- Responsibilities
- Benefits
- Training requirements
- Contact person for job
- Volunteer work site
- Evaluation requirements for the job

After reviewing the applications, checking any references, and checking for valid driver's license, etc. when required, you may begin interviewing those applicants who meet the organization's qualifications.

Avoid recruiting every person who interviews; it is better for the volunteer and for your agency to employ only someone really suited for the job. When finding it necessary to turn down a volunteer applicant, it is best to state the reasons in a positive manner. Some possible ways to say no include expressing to the applicant that you think the job is not suited to him, that the job she is best qualified for is already filled, or suggest another organization which might be able to use the volunteer's skills.

Once the Volunteer Is Hired¹⁰

- Keep a file on each volunteer
- Review the job description, set a clear list of responsibilities, draw up a written agreement including work schedule, supervision, and types of training required

¹⁰*The Volunteer Toolbox: Visions for Improving the Service of America's Counties.* Washington DC: National Association of Counties, 1990, 51-52.

- Provide a copy of the agreement to the volunteer; keep an original in file

Volunteer Management

To keep volunteers satisfied and to ensure that your volunteers are successful, it is important to remember that volunteer jobs:

- Must be a complete and identifiable task
- Must be perceived by the volunteer as worthy of their time and effort
- Should allow the worker to take responsibility for the task and its decision-making process
- Should give a measure of feedback by its completion
- Should give some reward for the effort required

Create a Procedure and Policies Manual for Volunteers¹¹

Each volunteer should be aware of your organization's policies and procedures. The policies and procedures manual should include:

- Allowances for absences
- Attendance requirements
- Benefits
- Confidentiality policies
- Continuing education opportunities
- Dress code
- Expense reimbursement
- Guidelines for equipment and facilities use
- History of agency

¹¹ McCurley, Steve and Sue Vineyard. *101 Ideas for Volunteer Programs.* Downers Grove, IL: Heritage Arts Publishing, 1986, 12.

- Individual job description
- Insurance coverage
- Notice of time off
- Organizational chart
- Phone directory and staff list
- Performance evaluation procedures
- Resignation and termination procedures
- Procedure for voicing grievances
- Requirements for record-keeping
- Risk management procedures
- Tardiness policy
- Timeline of year's events and tasks

Training Volunteers

The importance of thorough training cannot be overstated. A well-trained volunteer will be a better asset to your organization and will have more confidence and pride in the job. An orientation session which explains the workings of the organization not necessarily specific to the volunteer's tasks is also important; it fosters feelings of membership in the organization and importance in its greater mission.

Retaining Volunteers

The organization must provide recognition for good performance. A simple thank you as well as an expression of appreciation and satisfaction with a job well-done is always necessary. Further, sometimes organizations will hold special dinners or receptions for the volunteer staff, give out awards, and promote the volunteer both in title and in level of responsibility. It must be remembered that there is no monetary reward, thus the worker is performing these tasks for some sort of personal need for recognition.

In order for the volunteer to be satisfied with the organization and for the organization to be satisfied with the volunteer, it is a good idea to provide routine evaluations, both of the volunteer's performance and of the volunteer's input about their work environment.

There are some things volunteer programs and managers should never do.

Never:

- Ask a volunteer to do something you would not do or do not believe in
- Sign up volunteers who are not appropriate just to have more bodies on staff
- Limit a volunteer's effectiveness by not providing adequate training or facilities
- Ask salaried employees to work with volunteers if you will not
- Ignore the rights and needs of your volunteer staff
- Offer volunteers opportunities or benefits that you cannot deliver
- Waste a volunteer's time

***Supervising Volunteers Successfully*¹²**

- Treat volunteers fairly
- Know your volunteers by name
- Keep personal beliefs to yourself
- Do not interfere in the volunteer's personal life
- Encourage the worker

¹² *The Volunteer Toolbox: Visions for Improving the Service of America's Counties*. Washington DC: National Association of Counties, 1990, 52-54.

