



SPARK POLICY INSTITUTE  
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# Health Advocacy Field Assessment

## A Research Report [Executive Summary Only]

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*A Research Report*



**Prepared on behalf of The Colorado Trust  
by Spark Policy Institute**

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As The Colorado Trust explores a field building strategy, one of the first steps is mapping the advocacy field. In this field mapping process, which focused on mapping the health and health equity advocacy fields, the advocates had the opportunity to participate in a survey (made widely available) and an interview (with 30 selected advocates). They were asked about the five dimensions of advocacy fields, as defined in a brief published by The Trust (Beer, Ingargiola, & Beer, 2012). This report shares the findings of the interviews, building on the findings of the survey and integrating many of the examples and ideas shared in previous reports supported by The Colorado Trust. For a list of interviewees, please see Appendix A. The following definitions are used for the five dimensions of field building (Beer, Ingargiola & Lynn, 2013):

- **Field Frame.** A common frame of reference through which organizations identify themselves as a field and as part of a common enterprise.
- **Infrastructure.** The array of advocacy skills needed to make progress on a wide variety of policy issues throughout all stages of the policy processes.
- **Connectivity.** The capacity of different actors to communicate and cooperate in a way that allows skills and resources to be marshaled in increasingly productive ways over time.
- **Composition.** The variety of voices that can participate meaningfully and have influence in the policy process. This may include representing different demographic, socio-economic, geographic, disability and sector interests.
- **Adaptive Capacity.** The ability to conduct sound political analysis, select the tactics best suited for a particular situation, and adapt to the shifting moves of the opposition, allies, and potential allies.

## 1. DEFINING THE FIELD AND ITS FRAME

Based on the results of the interviews, building on the results of the survey, the field as relates to health advocacy in Colorado and the field as relates to health equity in Colorado *may not be one field in current practice*. While the two fields could be seen as one, with a central health advocacy core and a periphery, an equally legitimate choice would be to look at the organizations and see a different advocacy field entirely.

*Table ES-1. Comparing the fields and their frames*

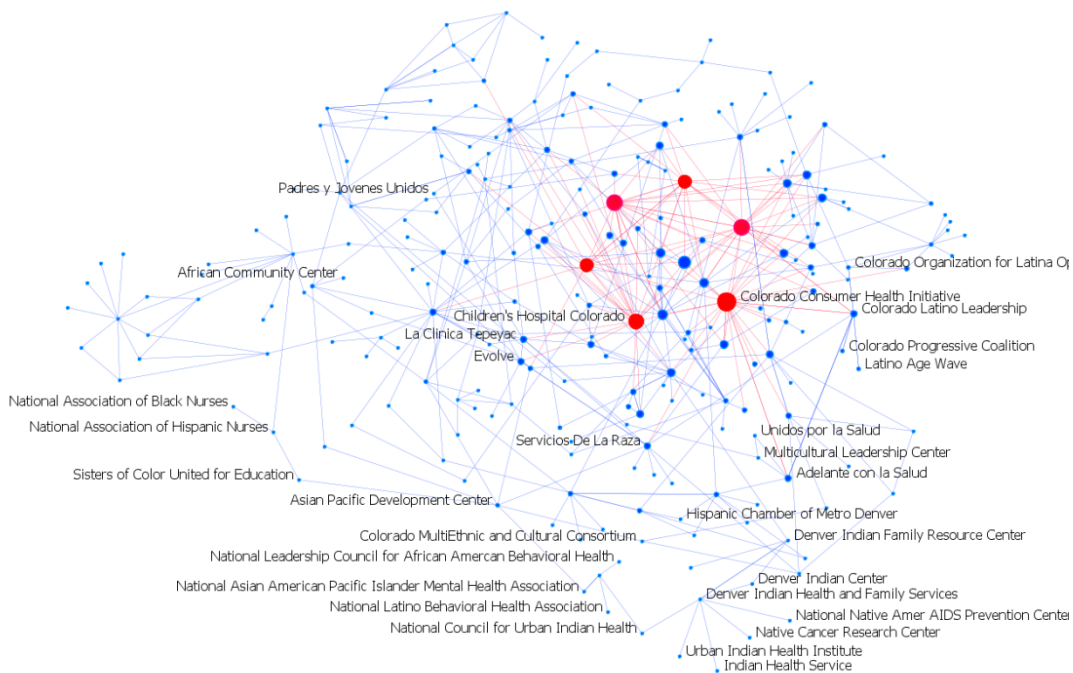
Health Advocacy Field	Equity Field
<ul style="list-style-type: none"> <li>• A strong health advocacy community with leading organizations that play distinct and complementary roles and a broader network of supporting organizations</li> <li>• Defined by the issues of health and healthcare</li> <li>• Prioritizes issues like coverage, quality of care, access to care, and affordability</li> </ul>	<ul style="list-style-type: none"> <li>• Very loosely defined and connected network of organizations that are positioned to build the power and voice of populations experiencing health disparities</li> <li>• Defined by issues of disparities and equity</li> <li>• Prioritizes many issues including health and social issues that affect health and other life outcomes, such as education, income, environment, housing, and food security just to name a few</li> </ul>

