Research-Informed Community Organizing Model Helps to Assess and Address Needs of Rural Immigrants in Colorado

WHY WE DID THIS STUDY

Due to long-standing systemic and structural barriers, Colorado’s immigrants, particularly undocumented immigrants, face limited health insurance coverage and a myriad of negative patient experiences. For those living in rural Colorado, these challenges are exacerbated by a more fragmented health care and social system, and by greater workforce deficiencies, such as limited or non-existent bilingual health care staff and limited access to diagnostic services, dental, behavioral and specialty care. In the face of a pandemic like COVID-19, inequities in coverage and reach are further exacerbated.

Addressing the health care needs of immigrants is challenging because of heterogeneity in federal, state, and local policies that unjustly target immigrants of color; in specific health care system characteristics; and in individuals’ personal contexts and health care needs. Available interventions to remove barriers include advocacy for health care policy change, as well as for non-health care policies related to health care.

Within the health care system, eliminating inequities in access and quality of care requires an examination of the institutional policies and practices that limit immigrants’ rights, resources, and sense of security. Understanding the sources of inequities to guide health systems improvement can only be accomplished through multilevel strategies that engage policy makers, health care systems, providers, and, most importantly, immigrant communities. Putting immigrant communities at the center of change efforts is necessary not only to understand their needs but also to identify and build on their strengths and lived experience.

Although a growing body of evidence underscores the contributions of community-engagement approaches to addressing health equity, one of the most powerful forms of engagement—community organizing—has attracted less attention in health research. Community organizing relies on building a broad base of organized people aligned around common values, priorities, and demands. Typically, even in projects with the best community engagement structures, institutions hold power over community members. A community organizing approach flips this power dynamic by building power in the community first, and engaging research, political, and health care systems from that place of power to effect change. The objective of this study was to understand how research-informed community organizing can serve as a model to build community power, identify immigrants’ health care needs, and ultimately address social and structural barriers to health care. This brief describes how formal research mechanisms served a community organizing strategy both before and during the COVID-19 emergency, identifying the factors that both facilitated and impeded the use of formal/traditional research.

KEY FINDINGS

- Research-informed community organizing was effective in identifying and addressing immigrants’ needs, while building trust, relationships, community capacity, and a larger organized base.
- A community organization’s maturity, institutional flexibility (e.g., funding, academy support, IRB); and researchers’ and staff’s learning dispositions are critical to partnership success.
- Barriers to partnerships include timing and pace of research, and a mismatch between the collection and reporting of data and community organization needs.

Support for this project was provided by a grant from the Robert Wood Johnson Foundation Interdisciplinary Research Leaders program. Interdisciplinary Research Leaders is a national program of the Robert Wood Johnson Foundation led by the University of Minnesota. The views expressed here do not necessarily reflect those of the Foundation or the University of Minnesota.
Figure 1. Locally Generated and Managed Data Helps Meet Downstream Immigrant Community Needs and Informs Health Care Access Advocacy

HOW WE DID THIS STUDY

The work described here is the result of a collaborative research partnership led by a Colorado statewide organization, Center for Health Progress (CHP). CHP builds power to win recognition, rights, and resources for its communities to realize health equity. It has community organizers (COs) on the ground in Fort Morgan, a rural community on the Eastern Plains, and in Pueblo, a small urban center in Southern Colorado.

Prior to the onset of the COVID-19 pandemic, a group of CHP-affiliated local community leaders (CLs) interviewed 47 members of the Mexican and Somali immigrant populations in Fort Morgan about their health and social care needs. The researchers met with the CHP’s local CO and CLs in advance to define research goals and methods, and to provide training on human subjects’ research, interview techniques, recruitment, and data collection. The researchers analyzed the data collected by CLs and shared initial findings with the CO and CLs. Next, the CO shared these findings in small house meetings, hosted by community members, to identify priority issues for which to develop interventions. The CO was in the midst of sharing findings via house meetings when the COVID-19 pandemic hit. The resulting health, economic and social crises, as well as social distancing requirements, necessitated a strategy shift.