- Recognize the volunteer's accomplishments
- Care about your volunteers
- Handle any problems or concerns immediately
- Offer an opportunity for growth and advancement

When Problems Arise With a Volunteer

The first step taken should be a review of the goals of the organization and the volunteers responsibilities within its operation. This also provides an opportunity for the volunteer to voice his own ideas about the problem. If this does not satisfactorily resolve the problem, the volunteer manager may attempt to find a more suitable position for the volunteer. If no resolution can be found the manager may find it necessary to dismiss the volunteer.

*Guidelines for Dismissing a Volunteer:*¹³

- Inform related staff of the decision
- Meet with the volunteer in a private setting
- State the purpose of the meeting
- Delineate the expectations of the job
- Identify how the volunteer did not meet those expectations; cite specific examples
- Allow the volunteer to respond
- Compliment the positive qualities brought by the volunteer
- Release the worker from his or her responsibilities without reprimand or apology
- Document the meeting and the final decision and
- Dismiss only as a last resort

¹³ *The Volunteer Toolbox: Visions for Improving the Service of America's Counties.* Washington DC: National Association of Counties, 1990, 63-65.

Readings on Volunteer Recruitment, Management & Retention

Battle, Richard V. *The Volunteer Handbook: How to Organize and Manage a Successful Organization*. Austin, TX: Volunteer Concepts, 1988.

Practical and easy-to-read, this handbook includes organizational tips for volunteer program administration both in the planning stages and financial management. Also included are comprehensive training and volunteer management sections.

Brudney, Jeffrey L. *Fostering Volunteer Programs in the Public Sector: Planning, Initiating, and Managing Voluntary Activities*. San Francisco: Jossey-Bass Publishers, 1990.

This book provides valuable information on economic considerations in running a volunteer organization and includes chapters on recruitment, management, and retention of volunteers.

Ellis, Susan J. *The Volunteer Recruitment (and Membership Development) Book*. Philadelphia: Energize Inc., 1996.

A good handbook that includes a great deal of advice on how to market the organization's volunteer positions as well as examples of successful brochures, etc. Ellis also provides worksheets to help design a new program in both its planning and recruitment stages.

Harris, Margaret and David Billis. *Organising Voluntary Agencies: A Guide through the Literature*. London: Bedford Square Press, 1986.

This guide is an excellent bibliographic source including thorough abstracts of journal articles and books published in the field of voluntary action.

McCurley, Steve and Sue Vineyard. *101 Ideas for Volunteer Programs*. Downers Grove, IL: Heritage Arts Publishing, 1986.

_____. *101 Tips for Volunteer Recruitment*. Downers Grove, IL: Heritage Arts Publishing, 1988.

Both of the above books are extremely useful workbooks, easy-to-read, illustrated with instructive charts, and comprehensive in content. The authors have included step-by-step guides for starting and managing successful volunteer programs.

McSweeney, Phil and Don Alexander. *Managing Volunteers Effectively*. Great Britain: Arena, 1996.

This book on volunteer management focuses on the managers' responsibilities and emphasizes how to get the most out of their volunteer staff.

The Volunteer Management Handbook. ed. Tracy Daniel Connors. New York: John Wiley and Sons, Inc., 1995.

This handbook is a compilation of essays by the experts in the field: professors of management, consultants in volunteer work, professionals working in non-profit agencies, etc. The editors included sections on volunteer development, volunteer management, and laws governing such organizations.

The Volunteer Toolbox: Visions for Improving the Service of America's Counties. Washington DC: National Association of Counties, 1990.

This useful tool brings together a representative collection of documents and tips compiled by the National Association of Counties Task Force on County Volunteerism in America. The book provides solid advice and includes actual forms used in volunteer agencies, such as pamphlets, applications, reports, surveys, etc.

Competencies for Serving the Medically Underserved

Patients' cultural and ethnic backgrounds can influence perceptions of pain and urgency, definitions of appropriate treatment, and the ability and propensity to follow treatment plans. Additionally, there may be language barriers that seriously impede communication. It has become increasingly evident that a one-size fits all method of health care delivery no longer provides optimum results in a multi-cultural environment. Providing services to the medically underserved involves understanding issues of class, ethnicity, race, and gender and how these characteristics can impact the patient-provider relationship. This chapter focuses on the issues that medical providers are most likely to encounter when caring for the medically underserved.