A small number of organizations appear to sit in both fields – they have advocacy capacity themselves *and* engage with both the organizations on the periphery and the more mainstream advocates. Additionally, a few of the mainstream advocacy organizations have taken it upon themselves to reach into the equity field and draw upon others in order to achieve their advocacy wins, including CCLP and CCHI.

## 2. NETWORK ORGANIZATIONS

Many advocacy organizations have specific populations as the focus of their work. The organizations focused on advocacy for children are among the most well connected organizations in the network. In contrast, organizations representing people of color are largely outside of the advocacy network (Figure ES-1). The organizations advocating for Native Americans (bottom right of the visual) are very well connected to each other yet fairly isolated from the network as a whole. The organizations advocating for Asian American and African American populations are generally connected to other organizations advocating for people of color, but rarely connected into the main advocacy network. In fact, in order gain access to the main advocacy network, they have to go through other groups who also have narrow advocacy foci. Multi-cultural organizations are also generally isolated, relying on limited connections that fail to reach to the core center of the advocacy network. Organizations advocating for Latinos are scattered throughout the periphery of the network, but a cluster are connected on the right side. This group has direct ties into the core of the advocacy network indicating it has greater involvement with mainstream advocacy organizations.

Figure ES-1



### 3. DIAGNOSING THE STRENGTHS AND WEAKNESSES OF THE FIELD

A field mapping strategy seeks to diagnose the strengths and weaknesses of a field, revealing the opportunities to leverage and issues to overcome as the field is built. This type of mapping informs not only potential funding strategies, but also where to deploy auxiliary resources to build the field.

Dimension	Summary of Findings
Influence over Policy Agenda	<p>Groups with greatest influence include:</p> <ul style="list-style-type: none"> <li>• Executive branch, regulatory system and insurance companies.</li> <li>• Advocates (most often named were CCHI, CCMU, CCLP).</li> <li>• Industry groups (Colorado Hospital Association, Colorado Medical Society).</li> <li>• Funders, including The Colorado Health Foundation and The Colorado Trust.</li> </ul> <p>Within periphery groups, organizations identified as raising the power and voice of Latinos were more likely to be seen as having influence than organizations focused on other populations.</p>
Framing Related to Health Equity	<p>Interviewees described how their organization focuses on health equity through a lens that was more about <i>equitable access to healthcare</i> than social determinants of health. A few organizations within this network have missions that allow for a broader focus than just healthcare were noted as pursuing the issues in siloed ways, rather than bringing them together.</p>
Infrastructure	<ul style="list-style-type: none"> <li>• <i>Organizations on the periphery lack capacity to engage in advocacy. In addition to funding, these groups need an increased understanding of advocacy in order to more fully participate.</i></li> <li>• <i>Shared messaging</i> is needed and there are some examples of it happening. Messages need to be collaboratively developed, relevant to communities of color and more widely translated.</li> <li>• <i>Policymaker education</i> is an area with capacity, but primarily among mainstream advocates. Mainstream advocates reported that a health equity frame would not be useful in this setting. Periphery groups lack the capacity, credibility, influence and access to policymakers.</li> <li>• <i>Grassroots engagement</i> is generally weak with significant disconnects between advocates and the communities they seek to recruit. Mainstream interviewees believe the community is not interested in participating, while periphery organizations reported advocates don't understand race, privilege and how to speak to communities.</li> <li>• <i>Ballot initiatives, voter outreach, and voter canvassing</i> are areas of low capacity and many interviewees are concerned about this as part of successful advocacy is having the right people elected as legislators and there is a need to have communities of color engaged and voting. Where capacity exists, it is primarily among organizations engaging the Latino community.</li> <li>• <i>Public engagement</i> is another area with room for growth with a lack of strategies, challenges with finding the right channels of information sharing, and differences of opinion between mainstream and periphery organizations on how to address the challenges.</li> <li>• <i>Political and policy analysis</i> was identified as largely focusing on coverage and care. The interviewees called for a more visionary analysis to drive policy.</li> </ul>