Consequently, from March to December 2020, CHP initiated data collection through a phone tree outreach approach. The approach allowed CHP to actively communicate with immigrants and ascertain their needs regarding COVID-19, health care access, and the policies necessary to facilitate an inclusive and equitable recovery in Colorado. The topics of each phone tree were determined by CHP’s COs, CLs and policy team, based on local need and state legislative initiatives. CLs, already engaged with CHP’s work before the onset of the COVID-19 pandemic, were trained by COs to conduct the outreach. Outreach recipients were identified by formal snowball sampling and direct referrals based on need. Through the effort, CLs reached 330 immigrants: 106 in Fort Morgan and 224 in Pueblo. CLs used a questionnaire designed for the specific phone tree round, which was available in English and Spanish, and consisted of closed- and open-ended questions. Researchers provided support by obtaining human subjects approval, aiding questionnaire design, and rapidly compiling data analysis reports in English and Spanish after each round of data collection.

The data collected was used to connect community members with general resources (e.g., food banks, rent assistance); to facilitate access to health care (e.g., providing support to enroll and understand Medicaid, or to access testing and vaccination); to enroll eligible families in Pandemic Electronic Benefits Transfer; and to launch a relief fund for individuals with significant needs. Each CL established bidirectional communication with members of their phone tree, increasing their individual outreach from 10 to up to 50
people. In addition, the number of CLs leading phone trees increased from 10 to 18, expanding CHP’s community base.

Phone tree reports were ultimately shared by COs with CLs and with CHP’s policy team.

**WHAT WE FOUND**

Figure 1 describes how locally generated and managed data, with the support of the researchers, was paired with CHP’s community organizing and policy advocacy strategy. Both CLs and COs are members of the local immigrant communities. Data collected by CLs supported CHP’s communication with state legislators and state health agency representatives about the urgent needs of immigrant groups during the COVID-19 emergency.

The data were also presented to the Colorado Department of Health Care Policy and Financing, ultimately contributing to the securing of Emergency Medicaid (EM) expansion to this population to include COVID treatment, including respiratory therapies and two outpatient follow-up appointments. Data also informed continued implementation advocacy to ensure the effectiveness of EM program expansion.

Research centered on a community organizing model, like the work described here, is still novel and only possible when supported by adequate resources. We identified factors that can facilitate research partnerships with community organizing efforts (Table 1). A primary facilitator is the participation of mature community organizations with well-organized staff who have deep roots in their communities. Another facilitator is institutional flexibility, including funders open to adapting methods and goals, universities open to rewarding this type of work for researchers, and Institutional Review Boards (IRB) with a clear understanding of how to recruit effectively marginalized populations, while protecting their rights, safety and welfare. Other facilitators include capacity building and culturally responsive training for CLs participation in research; and researchers open to learning about community organizing and flexible in adapting their data collection and reporting pace.

We also identified barriers that need to be addressed to continue growing these kinds of collaborations. Overall, the time and pace of traditional research must be adapted to community organizing needs. Our experience made evident that traditional data collection methods and recruitment (e.g., key informant interviews) do not adapt well to community organizing-specific relationship building. The latter require many bi-directional interpersonal contacts, rather than a more traditional one-time, primarily one-directional contact. We also identified the need for continuous refinement of rapid data analysis and feedback methods. Waiting until data collection is complete for analysis and reporting breaks the momentum crucial to community participation.

**WHAT THESE FINDINGS MEAN**

While our findings are not directly generalizable to other immigrant communities, we hope these lessons facilitate the scaling of these methods and strategies to other communities. In general, institutional support of research-informed community organizing will promote continuous improvement of data collection and analysis methods, better suited to the structure and pace of organizing efforts; community organizers’ and leaders’ research capacity building; and mature partnerships, which will be ready to respond to immediate community needs in times of crisis and to use their power to advocate for policies to realize health equity.

We are grateful to community leaders, as well as to community organizers Perla Rodriguez and Yesenia Beascochea; Director of Community Organizing, Theresa Trujillo; and Maggie Gómez, who provided organizing and policy expertise.

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**ABOUT THE AUTHORS**

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**Table 1. Facilitators and Barriers of Community-Led Research Partnerships**

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<thead>
<tr>
<th>Facilitators</th>
<th>Barriers</th>
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<tr>
<td>• Mature, well-organized community-grassroots organization</td>
<td>• Timing and pace of research</td>
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<tr>
<td>• Institutional support (funders, universities, IRB)</td>
<td>• Methods of data collection and data analysis that do not respond to community organizing needs (i.e., continuous relationship building, growing momentum)</td>
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<td>• Culturally responsible capacity building (e.g., human subjects, recruitment, and data collection training)</td>
<td>• Lack of common language among researchers and community organization</td>
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<td>• Collaboration, growth and learning mindset of researchers and community organization staff</td>
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