An important part of providing medical services to the medically underserved is understanding the unique cultural characteristics that these patients may bring with their physical symptoms that make them different from their providers. Patients may differ culturally from their providers in many ways:

- Financially
- Ethnically
- Racially
- Socially

Patient, Providers, and Culture

There are two main ways to address cultural differences between patients and providers. First, it is important for providers to understand the culture that they bring to the medical environment and how it can impact their attitudes and actions toward their patients. After recognizing these potential influences, providers need to know what steps can be taken to minimize the impact of these differences. Second, providers must understand how patients' cultural

backgrounds can influence their behavior in relation to their medical condition and other factors that providers need to be aware of when creating treatment plans for their patients. By understanding the patient-provider relationship from both perspectives, both patients and providers will be more satisfied with their treatments and outcomes.

Providers and Culture

It's important for providers to understand that their own culture can impact their interactions with their patients. There are key points that are important for providers to remember when dealing with patients from diverse cultures.¹

- **Definitions of "health" may differ for peoples of diverse cultures.**

Our definitions of "health" and "healthy" are influenced by the health of those around us, our standards of

¹ Adapted from Gorrie, M. (1989). Reaching Clients through Cross Cultural Education. *Journal of Gerontological Nursing*, 15 (10), 29-31.

living, and our expectations. Patients' standards should not automatically be considered low just because they differ from a typical middle-class standard.

- ***Similarly, it is important to realize that there may be differences in caring behaviors between cultures.***

Differences in the behaviors of family members, for example, may reflect cultural norms rather than a lack of concern.

- ***Education programs for health care providers can help bridge the cultural divides between care givers and patients.***

These programs can be general, covering many cultures, or they may be directed specifically at the culture or cultures that the providers deal with most frequently. It is also important for these educational efforts to include sessions in which providers are able to share their experiences in working with patients of diverse cultures with others to create an environment in which the community becomes aware of potential problems and works to create solutions together.

- ***Education programs have been shown in practice to make providers and patients more comfortable and satisfied with the level of care provided.***

By preparing providers for the cultural differences they may encounter in the field, they are better able to be proactive, rather than

reactive, facilitating the provision of the ideal of "holistic" care, which encompasses both the patient's physical and emotional well-being. By avoiding potential misunderstandings created by cultural differences, providers can create more trustful and productive relationships with their patients.

- ***Education programs have been shown to facilitate a questioning attitude toward patients' behavior and attitudes, which creates a more open and beneficial healing environment.***

Encouraging providers to understand their patients' behaviors through open communication helps them to overcome their fear of differences and provide more individualized care. Providers will earn greater respect and cooperation from patients who feel that they have been treated as unique individuals.

Patients and Culture

Providers must understand that there are many specific areas in which they may differ from their patients from diverse cultures. These differences can lead to misunderstandings and difficulties in carrying out treatment orders. Some of the most common behaviors and areas that may not be viewed the same way by care providers and patients include:

- ***Touch***
While for many patients, the touch of hand may be comforting in times of stress, in some cultures touching, especially between members of the

opposite sex, may be inappropriate and cause more stress than it alleviates. Awareness of cultural norms about physical contact can help caregivers to avoid making mistakes in already difficult situations.

- **Food**

Some cultures and religions prohibit eating certain foods. Sometimes these cultural prohibitions will conflict with the treatment plans created by the caregivers, giving the impression that patients are uncooperative. An understanding of common dietary restrictions can help providers create appropriate treatment plans from the beginning to help ensure continuity of care.

- **Family**

In our culture, we tend to place the responsibility for decision-making upon the individual whose health is in question. However, in some cultures decision-making is considered a family responsibility, or may be assigned by gender and age. Therefore it is important to understand that some patients from diverse cultures will be uncomfortable making certain decisions without assistance and input from other family members.