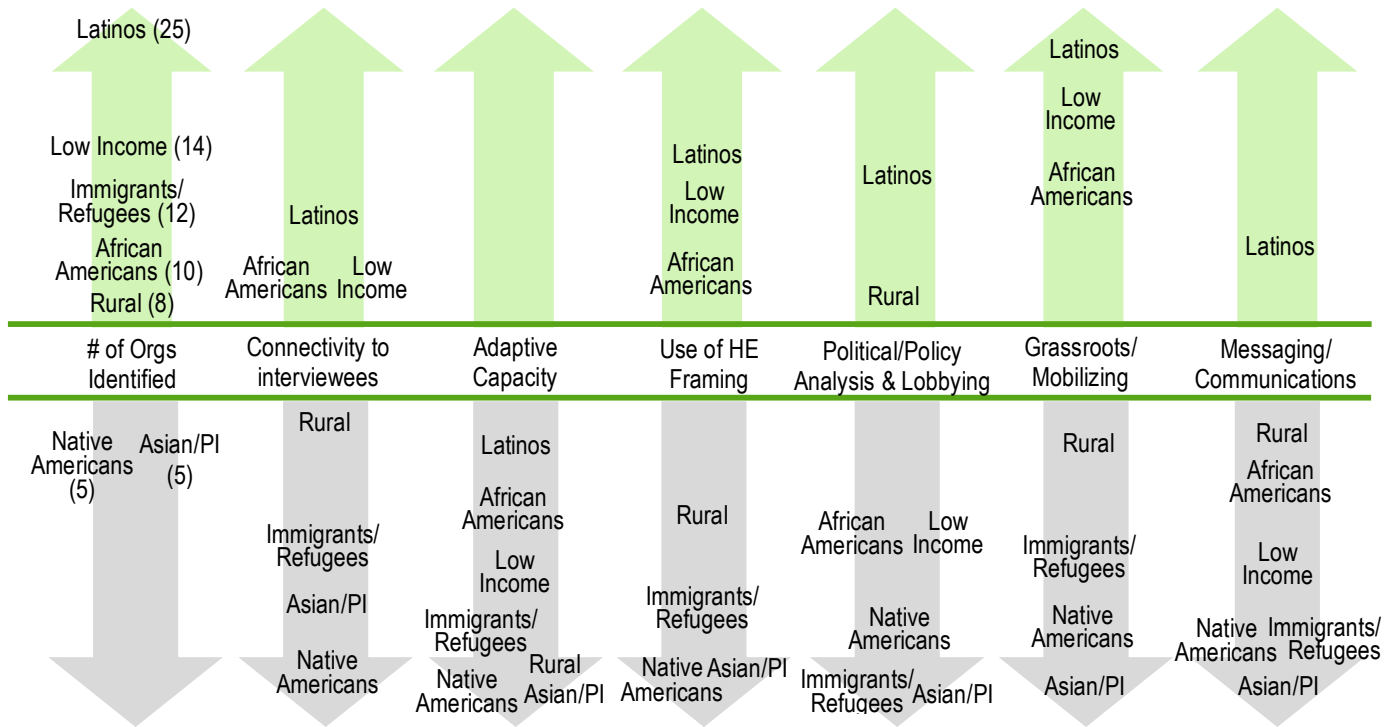
Dimension	Summary of Findings
	<ul style="list-style-type: none"> <li>• <i>Coalitions and partnerships</i> are areas of both strength and greater need. The Civic Engagement Roundtable was highlighted as an example of a partnership, as was Project Health Colorado.</li> </ul>
Connectivity	<p>Connectivity across these different organizations is complex. It is not just a question of whether relationships exist, but when they exist, who initiates them and the perceptions and consequences of the relationships. Barriers to connectivity include:</p> <ul style="list-style-type: none"> <li>• Limited capacity among periphery organizations.</li> <li>• Issue framing.</li> <li>• Lack of mutual understanding about each other’s contexts and disconnects between missions.</li> <li>• Lack of diversity among staff at central advocacy organizations.</li> <li>• Unspoken dynamic of conflicts based on individual personalities and organizational actions.</li> </ul>
Adaptive Capacity	<p>Limited adaptive capacity was reported, with only four organizations being repeatedly identified as having capacity: CCLP, CCC, CCMU and CCHI.</p> <p>Adaptive capacity described as the ability to turn on a dime, transition priorities, have a proactive agenda and ebb and flow as needed.</p>
Composition	<p>Interviewees widely agree that the health advocacy arena is composed of a “sea of white people” and needs to diversify. Individuals are the drivers of the advocacy field, not organizations.</p>