- **Roles and Responsibilities**

Patients of diverse cultures may feel that the responsibilities they have based on certain roles they play within their families and communities outweigh their responsibility to their own health. These attitudes may translate into a

feeling that one's role as primary earner or childbearer, for example, takes precedence over certain things that a health provider considers important. Caregivers must understand the importance of culturally defined roles when helping patients make decisions regarding their health, particularly when creating plans for health maintenance and illness management.

- **Sources of Stigma**

Certain health services, such as mental health services, carry even greater social stigma for patients of diverse cultures. Providers need to be aware that patients may report physical symptoms when in actuality they are suffering from psychological symptoms. Some cultures are also very sensitive to certain issues such as terminal illness and infertility. Understanding the cultural meanings of certain diseases and conditions will help providers to better understand patients' reactions to their diagnoses and help them to deal with their conditions.

- **Unique Experiences**

Especially for patients who are recent immigrants to this country, patients of diverse cultures have often had experiences, sometimes traumatic, that are quite foreign to the experiences of their caregivers. These experiences could involve refugee experiences, war, illegal entry, and persecution in their country of origin. Additionally, patients from this country who have

lived in poverty may have very different experiences from their providers. All of these experiences can influence patients' reactions to medical intervention. Potentially uncomfortable and unproductive situations can be avoided by understanding patients' previous experiences outside of the clinic environment.

Ways to Prepare Your Practice for Patients of Diverse Cultures

There are many ways that providers of services for the medically underserved can prepare their staff and practices to provide the best services for these unique populations. By creating an atmosphere that is receptive and sensitive to their patients' special needs, these practices will help to ensure the highest standard of care. The following elements are essential to the practice devoted to caring for the medically underserved.²

- ***Hire a well-trained bilingual staff or medically prepared interpreters.***

The language barrier can be the first and most difficult barrier to providing complete and appropriate care. Unfortunately, family members are often called upon to translate technical medical terms with which they may be unfamiliar. Using family members to interpret can also place them in extremely difficult situations in which they must communicate serious and/or disturbing news. Given that children must often serve as

²Adapted from Moffic, H.S., & Kinzie, J.D. (1996). The History and Future of Cross-Cultural Psychiatric Services. *Community Mental Health Journal*, 32 (6), 581-592.

interpreters for their adult relatives in these situations, having bilingual staff or interpreters is of the utmost importance to spare them from bearing the burden of relaying such important and often technical information.³

- ***Clients are often best served by practices that provide for multiple health care needs.***

For example, having mental health services provided at the same location as physical health services may serve to reduce the stigma attached to seeking assistance for psychological distress. Also, the medically underserved may have limited resources for traveling to the practice, providing for childcare, or leaving work. Providing multiple services in one location will make for less disruption to clients' lives and help ensure that they are able to obtain the full range of services they need.

- ***The physical location of the practice should be convenient to the largest portion of the patient population as possible to minimize the resources clients must devote to getting to the practice.***

Additionally, the physical environment should be made as similar to a private provider's office as possible to reduce the stigma that patients may feel. Medically underserved clients should never be made to feel that they stand out as different from a "regular" patient.

³Haffner, L. (1992). Translation is Not Enough: Interpreting in a Medical Setting. *Western Journal of Medicine*, 157 (3), 255-259

The comforts typically offered to private patients, such as warm and inviting waiting room with toys and books for children, should also be considered important for medically underserved clients to help convey their importance to the practice.

- ***Development of meaningful relationships with clients will help to bring other clients to the practice through reputation and word-of-mouth.***

Likewise, successful practices will be sensitive to their community's needs and will strive to maintain a dialogue with community members to ensure the most needed services are provided and so that community members will realize their importance to the success and well-being of the practice. Creation of patient advisory boards, when feasible, will go a long way toward fostering a community-practice relationship.

- ***Provide as many different services as feasible within the financial, human, and physical resources of the practice.***

Inclusion of other services often used by the medically underserved such as social services, rehabilitation services, and educational services will maximize the successes begun in the medical and mental services portions of the practices. Creating one environment in which many different health services are provided will reduce the number of new and stressful situations that patients of diverse cultures must face in their quest for adequate care.

Understanding that patients are important individuals with unique experiences that influence their health and behavior will help health care providers to create the best environments that are the most conducive to health and well-being. Preparing health care staff for the differences they will encounter between their own and their patients' cultures will help them to provide the most appropriate care and services from the very beginning. Patients will be more likely to seek medical care in an environment in which they feel respected as human beings of equal status.

Readings on Competencies for Serving the Underserved

Bell, Karen and Linda Simkin. *Caring Prescriptions: Comprehensive Health Care Strategies for Young Children in Poverty*. New York: National Center for Children, 1993.

This book focuses on the primary health care needs of infants and children who live in poverty and strategies for dealing with their special physical and emotional needs.

Blount, Alexander. *Integrated Primary Care: The Future of Medical and Mental Health Collaboration*. New York: Norton, 1998.

Blount stresses the importance of integrating mental and physical health care services as the best method for resolving health crises. This book includes a special emphasis on developing and implementing integrated health care programs.

Diaz-Gilbert, M. *Communicating Effectively with Hispanic Patients: The Complete Guide to Key Vocabulary Words and Essential and Functional Phrases in Spanish for Direct Patient Contact*. Haddonfield, N.J.: Intercultural Communications Publishing Corp., 1991.

_____. *English and Spanish: Medical Words and Phrases*. Springhouse, PA: Springhouse Corporation, 1994.

Both books cover the essential vocabulary needed to provide adequate health care to Spanish-speaking patients. Both guides go beyond the dictionary format by providing common phrases often needed by health care providers.

Ewalt, Patricia. *Multicultural Issues in Social Work*. Washington, D.C.: National Association of Social Workers Press, 1996.

Ewalt deals with multiculturalism from an advocacy point of view and includes sections on health care and service delivery. This book covers the most common racial and ethnic groups found in the U.S., such as African Americans, American Indians, Asians, Latinos, and Pacific Islanders, as well as cultures defined by location or standard of living.

Galanti, G.A. *Caring for Patients from Different Cultures: Case Studies from American Hospitals*. Philadelphia: University of Pennsylvania Press, 1991.

This book covers topics such as communication, pain, religion, dietary practices, birth, death, family, gender relations, and folk medicine among culturally diverse patient populations. Galanti focuses on how to avoid common problems encountered in multicultural health care settings by providing analyses of cases studies.

Giger, J., and R. Davidhizar. *Transcultural Nursing: Assessment and Intervention*. St. Louis: Mosby, Inc., 1991.

The authors stress holistic care for patients from diverse cultures. In addition, they provide a model for cultural assessment, with emphasis on the integration of the biological and social characteristics of patients.

Journal of Western Medicine, Volume 157, Number 3, September 1992. Entire issue devoted to "Cross-Cultural Medicine."

This special issue provides an overview of cross-cultural medicine during the previous decade. It includes articles on issues such as translation, modesty and sexuality, and special health care needs of immigrants.

Julia, Maria. *Multicultural Awareness in the Health Care Professions*. Boston: Allyn and Bacon, 1996.

Each chapter focuses on a specific culture found in the United States. The chapters cover beliefs, practices, and service delivery issues for groups such as African Americans, Arabs, Asians, Hispanics, and Native Americans.

Kerner, J.F., Dusenbury, L., and J.S. Mandelblatt. "Poverty and Cultural Diversity: Challenges for Health Promotion Among the Medically Underserved." *1993 Annual Review of Public Health*, 14, 355-377.

This article investigates the connections between diverse cultures and poverty, and the implications for health promotions programs and management of high-risk and health threatening behaviors.

Okun, Barbara. *Understanding Diverse Families: What Practitioners Need to Know*. New York: Guilford Press, 1996.

This work helps counselors and other mental health providers to understand that the term "family" can reflect many different living situations and the influences of gender, class, ethnicity, and race on individuals and families.

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