### Strengths and Weaknesses by Population Group

Interviewees were asked which groups are positioned to raise the power and voice of specific populations experiencing health disparities. Overall, more organizations with greater capacity and connectivity were identified related to Latino communities than any other groups experiencing disparities. Organizations raising the power and voice of Native Americans were particularly isolated and low capacity, as were organizations raising the power and voice of Asian American/Pacific Islander communities. Very little adaptive capacity was reported across all the organizations raising the power and voice of different populations experiencing disparities.

While the connectivity, infrastructure, and adaptive capacity were all low, it may be that interviewees lacked sufficient knowledge of some of these communities.

Figure ES-1. Summary of interviewees' perceptions about organizations they believe are building the power and voice of different population groups



#### 4. STRATEGIES FOR BUILDING THE FIELD

As field building is not new in practice, there are example strategies that The Trust can look to as they develop their approaches. Some of these strategies align well with the recommendations and thoughts of the interviewees. Some conflict with the interviewees' feedback and others are outside the range of what interviewees identified as important.

Strategy	Brief Description
1. Changing the set of organizations working to influence the policy domain.	The core of this strategy is to engage organizations in influencing policy that previously were disengaged, either due to a lack of capacity or lack of priority on the issue. Without dedicated and sufficient resources for periphery organizations, participating in advocacy capacity building, much less being active and influential advocates, is unlikely to happen.
2. Changing the set of individuals working to influence the policy domain.	Leadership development strategies have potential not only to diversify the field, but also to develop advocates with key skills, such as adaptive capacity, that are needed in the field more broadly.
3. Engaging the field in developing a common frame focused on health equity.	Field frames are not messages, but rather frames of references that shape how advocates see themselves and others as part of a shared field. The Trust could work with grantees to uncover, expand, and explore the field frame. A framing effort may need to begin with learning before an equity frame is even possible.

Strategy	Brief Description
<p>4. <i>Engaging the field as a whole in opportunities for technical assistance, not just grantees.</i></p>	<p>Technical assistance that is broadly disseminated may allow The Trust to reach more of these organizations than funding alone would permit. However, given capacity issues identified, this strategy might fail to engage some or even many of these organizations if their basic staffing capacity needs are not met.</p>
<p>5. <i>Targeting resources to specific gaps in infrastructure, while building connectivity among just those organizations.</i></p>	<p>Mirroring the recent work of Project Health Colorado, a similar strategy could focus on:</p> <ul style="list-style-type: none"> <li>• Overcoming the capacity gaps among the equity field,</li> <li>• Building a base of advocacy time and skills for multiple organizations.</li> </ul> <p>This approach would allow for a group of periphery advocates to build the capacity to develop their policy priorities together, without the influence of mainstream advocates and their typical strategies.</p>
<p>6. <i>Changing the body of knowledge and experience that advocates draw upon through creating a “hub”</i></p>	<p>While this concept has intuitive appeal – placing the responsibility for building the capacity of the field in an organization outside of the foundation and in one organization, rather than a coalition, which could be messier and slower to move, it may not resonate in the Colorado context due to power dynamics and limited funding for the advocacy field.</p>
<p>7. <i>Changing the body of knowledge and experience that advocates draw upon by providing new information and technical assistance.</i></p>	<p>Mainstream advocates primarily supported continued investment in convenings for learning purposes with some support for funding data strategies. Periphery organizations overwhelmingly supported building skills and capacities of individual organizations to engage in advocacy, building knowledge among the public and policymakers of health disparities, and continuing to fund data strategies.</p>
<p>8. <i>Change the body of knowledge that advocates draw upon by providing assistance to the field to develop and deploy shared messaging.</i></p>	<p>Developing a shared message by:</p> <ul style="list-style-type: none"> <li>• Bringing organizations together to develop it;</li> <li>• Focusing on accessible language that the public will understand;</li> <li>• Using data and evaluation to guide message development;</li> <li>• Focus the content of the message on communities, not what funders want; and</li> <li>• Create messaging that resonates with diverse groups.</li> </ul>
<p>9. <i>Changing how the advocates connect and interact through convenings.</i></p>	<p>Developing a convening strategy that has some combination of learning, relationship building, and taking action together. Consider using different convening approaches with different participants over time as the field is built.</p>
<p>10. <i>Changing how the advocates connect and interact through strategic use of short-term transactional campaigns.</i></p>	<p>Based on the belief that engaging advocates in a shared strategy will help them to build new habits of interaction. Only encouraged by mainstream advocates, which may suggest a lack of readiness among periphery advocates to undertake specific policy priorities before their capacity is higher.</p>



Strategy	Brief Description
<i>11. Changing how the advocates connect and interact by funding collaborations and coalitions, not individual grantees.</i>	Requiring or creating strong incentives for collaboration. This strategy may be premature or may, at least, require some careful thought in order to ensure the less influential organizations are full partners in the collaborations.
<i>12. Design funding mechanisms to support adaptation.</i>	Consider general operating support, multiyear funding, and rapid turnaround funding to allow for greater adaptivity in advocacy organizations.
<i>13. Supporting advocates to lead the development of a field building strategy.</i>	Overcome hesitations about intentions behind the process and long-term disconnects between funders and communities of color by engaging advocates in the process of developing the strategy. It may also help with some of the dynamics of distrust and dislike among advocates in the field.
<i>14. Actively engaging in building the framing, connectivity and even adaptivity and composition of the field of health advocacy and equity funders.</i>	Convene the foundation community to talk about what was learned in the mapping and develop aligned strategies for building the advocacy field or fields. Work together to build connectivity and adaptive capacity among the funders.

## 5. DEPLOYING AND SEQUENCING STRATEGIES

The decisions about how to define the field, deploy the strategies, and sequence the strategies are just as important as which strategies to deploy. With each choice made, The Trust will be shifting the power dynamics within the field and causing both intended and unintended consequences. This would be true of any funding strategy and certainly of any funding strategy in advocacy. What is different is that the focus on field building creates an opportunity for funding strategies to be designed with awareness about the way that funding choices will influence an entire field, not just an organization or small subset of organizations.

Deployment choices, such as the types of capacity to build, when to engage advocates, whether to do connectivity strategies before or after capacity strategies, whether The Trust is part of the field or a neutral convener, etc. will have significant impacts on the outcomes. The possible consequences of these types of decisions include the extent to which advocates buy in to the strategy, whether capacities are developed in isolation or in a field context, the extent to which policy priorities continue to be driven by mainstream advocates rather than by periphery groups, and the overall power dynamics of the field.

## 6. NEXT STEPS

Although this report highlights many strategies and opportunities, a some key decisions must be made before any of the strategies can be designed, including the desired outcomes of the strategy, the definition of the field, the identification of who needs to be involved in developing the funding strategy and at what point, and the time horizon for building the field.

Once the strategy is more fully designed, whether in partnership with advocates and other funders or largely by The Trust's staff and leadership, in addition to implementing the strategy, an evaluation will be needed. Questions to explore include which dimensions are priorities for the Trust and given those, what evaluation strategies can provide the most useful information; the extent to which real-time information will be useful; and how advocates will be involved in the evaluation.

As The Trust seeks to answer these questions, there are many funders nationally that have gone through a similar process – mapping, defining a strategy, implementing and evaluating. An opportunity exists to learn from these funders about what has worked for them as well as what they would have done differently.

## REFERENCES

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- Beer, T., Ingargiola, P.S., and Lynn, J. (2013). *Field building in advocacy: Framing the 2013 Dialogue*. Prepared by behalf of The Center for Evaluation Innovation for the 2013 Field Building in Advocacy Convening.

## APPENDIX A

Thank you to the interviewees for their participation in this project:

- Dr. Jandel Allen-Davis, Vice President of Government and External Relations, Kaiser Permanente Colorado
- Elisabeth Arenales, Director, Health Program, Colorado Center for Law and Policy
- Heidi Baskfield, Executive Director of Advocacy, Strategy and External Affairs, Children's Hospital Colorado
- Cody Belzley, Vice President of Health Initiatives, Colorado Children's Campaign
- Kelly Brough, President and CEO, Denver Metro Chamber of Commerce
- Wade Buchanan, President, The Bell Policy Center
- Monica Buhlig, Director of Basic Human Needs, Denver Foundation
- Brad Clark, Executive Director, One Colorado
- Whitney Connor, Senior Program Officer – Health; Janet Lopez, Program Officer – Education; and Elsa Holguin, Senior Program Officer - Child & Family Development; Rose Community Foundation
- Deborah Costin, Executive Director, Colorado Association for School-Based Health Care
- Denise (Dede) de Percin, Executive Director, Colorado Consumer Health Initiative
- Corrine Fowler, Economic Justice Director, Colorado Progressive Coalition
- Kelli Fritts, Associate State Director for Advocacy, American Association of Retired Persons
- Jim Garcia, Executive Director, Clinica Tepeyac

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- Rudy Gonzales, Executive Director, Servicios de La Raza
- Gabriel Guillaume, Vice President of Community Investments, LiveWell Colorado
- Gretchen Hammer, Executive Director, Colorado Coalition for the Medically Underserved
- Alicia Haywood, Policy and Advocacy Manager, Colorado Rural Health Center
- Nita Henry, Executive Director of Career Service Authority, City and County of Denver and Founder/Director of The Kaleidoscope Project
- Susan Hill, Vice President of Programs, Caring for Colorado Foundation
- John Jewett, Behavioral Health Supervisor, Denver Indian Family Resource Center
- Moe Keller, Vice President for Policy, Mental Health America of Colorado
- Ashlin Malouf-Spinden, Associate Director, Together Colorado
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- Olivia Mendoza, Executive Director, Colorado Latino Leadership, Advocacy and Research Organization
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- Mauricio Palacio, Director, Office of Health Equity, Colorado Department of Public Health and Environment
- Kathy Underhill, Executive Director, Hunger Free Colorado
- Lisa VanRaemdonck, Executive Director, Colorado Association of Local Public Health Officials and The Public Health Alliance of Colorado
- Christine Wanifuchi, Chief Executive Officer, Asian Pacific Development Center